

OPUS2

Manchester Arena Inquiry

Day 2

September 8, 2020

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1 Tuesday, 8 September 2020
 2 (9.00 am)
 3 SIR JOHN SAUNDERS: Mr Greaney.
 4 Opening statement by MR GREANEY (continued)
 5 MR GREANEY: Sir, thank you. At the end of yesterday we
 6 provided a brief introduction to chapter 10. We
 7 anticipate that we'll deal with most of that chapter
 8 today, but we do not expect to conclude it. At the
 9 outset of today we will set out the structure of what we
 10 propose to say about the emergency response in this
 11 opening statement. It will be in four broad parts.
 12 In part 1 we will provide a brief introduction to
 13 some of the terms and concepts that will be used
 14 extensively in the course of the evidence in chapter 10,
 15 namely, first, the levels of command that are expected
 16 to deploy in response to an incident such as the
 17 Manchester attack, known by the police as
 18 Gold Commander, Silver Commander and Bronze Commander.
 19 Second, we'll deal with what is meant by JESIP and,
 20 moreover, what JESIP should involve. Third, with what
 21 is meant by a major incident. Fourth, with what is
 22 meant by Operation Plato, and fifth, the concept of
 23 primacy, that is to say whether GMP or BTP had principal
 24 responsibility for preparing for and responding to an
 25 attack at the arena.

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1 We don't pretend that we'll be providing detailed or
 2 definitive definitions of terms such as JESIP at this
 3 stage; that will be for the expert witnesses when they
 4 give evidence. Instead, we're simply seeking at this
 5 point in time to make what we say in the balance of this
 6 opening statement comprehensible.
 7 In part 2 we will deal with some general evidence
 8 about the role of the Greater Manchester Resilience
 9 Forum in planning for the response to a terrorist
 10 attack. We will explain what a local resilience forum
 11 is and what it should do. We will identify also the
 12 issues that arise for the inquiry to consider in respect
 13 of the Greater Manchester Resilience Forum, which we'll
 14 refer to as GMRF.
 15 In part 3 we will provide an overview of the
 16 emergency response on the night. We will introduce
 17 a document called "the sequence of events" that will
 18 enable us to identify the moment at which particular
 19 first responders arrived at the scene. This document
 20 contains some still images taken from the CCTV footage.
 21 Some of those stills will be shown on the screen along
 22 with parts of the CCTV itself, although not much of the
 23 latter.
 24 We don't anticipate that we will show any
 25 distressing images on the screen during this part of our

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1 opening. If there is any chance of that, we'll give
 2 a warning and an opportunity for anyone who wishes to
 3 leave the room or turn away from their screen to do so.
 4 In part 4 of this opening statement on chapter 10,
 5 we will turn to address the role of each emergency
 6 service in turn. We will deal with the preparedness of
 7 each service for an attack of the sort that occurred
 8 at the arena, what the experts consider went right and
 9 what they conclude went wrong, setting out in summary
 10 what each service did when it arrived.
 11 We will deal also in summary with the lessons that
 12 each service considers it has learnt from the events of
 13 22 May.
 14 Pausing for just one moment, there are three short
 15 further points to make about part 4 of the opening
 16 statement on chapter 10.
 17 1. We will be dealing with the emergency services
 18 in the order in which they arrived in the City Room, by
 19 which we mean the point at which a representative of the
 20 particular organisation entered that area.
 21 2. Although not formally emergency services,
 22 we will also deal in our opening of this chapter with
 23 the involvement of Emergency Training UK, that is to say
 24 ETUK, and the station staff from Northern and
 25 Network Rail.

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1 3. The focus of chapter 10 will principally be on
 2 the period up to midnight.
 3 We will turn now, having provided that structure, to
 4 deal with the terms that will be used extensively in the
 5 course of the evidence and indeed in the course of this
 6 opening statement. In other words, we're turning now to
 7 deal with part 1 of chapter 10.
 8 First then, levels of command. This can be dealt
 9 with shortly. Witnesses will refer extensively to the
 10 terms Gold, Silver and Bronze Commander. Formally, the
 11 levels of control are: strategic, which equates with
 12 Gold; tactical, which equates with Silver; and
 13 operational, which equates with Bronze.
 14 The position is, as we currently understand it, that
 15 Gold, so strategic, issues strategy and approves the
 16 tactical plan; Silver, so tactical, develops implements
 17 and directs the tactical plan; and Bronze, so
 18 operational, implements direction from Silver on the
 19 ground. This will all be explained in more detail by
 20 the policing experts and will be developed as we look in
 21 detail in this opening statement at the actions of each
 22 emergency service on the night.
 23 Next, JESIP. By using the term JESIP we mean the
 24 Joint Emergency Services Interoperability Programme, as
 25 it was known until 2015, or Joint Emergency Services

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1 Interoperability Principles as it was known from 2015.
 2 But in either case, we will not distinguish during the
 3 course of this opening statement, but instead refer just
 4 to JESIP.
 5 JESIP will be referred to repeatedly as we begin to
 6 delve into the response of each emergency service.
 7 JESIP will be explained by the policing experts when
 8 they give their overview evidence at the beginning of
 9 the oral evidence hearings on chapter 10. But it's
 10 important that we should summarise the position at this
 11 stage so that what we say in our opening statement makes
 12 sense.
 13 JESIP was established in 2012 with the aim of
 14 improving interoperability between the emergency
 15 services. It established a set of apparently simple
 16 principles designed to achieve that aim. So we will
 17 place on the screen a diagram from the overview report
 18 of the policing experts. This is figure 8
 19 {INQ024271/54}.
 20 The principles designed to achieve the aim of
 21 improving interoperability are co-locate, that is to say
 22 co-locate with commanders as soon as practicably
 23 possible at a single, safe and easily identified
 24 location near to the scene.
 25 Communicate, that is to say communicate clearly

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1 using plain English.
 2 Coordinate, that is to say coordinate by agreeing
 3 the lead service and identify priorities, resources and
 4 capabilities for an effective response, including the
 5 timing of further meetings.
 6 Jointly understand risk, that is to say jointly
 7 understand risk by sharing information about the
 8 likelihood and potential impact of threats and hazards
 9 and to agree potential control measures.
 10 Shared situational awareness, in other words, shared
 11 situational awareness should be established by using
 12 what are known as METHANE and the joint decision model.
 13 We can take that from the screen, Mr Lopez.
 14 Situational awareness, to which we've just referred,
 15 is the idea that the emergency services should have
 16 a common understanding of the circumstances, immediate
 17 consequences and implications of the emergency that they
 18 are concerned with, along with an appreciation of the
 19 available capabilities and priorities of those emergency
 20 services. As we have just said, JESIP refers to
 21 a concept known as METHANE. Again, we can put on the
 22 screen a diagram from the report of the police experts.
 23 This is figure 9, please, Mr Lopez {INQ024271/57}.
 24 We don't wish to descend into too much detail at
 25 this stage, but METHANE is an acronym and it stands for:

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1 M, major incident. Has a major incident or standby
 2 been declared?
 3 E, exact location. What is the exact location or
 4 geographical area of the incident?
 5 T, type of incident. What kind of incident are we
 6 dealing with?
 7 H, hazards. What hazards or potential hazards can
 8 be identified?
 9 A, access. What are the best routes for access and
 10 egress?
 11 N, number of casualties. How many casualties are
 12 there and what conditions are they in?
 13 E, emergency services. Which, and how many,
 14 emergency responder assets and personnel are required or
 15 are already on scene?
 16 Later on, during the course of this morning or this
 17 afternoon, we will hear an actual example of a METHANE
 18 message from the night of 22 May.
 19 The joint decision model, or JDM, referred to within
 20 JESIP in the context of situational awareness, is
 21 designed do enable commanders to collate jointly all
 22 available information with a view to making decisions.
 23 Could we have figure 10, please, on the screen?
 24 {INQ024271/60}
 25 The central principle is that people work together

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1 to save lives and reduce harm. The importance of that
 2 principle in the context of the Manchester Arena attack
 3 is obvious. The bombing cried out for an effective,
 4 coordinated response. The joint decision model goes on
 5 to describe a number of stages.
 6 First, gathering information and intelligence.
 7 Second, assessing risk and developing a working
 8 strategy.
 9 Third, considering powers, policies and procedures.
 10 Fourth, identifying options and contingencies.
 11 Fifth, taking action and reviewing what happened.
 12 It's by reference to JESIP, METHANE and JDM that the
 13 inquiry will hear evidence about the response of the
 14 emergency services on the night of the bombing and make
 15 its judgments about that response.
 16 That then is a very brief introduction to JESIP and
 17 we will learn much more about it during the evidence
 18 itself.
 19 Mr Lopez, we can take the diagram from the screen,
 20 please.
 21 Without seeking in any way to make a prejudgment,
 22 the evidence gathered by the inquiry to date suggests
 23 that the JESIP principles may not have been applied, at
 24 least not adequately, in the aftermath of the
 25 Manchester Arena attack, including within the various

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1 control rooms of the emergency services. The inquiry
2 will need to consider whether that is so, and, if it is,
3 why that occurred and whether life was lost as a result
4 of any failure.

5 As is beyond obvious, even the loss of a single life
6 due to such a failure would be completely unacceptable.
7 If there was a failure, whether causative of death or
8 not, the inquiry will need to identify what should be
9 done in order to prevent such a failure in the future.

10 We will also hear reference in the course of the
11 evidence to the term "major incident". Indeed, we've
12 mentioned it already because that term is the M in
13 METHANE. JESIP defines a major incident as:

14 "An event or situation with a range of serious
15 consequences which requires special arrangements to be
16 implemented by one or more emergency responder agency."

17 Declaring a major incident triggers a predetermined
18 strategic and tactical response from each emergency
19 service and other responder agencies, or should do so.
20 It takes time for operational structures, resources and
21 protocols to be put in place and declaring that a major
22 incident is in progress as soon as possible means that
23 these arrangements can be put in place as quickly as
24 that can be achieved.

25 Next, Operation Plato. This term too will be used

1 extensively during the course of the opening statement
2 on chapter 10 and during the course of the evidence
3 in that chapter. Again, therefore, we'll provide
4 a brief introduction to what Operation Plato is.

5 Following the coordinated terrorist attacks in
6 Mumbai by an Islamist terrorist organisation in
7 November 2008, the authorities within the UK conducted
8 a major review of their planning, preparedness and
9 response to what had occurred in Mumbai, namely
10 a marauding terrorist firearms attack, or as we said
11 yesterday, an MTFA.

12 Thereafter, Operation Plato became the national
13 identifier for such an attack. The first edition of
14 Operation Plato was published in 2012 and was thereafter
15 updated.

16 An MTFA is obviously an extraordinary event placing
17 very significant demands upon the resources of the
18 emergency services. It had been recognised for years
19 prior to the Manchester Arena attack that the emergency
20 services needed a well-briefed and rehearsed plan for
21 dealing with such an event, with clarity of roles and
22 responsibilities having been identified pursuant to
23 plans.

24 By May 2017, it was well understood within the
25 emergency services that the early identification of

1 an MTFA and the rapid implementation of an appropriate
2 joint response in accordance with the JESIP principles
3 was crucial to protecting the lives of both members of
4 the public and responders.

5 The answer given to the questions posed by such an
6 incident was that in the event of an MTFA the local
7 police force should declare Operation Plato, which would
8 then generate, or should generate, a structured and
9 coordinated multi-agency response. Once Operation Plato
10 had been declared, that should be shared immediately
11 with the control rooms of all other emergency services.
12 A proper command structure should then be put in place
13 with different zones designated as hot, warm and cold
14 depending upon the threat in a particular area.

15 A hot zone is a zone in which live terrorist
16 activity is occurring into which only suitably trained
17 and equipped police firearms officers should advance in
18 order to prevent the terrorist activity.

19 A warm zone is an area in which active terrorist
20 activity has stopped but which cannot be guaranteed to
21 be safe because, for example, an improvised explosive
22 device, or IED, may be present and into which
23 multi-agency specialist teams, trained and equipped to
24 operate within such an area, may be deployed to treat
25 and/or evacuate casualties.

1 A cold zone is an area where active terrorist
2 activity has stopped and into which non-specialist
3 responders may be deployed.

4 These three designations of area will be of
5 relevance to our analysis of the decisions of the
6 emergency responders on 22 May.

7 On 22 May, Operation Plato was declared by an
8 officer of Greater Manchester Police, namely
9 Inspector Dale Sexton. He did so at 10.47 pm,
10 16 minutes after the bomb had been detonated by
11 Salman Abedi. The inquiry will need to consider whether
12 that declaration was correct, whether it was
13 communicated to other emergency services, and, if so,
14 whether it was communicated at the right time and
15 whether it was maintained for an appropriate period of
16 time. Only the police can cancel Operation Plato.

17 Neil Basu is now an assistant commissioner with the
18 Metropolitan Police Service and is currently the
19 assistant commissioner specialist operations, ACSO,
20 which includes command for the SO15 counter-terrorism
21 command. He will give evidence to the inquiry in
22 chapter 10 to explain the structure for
23 counter-terrorism policing within the UK. It is not
24 necessary to describe that at this stage, but it is
25 relevant to note that he will address a review that was

1 undertaken of Operation Plato at a national level as
 2 a result of the events in Manchester.
 3 Furthermore, as it happens, on 22 May, Neil Basu was
 4 a deputy assistant commissioner and the senior national
 5 coordinator for counter-terrorism policing as it was
 6 then known. That means that it was his job to assume
 7 national strategic command of the events in Manchester
 8 and the investigative response to that attack. In
 9 evidence, he will describe the steps that he took on
 10 becoming aware that the Manchester Arena attack had
 11 occurred.
 12 We will turn next to the issue of primacy. The
 13 freehold for the arena and City Room was owned by
 14 Network Rail. As a result, by reason of section 31 of
 15 the Railways and Transport Safety Act 2003, the
 16 City Room was within the jurisdiction of British
 17 Transport Police. In this context, the word
 18 "jurisdiction" means the parts of the country in which
 19 BTP officers have powers to operate as a constable. In
 20 other words, BTP had jurisdiction within the City Room.
 21 Unlike BTP, GMP officers, as officers of what is
 22 termed a Home Office force, are not similarly
 23 circumscribed in terms of their jurisdiction. They have
 24 the powers of a constable generally. The consequence
 25 is that they had jurisdiction in the City Room as well

1 as BTP.
 2 Accordingly, given that both BTP officers and GMP
 3 officers have jurisdiction to operate in the City Room,
 4 the question arises of which organisation would take the
 5 lead for the policing of that area. This question can
 6 neatly be described as the issue of primacy.
 7 On 22 May 2017, the understanding between both
 8 organisations, as is agreed by each of them, as we
 9 understand it, was that BTP had primacy in relation to
 10 any property in which they have jurisdiction. So,
 11 because BTP has jurisdiction in the City Room, by this
 12 agreement primacy rested with BTP and, as such, BTP had
 13 responsibility for leading the policing of that area,
 14 namely the City Room.
 15 It may be, and we will need to explore whether this
 16 is so, that there was an exception to this general rule,
 17 namely in relation to the response to terrorist
 18 incidents in relation to which GMP would have primacy.
 19 Whether there was such an exception, and if so whether
 20 in theory or in practice and how it was expected to work
 21 in response to any given event will be matters for this
 22 inquiry to investigate.
 23 Counsel to the inquiry consider that the issue of
 24 primacy is an important one. It is important because
 25 BTP's principal expertise is in the policing of the

1 railways. Its jurisdiction in relation to the City Room
 2 and arena is purely by dint of the fact that the
 3 freehold of the arena is owned by Network Rail.
 4 Ordinarily, such large scale public entertainment
 5 venues -- and the arena was one of the largest such
 6 venues in Europe, as we have said -- would be policed by
 7 the Home Office force, in this case GMP. So there is to
 8 be a legitimate question about whether it was
 9 appropriate and/or whether it gave the best protection
 10 to the public that it was the police specialising in the
 11 railways, namely BTP, that took the lead for all events
 12 which took place in the arena, rather than the local
 13 force, namely GMP.
 14 To take just one consequence of the fact that BTP
 15 had primacy, GMP did not know at an organisational level
 16 of the Ariana Grande concert and had not made any
 17 provision or plan for the concert that night. On the
 18 face of it, that may seem surprising and serves to
 19 emphasise why this issue, the issue of primacy, demands
 20 investigation.
 21 The inquiry will therefore need to investigate
 22 a number of matters related to the issue of primacy.
 23 These include:
 24 1. The nature of the agreement which existed
 25 between the two forces and how it was defined, where it

1 was documented and where it appeared in plans. In this
 2 regard, as we shall see, the fact that there had been
 3 a recent multi-agency exercise, which included the
 4 City Room, namely Operation Sherman, to which we'll
 5 refer again in a few moments, may be a relevant
 6 consideration when it came to whether there was a real
 7 opportunity to give this issue, the issue of primacy,
 8 close consideration prior to the attack and, if so,
 9 whether both organisations seized that opportunity.
 10 2. What the understanding of the issue of primacy
 11 was amongst the commanders of both BTP and GMP, and
 12 amongst those officers who were on the ground.
 13 Regardless of what formal agreements may have existed
 14 between the two organisations, the understanding by
 15 those charged with planning for and responding to an
 16 incident such as occurred on 22 May is also
 17 a significant area for investigation. In this regard,
 18 whether there was a confusion when describing primacy,
 19 such as by the use of the word "jurisdiction" when what
 20 is meant is primacy, will also fall for consideration.
 21 There are for example repeated assertions within the BTP
 22 radio traffic at an early stage that BTP
 23 had "jurisdiction". The inquiry will need to consider
 24 whether this had consequences on the night and, even if
 25 it did not, whether things can be done better in the

1 future, both at the arena and more generally throughout
2 the country.

3 3. Whether the understanding of primacy had any
4 effect on the preparedness of either GMP or BTP for the
5 attack.

6 4. Whether the issue of primacy had any effect on
7 the response of either BTP or GMP.

8 As we have indicated, flowing from what we have just
9 identified, there may be important lessons for the
10 future about sites which give rise to the same or
11 similar issues across the country.

12 That's the end of what we have to say about part 1
13 of chapter 10, the definition of terms. We will turn
14 next to deal with the role of the Greater Manchester
15 Resilience Forum. This is chapter 10, part 2.

16 The Civil Contingencies Act of 2004, together with
17 other measures, provide a framework for civil protection
18 in the United Kingdom. The 2004 Act deals with
19 emergencies. It contains a detailed definition of an
20 emergency and, entirely unsurprisingly, that definition
21 includes a terrorist attack such as occurred at the
22 Manchester Arena.

23 The 2004 Act divides those who respond to an
24 emergency into two distinct categories: category 1
25 responders and category 2 responders.

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1 Category 1 responders are local authorities,
2 emergency services, NHS bodies, including ambulance
3 services, and various others of no relevance to this
4 inquiry. They have the full set of civil protection
5 duties. By section 2 of the Act they're required, among
6 other things, to assess the risk of an emergency
7 occurring and maintain plans for the purpose of ensuring
8 that if an emergency occurs, the responder is able to
9 perform its functions:

10 "... so far as necessary or desirable for the
11 purpose of reducing, controlling or mitigating the
12 emergency's effects".

13 Category 2 responders, so far as relevant to the
14 inquiry, include railway operators. They have a lesser
15 set of responsibilities than category 1 responders,
16 principally requiring them to cooperate and share
17 information with category 1 and other category 2
18 responders.

19 The emergency services experts will provide
20 a detailed explanation of what emergency planning under
21 the Act really means in their view. What we intend to
22 do at this stage is provide no more than a summary to
23 aid understanding. It is, as with everything we've said
24 and will say in this opening statement, subject to the
25 evidence that will be heard over the next number of

18

1 months.

2 The Civil Contingencies Act 2004, the contingency
3 planning regulations of 2005, require category 1
4 responders to cooperate with each other and with
5 relevant category 2 responders in connection with the
6 performance of the duties under section 2 of the Act, to
7 which we've just referred. Regulation 4 of the
8 regulations mandates that one form that any such
9 cooperation must take is through a forum of all relevant
10 category 1 and category 2 responders, and such a forum
11 is known as a local resilience forum, an LRF.

12 England has 42 LRFs established in areas consistent
13 with the boundaries of police forces. In Manchester,
14 the LRF was known as the Greater Manchester Resilience
15 Forum, as we have said, GMRF. Its members included
16 Greater Manchester Police, British Transport Police, the
17 North West Ambulance Service and the Greater Manchester
18 Fire and Rescue Service, but not North West Fire
19 Control.

20 One of the issues the inquiry will need to
21 investigate is whether GMRF, the Greater Manchester
22 Resilience Forum, discharged its statutory
23 responsibilities in the period leading up to the
24 Manchester Arena attack. The inquiry will also need to
25 consider whether the level of engagement of members of

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1 GMRF was adequate, something upon which the policing
2 experts have expressed views.

3 At the date of the arena attack, the chair of GMRF
4 was Paul Argyle, the director of emergency response for
5 GMFRS, the Fire and Rescue Service. In a witness
6 statement, Mr Argyle explains that the GMRF had a number
7 of purposes. First, as a coordinating group for local
8 responders engaged in preparedness for emergencies.
9 Second, to enable the development of a consistent
10 understanding of hazards and threats across the
11 Greater Manchester area. Third, to reflect the fact
12 that many emergency situations demand what Mr Argyle
13 describes as:

14 "Multi-agency working across all the partners,
15 including the development of multi-agency LRF plans and
16 the exercising of those plans."

17 We will repeat that. It requires:

18 "Multi-agency working across all the partners,
19 including the development of multi-agency LRF plans and
20 the exercising of those plans."

21 Pausing for just a moment, it might reasonably be
22 thought that the Manchester Arena attack provides the
23 perfect example of why multi-agency working and planning
24 is of the utmost importance. The fourth purpose of
25 an LRF, explains Mr Argyle, is to liaise with

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1 government. Mr Argyle goes on to explain that whilst
 2 an LRF does not have an operational role in the event of
 3 an emergency, it should facilitate preparedness at
 4 a local level. To that end GMRF had agreed terms of
 5 reference so as to ensure that there is:
 6 "An appropriate level of preparedness to enable an
 7 effective multi-agency response to emergency incidents
 8 which may have a significant impact on the communities
 9 of Greater Manchester."
 10 The objectives of GMRF included, among other things:
 11 ensuring that appropriate multi-agency plans,
 12 procedures, training and exercises necessary to address
 13 identified or foreseeable local and wider area hazards
 14 are in place and outstanding gaps identified; and
 15 coordinating the individual approaches and
 16 responsibilities of each organisation to ensure that
 17 they complement each other and dovetail with partners'
 18 arrangements.
 19 Once more, the importance of those objectives cannot
 20 be underestimated in the context of seeking to
 21 understand the response of the emergency services to the
 22 Manchester Arena attack and in seeking to gauge whether
 23 it was adequate.
 24 At the time of the Manchester Arena attack, GMRF had
 25 a number of multi-agency plans in place. We will need

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1 to investigate whether those were fit for purpose. GMRF
 2 also facilitated training and exercising events, some
 3 delivered by GMRF members and some by external
 4 providers. A number of these exercises concerned
 5 terrorist incidents.
 6 Exercise Winchester Accord took place in May 2016,
 7 a year before the attack upon the arena. The exercise
 8 scenario was a marauding terrorist firearms attack on
 9 the Trafford Centre. It was a multi-agency response
 10 with the aim of testing and evaluating the response to
 11 a major terrorist attack. The policing experts comment
 12 extensively upon this exercise in their report and
 13 express serious concerns about whether the necessary
 14 lessons were learnt from it, and the other experts
 15 appear to share these concerns.
 16 Subsequent exercises included Exercise Sherman in
 17 July 2016 and Exercise Hawk River in March 2017. Both
 18 were multi-agency tabletop exercises focused upon
 19 an MTFAs and participants included GMP, GMFRS and NWAS.
 20 Exercise Sherman, as we shall explain in further
 21 detail when we address the role of BTP on the night of
 22 the bombing, is likely to be of particular interest to
 23 the inquiry given that it was based upon a terrorist
 24 attack in the City Room, the very thing that occurred on
 25 22 May.

22

1 The inquiry legal team is seeking information about
 2 whether BTP took part in that exercise.
 3 In response to the Kerslake Report, Kathy Oldham,
 4 the chief resilience officer for GMCA, wrote to the
 5 mayor. She emphasised that regular meetings now take
 6 place to ensure that lessons have been learnt from the
 7 arena attack and that plans are in place to ensure that
 8 this is achieved. It will be necessary to consider
 9 whether the report by Ms Oldham represents much by way
 10 of concrete proposal.
 11 The current chair of the Greater Manchester
 12 Resilience Forum is Nick Bailey, the assistant
 13 Chief Constable of Greater Manchester Police. He has
 14 provided the lessons learned statement on behalf of
 15 GMRF. He observes, perhaps with a degree of
 16 understatement:
 17 "It was clear in the immediate aftermath of the
 18 attack that there had been [what he describes as] some
 19 issues with multi-agency communication and the
 20 deployment of some agencies."
 21 He goes on to describe the process of debriefing and
 22 reporting, undertaken by the resilience forum with
 23 a view to ensuring that such issues did not recur.
 24 ACC Bailey expresses the view that, as he puts it:
 25 "GMRF has taken an extremely robust and methodical

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1 approach to identifying areas of learning and
 2 development from the multi-agency briefings and the
 3 Kerslake Report."
 4 The inquiry will need to consider whether that is
 5 correct and, in any event, whether there are further
 6 lessons that should be learned about the operation of
 7 the Greater Manchester Resilience Forum and the Local
 8 Resilience Forum more generally.
 9 We're going to turn next to part 3 of our chapter 10
 10 opening, namely a non-exhaustive review of the sequence
 11 of events for the arrival and movements of the emergency
 12 services from the moment the explosion occurred. This
 13 will not be a recitation of the movements of everyone
 14 and as the inquiry's investigation deepens, no doubt it
 15 will be capable of being added to. However, for present
 16 purposes, what we're about to do has the purpose of
 17 capturing the substance and speed, or otherwise, of the
 18 initial emergency response of each emergency service or
 19 of other agencies. So far as those who died are
 20 concerned at this stage we'll only refer to those who
 21 were moved out of the City Room. Our review will cover
 22 the first hour or so in substantial detail before
 23 covering the subsequent 90 minutes at a higher level of
 24 overview.
 25 As will already be apparent, and indeed as we have

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1 already said, the review we're about to undertake is
 2 based upon the CCTV footage. We do not intend to show
 3 footage of the body of any person who died, but
 4 nonetheless we are going to be watching images of the
 5 aftermath of the bombing. That will be affecting for us
 6 all and, we have no doubt, distressing for some. So we
 7 give a warning, as we did yesterday, this part of the
 8 opening will, we expect, take us at least to the morning
 9 break and probably beyond the morning break, we remind
 10 everyone, being taken at 10.30.

11 We're going to start with the first hour of the
 12 response, dealing with that period in 10-minute
 13 durations or thereabouts. But before we do so, we will
 14 look at a plan of the arena complex on the screen so
 15 we can understand what is being described in the
 16 sequence of events as we review it. We have looked at
 17 this plan already at the very beginning of this opening
 18 statement, but it's worth reminding ourselves of the
 19 geography.

20 So Mr Lopez, could we have on the screen
 21 {INQ033841/1}. Thank you very much.

22 Could we all note, please, what will be described
 23 in the evidence and in this opening statement as "the
 24 war memorial entrance", which is above the word
 25 "Victoria" in the words "Victoria Station Approach".

25

1 SIR JOHN SAUNDERS: Is the cursor in the right place or is
 2 it the left-hand side?
 3 MR GREANEY: It's the left-hand one, sir, so it's to the
 4 left of the ticket office. That is the war memorial
 5 where I indicated yesterday the casualty clearing
 6 station was set up.
 7 Secondly, we see the lift and stairs leading to the
 8 walkway, with which we are becoming increasingly
 9 familiar. We see the Trinity Way tunnel marked as
 10 "tunnel" to the left of the words "City Room".
 11 We can see Trinity Way, which will feature in the
 12 evidence, and Victoria Station Approach, at the front of
 13 the station, and Hunts Bank running at right angles to
 14 Victoria Station Approach with a steep set of stairs
 15 leading into the arena bowl itself.

16 SIR JOHN SAUNDERS: And Hunts Bank where the ambulances
 17 mainly were?

18 MR GREANEY: Yes, quite so, sir.

19 As we have said, we'll deal with the first hour in
 20 10-minute segments. So we'll deal first with 22.31 to
 21 22.40. We're simply going to give a running account of
 22 the principal events that occurred during that period.

23 The station concourse CCTV captures BTP Police
 24 Constable Bullough, to whom we made extensive reference
 25 yesterday, and BTP PCSOs Renshaw, Brown and Morrey, and

26

1 Travel Safe officers Philip Clegg, Reece Mackay and
 2 Niall Pentony, all reacting within seconds to the sound
 3 of the explosion and beginning to make their way in the
 4 direction of the City Room.

5 SIR JOHN SAUNDERS: Mr Greaney, I really will not interrupt
 6 a lot, but Travel Safe officers, who do they work for
 7 and what's their job?

8 MR GREANEY: I will ensure we have a precise definition
 9 before we start at 11 o'clock. But in general terms
 10 they are officers whose job it is to move principally on
 11 the trains ensuring that those who are using the trains
 12 travel safely.

13 SIR JOHN SAUNDERS: And they're BTP?

14 MR GREANEY: I'm not confident that's correct, sir.

15 SIR JOHN SAUNDERS: Okay.

16 MR GREANEY: But we'll have a definitive answer when we
 17 resume.

18 So we're going to see those BTP officers and the
 19 Travel Safe officers reacting to the sound of the
 20 explosion. We are going to have the sequence of events
 21 for the emergency response to the screen extensively
 22 this morning.

23 The INQ reference for that is {INQ032822/2}.

24 We will start at page 2 and by page 2, I think you now
 25 know which page reference I mean, it's the INQ

27

1 reference.

2 (Pause)

3 The system has frozen.

4 SIR JOHN SAUNDERS: We'll take a short break. Ten minutes.
 5 (9.43 am)

6 (A short break)

7 (10.16 am)

8 MR GREANEY: Sir, the problem hasn't been entirely solved,
 9 but we think we have found a workaround which would take
 10 us up to lunch, in which regard we propose, sir, subject
 11 to your view, to treat the time we have just lost as the
 12 morning break and sit through until midday and then take
 13 our lunch break at that stage.

14 SIR JOHN SAUNDERS: Is everybody happy with that? Yes.

15 MR GREANEY: We canvassed the room and everyone is content
 16 with that. If anyone who's watching remotely has any
 17 insuperable difficulty created by that, perhaps they
 18 could tell Mr Suter by email.

19 We are turning now to deal with part 3 of our
 20 opening on chapter 10, which will involve reviewing the
 21 arrival and movements of the emergency services from the
 22 moment the explosion occurred. We're going to begin by
 23 dealing with the first hour in 10-minute blocks and
 24 therefore with the period from 22.31 to 22.40.

25 As I indicated just before the break, the station

28

1 concourse CCTV captures British Transport Police
 2 constable Jessica Bullough and BTP PCSOs Renshaw, Brown
 3 and Morrey, along with Travel Safe officers Philip
 4 Clegg, Reece Mackay and Niall Pentony all reacting
 5 within seconds of the sound of the explosion and
 6 beginning to make their way in the direction of the
 7 City Room.

8 Before we look at still images of those events on
 9 the screen, I can answer now the question that you posed
 10 before the break. Travel Safe officers, such as
 11 Philip Clegg from whom we'll hear live evidence, work
 12 for a company called STM, and they are contracted in
 13 turn to work for Northern Rail. Their role is to
 14 provide a visible presence on the railway network, which
 15 will involve both trains and stations, in order to
 16 prevent crime and disorder.

17 We're going to have on the screen -- this should be
 18 INQ032822 -- but I think, Mr Lopez, you are providing
 19 this from a different source, thank you -- and we'll
 20 start at {INQ032822/2}.

21 We can see there Philip Clegg and Niall Pentony, the
 22 Travel Safe officers, at 22.31.06. As we indicated
 23 yesterday, the station CCTV footage is out by between 4
 24 and 13 seconds, so it's running fast to that extent, so
 25 this is an image that is taken either just before or

29

1 just after the explosion has occurred.
 2 {INQ032822/3} next, please. So a similar
 3 observation about timing applies to this image, either
 4 just before or just after the explosion, and it is
 5 showing a group of BTP officers, all in close proximity
 6 to each other, and in close proximity to the war
 7 memorial. The war memorial in fact is beneath where we
 8 see the words "PCSO Morrey". So if one were to walk to
 9 the left, one would walk out of the war memorial
 10 entrance/exit.

11 {INQ032822/4} next, please. By now at 22.31.42, as
 12 timed, the explosion has plainly occurred. We see
 13 Philip Clegg and Niall Pentony, the Travel Safe
 14 officers, beginning to make their way to the City Room.

15 {INQ032822/5} next, please. Immediately behind them
 16 are PC Bullough and her colleague PCSO Morrey. They too
 17 are running, as we're able to see in the live images
 18 that we won't show, towards the City Room.

19 So at this stage the BTP officers are behind the
 20 Travel Safe officers, but as we are going to see.
 21 PC Bullough actually catches up the Travel Safe officers
 22 and overtakes them.

23 Next, {INQ032822/6}, please. There is another PCSO
 24 making his way to the City Room. That is
 25 PCSO Lewis Brown.

30

1 {INQ032822/7}, please. There, another BTP officer,
 2 PCSO Renshaw, is beginning to run towards the City Room
 3 at a time on the screen of 22.31.58.

4 We'll move forward at this stage, please, to
 5 {INQ032822/11}. So we can see that at this stage,
 6 22.32.29, PC Bullough has entered the Fifty Pence
 7 entrance from the station and by this stage she has
 8 caught up with the Travel Safe officers.

9 {INQ032822/12}, please. There are the other BTP
 10 officers together with the Travel Safe officers entering
 11 into that area shortly after Jessica Bullough --
 12 {INQ032822/13}, please -- followed by PCSO Morrey.
 13 Thank you very much.

14 Sir, can I indicate that there has been some
 15 concern, that might not be the right word, but people
 16 have wanted to know what sort of images we're going to
 17 be showing during the course of this section of our
 18 opening statement. That in general terms illustrates
 19 what we are going to be looking at.

20 SIR JOHN SAUNDERS: Thank you.

21 MR GREANEY: That can be taken from the screen now,
 22 Mr Lopez, thank you.

23 To continue with the chronology, CCTV in the
 24 City Room captures Constable Bullough entering that area
 25 at 22.32.47 by the staircase, as we have seen, from the

31

1 Fifty Pence entrance. This was barely a minute after
 2 the explosion. Following seconds behind were Travel
 3 Safe officers Clegg, Mackay and Pentony, who were in
 4 company with BTP PCSOs Renshaw and Brown. PCSO Morrey,
 5 who was seconds behind the others as they passed through
 6 the Fifty Pence entrance to Victoria Railway Station,
 7 did not appear to immediately follow them up to the
 8 City Room.

9 At 22.33.38, 2.5 minutes after the detonation, an
 10 ETUK medic, Emergency Training UK, who is believed to be
 11 Elizabeth Woodcock, is captured making her way along the
 12 arena concourse towards the City Room, and she is
 13 recorded entering that room approximately 1 minute
 14 later.

15 Would you display on the screen, please, Mr Lopez,
 16 {INQ032822/19}, which will show the arrival --

17 SIR JOHN SAUNDERS: And these medics are working for SMG?

18 MR GREANEY: They are, yes.

19 SIR JOHN SAUNDERS: Thank you.

20 MR GREANEY: 22.33.38, the ETUK medic walking in the
 21 direction of the City Room.

22 At 22.33.58, PCSOs Renshaw and Brown left the
 23 City Room by the same route as they'd entered. They
 24 made their way via the main concourse to collect first
 25 aid kits, with which they returned fewer than 5 minutes

32

1 later .
 2 At 22.34.46, the experienced British Transport
 3 policeman, Stephen Corke, to whom we have referred
 4 extensively , entered Victoria Railway Station via the
 5 war memorial entrance. He made his way to the City Room
 6 via the raised footbridge entrance and, as we said
 7 yesterday , he is the BTP officer with considerable
 8 experience of policing events at the arena, but who was
 9 dealing with another task at a location other than at
 10 Victoria Station at the time of the concert .
 11 Mr Lopez, if we display {INQ032822/23}, we will see
 12 the arrival of PC Stephen Corke, who has come from the
 13 other location at which he was dealing with a person
 14 suspected of a burglary .
 15 At the same time as PC Corke arrived at Victoria
 16 Railway Station , BTP Constables Campbell and Ayers are
 17 captured running down the Trinity Way link tunnel
 18 towards the arena. They initially run past the Fifty
 19 Pence staircase and enter the railway station before
 20 turning around and going up into the City Room, which
 21 they enter in the company of Travel Safe officer Mackay
 22 less than a minute after they're recorded on the
 23 Trinity Way link tunnel. We will show an image of that:
 24 Mr Lopez, {INQ032822/24}, please. There we see those
 25 BTP officers heading down the Trinity Way link tunnel.

1 A further BTP officer, PC Martin, is recorded
 2 speaking to injured casualties on Station Approach as
 3 all of this is happening. {INQ032822/26}, please.
 4 Then at 22.35.07, so about 4 minutes after the
 5 explosion , BTP PC Trow is seen outside the arena on
 6 Trinity Way before he enters the arena via the Trinity
 7 roller entrance doors. He's recorded making his way
 8 around the arena concourse and then enters the City Room
 9 just over a minute later . He's recorded leaving the
 10 City Room via the Fifty Pence entrance a few minutes
 11 later and runs down the Trinity Way link tunnel. He's
 12 subsequently captured running back the same way with
 13 a large first aid kit bag.
 14 {INQ032822/28}, please. There is PC Simon Trow.
 15 At 22.35.30, two BTP patrol vehicles pull up on the
 16 station approach. PCSO Renshaw collects first aid
 17 equipment from one of the two patrol vehicles seconds
 18 after they arrive and he and PCSO Brown make their way
 19 back towards the City Room carrying four first aid bags.
 20 They arrive back in the City Room less than 90 seconds
 21 later . From one of the patrol vehicles , BTP
 22 PC Dale Edwards and PC Jane Bridgewater emerge and enter
 23 Victoria Railway Station and they too are carrying first
 24 aid kits . They make their way towards the City Room via
 25 the raised footbridge entrance. Those officers stop to

1 tend to some injured persons on the raised footbridge
 2 for a short time before moving on to enter the
 3 City Room.
 4 Also assisting injured persons on the raised
 5 footbridge was PC Corke, who was joined by PC Martin,
 6 although he subsequently entered the City Room.
 7 While PC Corke continued to tend to an injured
 8 person, PC Edwards briefly left the City Room to collect
 9 items from the first aid packs that were with PC Corke.
 10 {INQ032822/31}, please. There's the arrival at 22.35.30
 11 of two further BTP patrol vehicles .
 12 Also entering Victoria Railway Station seconds after
 13 PC Edwards and PC Bridgewater was BTP PC Roach. He too
 14 was carrying first aid equipment. They made their way
 15 to the City Room via the raised footbridge entrance
 16 before turning around having deposited the first aid
 17 equipment just before the City Room and running back to
 18 the main railway concourse and speaking to station
 19 staff . This prompted the station staff to obtain
 20 further first aid equipment. PC Roach then leaves the
 21 station . We will show the slide now of PC Edwards and
 22 PC Bridgewater arriving . It 's {INQ032822/36} and we can
 23 see one of the officers carrying a first aid kit bag.
 24 SIR JOHN SAUNDERS: The BTP police vehicles came from where?
 25 If you don't know the answer, don't worry, we can find

1 out.
 2 MR GREANEY: We'll have an answer after lunch.
 3 SIR JOHN SAUNDERS: That's very kind, thank you.
 4 MR GREANEY: I suspect they came from various locations, but
 5 we'll have a certain answer in due course.
 6 SIR JOHN SAUNDERS: Thank you.
 7 MR GREANEY: At 22.36.15, the director of ETUK, a man named
 8 Ian Parry, is seen walking along the area concourse
 9 towards the City Room which he enters seconds later .
 10 {INQ032822/38}, please.
 11 At 22.37.08, so by now we're 6 minutes after the
 12 explosion , PC Martin enters Victoria Railway Station , he
 13 speaks to some members of the public before making his
 14 way to the City Room.
 15 At 22.38.01, an ETUK first-aidier , who is believed to
 16 be Ken O'Connor, is captured walking from the first aid
 17 room towards the City Room carrying first aid equipment.
 18 At 22.39.30, an unidentified member of Northern Rail
 19 staff is captured on the raised footbridge moving
 20 towards the City Room and carrying a defibrillator .
 21 Seconds after this on the station concourse,
 22 Owen Sanderson and another unknown male, both platform
 23 staff , are seen carrying two very large NHS first aid
 24 kit bags which they deposit on the concourse. Several
 25 people are observed removing items from these bags to

1 treated the wounded and injured in the immediate
 2 vicinity . The bags are then carried upstairs .
 3 {INQ032822/58} on the screen, please. There is
 4 Owen Sanderson, an employee of Northern Rail, returning
 5 with those large first aid kit bags which are then
 6 deployed.
 7 At 22.40.12, a BTP sergeant named Peter Wilcock
 8 enters the arena complex via the Trinity roller entrance
 9 and seconds later , at 22.40.29, two further ETUK staff
 10 members, Marianne Gibson and Robina Jones are seen about
 11 to enter the City Room. {INQ032822/62}, please.
 12 In the 10 minutes or thereabouts following the
 13 explosion , three PCSOs, Brown, Renshaw and Morrey, eight
 14 police constables , Bullough, Corke, Trow, Campbell,
 15 Ayers, Bridgewater, Edwards and Martin, all 12 of them
 16 BTP officers, have made their way to or very near the
 17 City Room. As this period, the first 10 minutes, ended,
 18 a 13th officer , Sergeant Wilcock, had just entered the
 19 arena complex. Some of those who are captured
 20 responding in these first minutes were already within
 21 Victoria Railway Station but others arrived from
 22 elsewhere. Those who arrived in vehicles brought first
 23 aid kits and other such kits were fetched by those who
 24 were first into the City Room. The first officers from
 25 BTP who entered the City Room did so fewer than

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1 2 minutes after the explosion .
 2 So far as other organisations are concerned, four
 3 ETUK medics reached the City Room within those first
 4 10 minutes with a fifth , Ken O'Connor, entering seconds
 5 later . In relation to station staff , one had brought
 6 first aid equipment to the City Room, and two large NHS
 7 first aid bags had been brought out onto the station
 8 concourse before being -- in the process of being
 9 carried up to the City Room.
 10 Sir, it goes without saying that all of those who
 11 responded within minutes and entered the City Room
 12 behaved with bravery .
 13 We will turn next to the following 10 minutes and
 14 we'll be dealing with the period from 22.41 to 22.50.59.
 15 SIR JOHN SAUNDERS: Mr Greaney, so we can be prepared for
 16 this -- and I do apologise for interrupting again --
 17 there comes a time when Operation Plato is declared by
 18 GMP. I know there are problems about communication of
 19 that, but I would like to know, please, if someone could
 20 find the time within this chronology when that is
 21 actually declared .
 22 MR GREANEY: That is declared within the 10 minutes that
 23 we're going to now deal with. From memory it's declared
 24 at 22.47.
 25 SIR JOHN SAUNDERS: Thank you. Just so we're aware of that

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1 fact .
 2 MR GREANEY: That's a very good point, sir, if I may say so.
 3 As I said , we're going to deal with the period from
 4 10 minutes to 20 minutes after the explosion , so 22.41
 5 to 22.50.59.
 6 At 22.41.36, the CCTV captures the first Armed
 7 Response Unit from GMP arriving on Station Approach. It
 8 travels down Hunts Bank and on to Victoria Street .
 9 A second GMP Armed Response Unit is recorded arriving
 10 30 seconds later together with a GMP patrol vehicle
 11 crewed by PC Katie Shadwell and PC Steven Wright. Those
 12 officers remove first aid bags from their vehicle and
 13 begin to tend to casualties on Station Approach.
 14 {INQ032822/67}, please. There we see an armed
 15 response vehicle , ARV, on Station Approach.
 16 At 22.42.42, a sixth ETUK medic, Ryan Billington, is
 17 captured entering the City Room from the arena
 18 concourse. By 22.42.44, GMP armed officers
 19 PCs Tyldesley and Dalton are captured within the arena
 20 complex having entered by the lower Trinity Way exit
 21 doors and we can see they're wearing ballistic headgear.
 22 We'll have {INQ032822/75} on screen, please. There
 23 we see those two armed officers . Their weapons can be
 24 seen in their hands and on their heads is ballistic
 25 headgear and it will be relevant to compare and contrast

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1 this image with the presentation of firearms officers in
 2 later images in order to consider whether the officers
 3 in later images considered they were in a warm, hot or
 4 cold zone.
 5 At 22.42.58, a second GMP patrol vehicle crewed by
 6 GMP PCs Grace Barker and James Williams arrives on
 7 Station Approach. Those two officers assisted
 8 casualties outside the station . Seconds later at
 9 22.43.02, a BTP constable, Constable Roach, re-entered
 10 the station with a first aid pack, accompanied by two
 11 GMP firearms officers . These three officers together
 12 ran to the City Room via the raised footbridge entrance.
 13 They reached the City Room fewer than 60 seconds later
 14 and then travelled through the City Room and are
 15 recorded entering the arena via the main doors about
 16 30 seconds after they entered the City Room.
 17 {INQ032822/78}, please. So that we can orientate
 18 ourselves , these armed officers are arriving from the
 19 other side of the City Room from the armed officers that
 20 we saw in {INQ032822/75}.
 21 Another GMP Armed Response Vehicle is captured on
 22 Hunts Bank at 22.43.20, at which point two more GMP
 23 firearms officers , PCs Richardson and Lewis, can be seen
 24 making their way into the arena complex via the lower
 25 Trinity Way exit. PC Richardson undertook the role of

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1 operational firearms commander.
 2 Two more GMP firearms officers are regarded entering
 3 via the same exit doors 10 seconds later .
 4 By 22.44.06, 13 minutes after the explosion , the
 5 operational firearms commander, PC Richardson, and
 6 PC Lewis reach the arena concourse.
 7 At 22.44.37, the two firearms officers who'd entered
 8 the City Room from the raised footbridge emerge from the
 9 City Room and on to the arena concourse. And then at
 10 22.44.41, GMP Inspector Michael Smith arrived together
 11 with Sergeant McGowan on Station Approach.
 12 Inspector Smith then assumed the role of GMP Bronze, or
 13 operational , Commander, that being one of the terms we
 14 defined earlier .
 15 At the same time, another GMP Armed Response Vehicle
 16 arrived with two further firearms officers . We'll see
 17 those events in {INQ032822/89}, please.
 18 Inspector Smith and Sergeant McGowan arrive and
 19 Inspector Smith then assumes the role of Bronze, or
 20 operational , Commander.
 21 Shortly thereafter , at 22.44.52, a GMP tactical aid
 22 unit, often referred to as a TAU carrier vehicle arrives
 23 on Station Approach. Initially officers from this
 24 vehicle deal with members of the public but within
 25 minutes of their arrival they enter Victoria Railway

1 Station. Another TAU carrier vehicle and another patrol
 2 vehicle arrive in the next couple of minutes. As
 3 they're doing so, two pairs of GMP firearms officers ,
 4 Tyldesley , Dalton, Richardson and Lewis, are captured
 5 moving through the arena concourse having emerged from
 6 the arena itself . They travel in the direction of the
 7 City Room. Four more follow these, three of whom enter
 8 the City Room, whilst the fourth meets up with the two
 9 firearms officers who have stationed themselves on the
 10 arena side of the entrance to the City Room.
 11 Could we on the screen , please , {INQ032822/101}?
 12 Here we see firearms officers about to enter the
 13 City Room. It is 22.46, so 15 minutes after the bomb
 14 had exploded.
 15 In the meantime, at 22.46.06, Inspector Smith
 16 entered Victoria Railway Station . He's captured using
 17 his police radio as he does so. Sergeant McGowan and
 18 two further GMP firearms officers follow . Following
 19 a short conversation , Inspector Smith and
 20 Sergeant McGowan run towards the City Room via the
 21 raised footbridge . One of the firearms officers runs
 22 back to his vehicle and collects a first aid pack.
 23 We will see the image of Inspector Smith entering the
 24 station . This is {INQ032822/99}.
 25 At 22.47.17 -- and, sir , this is the time at which

1 Plato is being declared -- Inspector Smith speaks to
 2 a BTP PC, PC Martin, on the raised footbridge .
 3 Sergeant McGowan and Constable Martin then enter the
 4 City Room while Inspector Smith speaks on his radio .
 5 Smith enters the City Room 30 seconds later. At the
 6 same time GMP PCs Whittell and Ho-McKenna are captured
 7 entering the Fifty Pence entrance area. PC ho-McKenna
 8 has a large first aid bag. They are captured entering
 9 the City Room at 22.47.34, having been shown the way by
 10 an NCP employee.
 11 At 22.47.46, the GMP firearms officers who collected
 12 the first aid kit following his conversation with
 13 Inspector Smith rejoins his firearms colleague and both
 14 make their way to the City Room and they do so at a run.
 15 At 22.47.52, GMP PCs Edwards, Meaney and Williams,
 16 together with a sergeant from GMP, Sergeant Prince, who
 17 arrived in a TAU carrier , are seen walking through
 18 Victoria Railway Station and in the direction of the
 19 City Room.
 20 At 22.48.06, 17 minutes after the explosion ,
 21 Inspector Smith is captured in the City Room speaking to
 22 Sergeant McGowan and two GMP firearms officers. At
 23 22.48.39, two GMP firearms officers leave the City Room,
 24 back out on to the raised footbridge and take up
 25 a guarding position . They're passed seconds later by

1 the two firearms officers with a first aid bag.
 2 At 22.49.01, ETUK medic Ryan Billington leaves the
 3 City Room and approaches injured people on the raised
 4 footbridge . Then, at 22.49.23, seven TAU GMP officers
 5 are observed to run through the station towards the
 6 City Room. Those officers are Sergeant Hare and
 7 Constables Sivori , Dawson, Hall, Tonge, Shott, Hill and
 8 Carmody. The latter of these appears to have
 9 a first aid box in his hands. They congregate at the
 10 base of the staircase up to the raised footbridge , where
 11 they are joined by GMP PC McLaughlin and GMP
 12 Sergeant Caldwell .
 13 If we have on the screen {INQ032822/124}, please, we
 14 see those officers .
 15 At 22.49.53, there is another significant
 16 development. NWS Advanced Paramedic Patrick Ennis is
 17 captured on Station Approach approaching the war
 18 memorial entrance.
 19 He enters Victoria Railway Station 30 seconds later
 20 and is captured speaking on his radio as he does so.
 21 This is the first involvement of any officer of NWS.
 22 Could we have on the screen , please , {INQ032822/127}.
 23 It's 22.49.53, so it's approaching 19 minutes after
 24 the bomb exploded, and NWS Advanced Paramedic Ennis is
 25 arriving at the scene. This, as we understand it ,

1 currently , is the first involvement of any officer of
 2 NNAS.
 3 Next, {INQ032822/130}, please. 22.50.32, so
 4 19.5 minutes after the explosion , or thereabouts.
 5 Patrick Ennis has now entered Victoria Station .
 6 Thank you.
 7 At 22.50.51, GMP Inspector Smith is captured in
 8 a huddle inside the City Room with a number of other GMP
 9 officers . Then at 22.50.55, Patrick Ennis, the NNAS
 10 advanced paramedic, is recorded in conversation with
 11 a number of GMP officers on the station concourse. So
 12 it 's now about 20 minutes after Salman Abedi has
 13 detonated his device and we'll pause once more.
 14 In the period covering from 10 to 20 minutes from
 15 the explosion , a significant number of GMP officers
 16 arrived at the area of Victoria railway station . These
 17 included four double-crewed patrol vehicles , two TAU
 18 carriers , and several Armed Response Vehicles. Amongst
 19 those who had arrived were the GMP Bronze Commander and
 20 at least 19 other unarmed officers and at least 10
 21 firearms officers , including the operational firearms
 22 commander. Before this period was over, four firearms
 23 officers had passed through Victoria Railway Station and
 24 over the raised footbridge into the City Room whilst the
 25 other four had passed through the arena itself and the

1 arena concourse in order to reach the City Room.
 2 Firearms officers had passed from one side of the
 3 City Room to the other and, by the end of this period,
 4 fewer than 20 minutes after the explosion , had assumed
 5 defensive positions on both the raised footbridge
 6 entrance to the City Room and the arena concourse
 7 entrance to the City Room.
 8 It was also, sir , as you've observed, during this
 9 period that Operation Plato was declared.
 10 To consider the CCTV evidence another way,
 11 approximately 15 minutes after the explosion , the first
 12 armed officers are recorded as entering the City Room,
 13 the GMP Bronze Commander entered the City Room fewer
 14 than 3 minutes after that. Also arriving in that period
 15 was the first paramedic, Patrick Ennis. The number of
 16 ETUK medics operating in and around the City Room by the
 17 end of this period was six .
 18 We're turning next to the 10 minutes following . So
 19 from 22.51.00 to 23.00.59.
 20 Between 22.51.38 and 22.52.59, Advanced Paramedic
 21 Patrick Ennis made had his way to the City Room via the
 22 raised footbridge . In the course of this journey he
 23 stopped briefly by some injured persons who were on the
 24 raised footbridge receiving treatment from others .
 25 Mr Ennis met up with GMP Inspector Smith at the raised

1 footbridge entrance to the City Room at 22.53.01.
 2 Following their conversation , Inspector Smith is
 3 recorded as using his radio and Mr Ennis can be seen
 4 briefly checking some casualties .
 5 At 22.54.14, a vehicle containing those we believe
 6 to be counter-terrorism specialist firearms officers ,
 7 CTSFOs, arrived in the rear yard of the arena. CTSFOs
 8 are elite police firearms officers , having received
 9 additional training over and above the extensive
 10 training which other police firearms officers receive .
 11 At 22.55.10, two GMP officers, PC James Lovelady and
 12 PC Christopher Edwards are pictured starting to apply
 13 a cordon to the Victoria Railway Station using crime
 14 scene tape.
 15 At 22.55.30, a group of seven GMP TAU officers, led
 16 by Sergeant Hare, enter the City Room and begin to
 17 assist the injured , including by carrying them out of
 18 the City Room. All may recall that Sergeant Hare was an
 19 officer I mentioned at the very beginning of dealing
 20 with this chapter, an officer we'll hear from who
 21 expresses his frustrations at the number of paramedics
 22 who entered the City Room.
 23 At that time, 22.55, officers led by Sergeant Hare
 24 enter the City Room and began to assist those who were
 25 injured , including by carrying them out of the

1 City Room.
 2 At 22.57.08, Saffie -Rose Roussos is seen being
 3 carried out of the Fifty Pence entrance of the City Room
 4 by a number of GMP officers, Bethany Crook, an off-duty
 5 nurse, and Paul Reid a member of the public.
 6 At 22.57, 34, three CTSFOs are captured about to
 7 enter the arena itself .
 8 At 22.57.59, nearly 27 minutes after the explosion ,
 9 Inspector Smith and Mr Ennis are recorded in
 10 conversation in the City Room.
 11 Four seconds later , at 22.58.03, GMP police officers
 12 break into the Beer House bar on the station concourse.
 13 At 22.58.21, Advanced Paramedic Ennis can be seen
 14 gesturing to the raised bridge entrance to the City Room
 15 whilst in conversation with members of the public and
 16 a member of ShowSec staff, who's pushing an injured
 17 member of the public in a wheelchair .
 18 Seven seconds, later at 22.58.28, six more GMP TAU
 19 officers enter Victoria Railway Station ,
 20 Sergeant Goodwin together with PCs Leicester , Lofthouse,
 21 White, Wood and Wray.
 22 At 22.58.33, the party of people who were carrying
 23 Saffie -Rose Roussos reach the end of the Trinity Way
 24 tunnel and place her on to the ground.
 25 At 22.58.37 an NNAS ambulance pulls up on

1 Station Approach. Then, at 22.58.44, Mr Ennis and ETUK
 2 medic Ryan Billington are captured in conversation
 3 in the City Room.
 4 At 22.59.57, NWAS Paramedic Ennis is recorded
 5 leaving the City Room via the raised footbridge. At
 6 about the same time at the war memorial entrance to
 7 Victoria Railway Station on Station Approach, NWAS
 8 Consultant Paramedic Daniel Smith, who was to assume
 9 Bronze Command on behalf of NWAS, is in conversation
 10 with NWAS MERIT Dr Michael Daley, MERIT being Medical
 11 Emergency Response Incident Team doctor. Both, so
 12 Consultant Paramedic Daniel Smith and MERIT
 13 Dr Michael Daley then enter Victoria Railway Station.
 14 We'll have on the screen, please, to show the
 15 arrival of those two members of NWAS staff, first
 16 {INQ032822/168}. There is Daniel Smith, the NWAS
 17 operational commander, whose actions we will deal with
 18 comprehensively when we turn to NWAS, meeting up with
 19 NWAS Doctor Michael Daley.
 20 {INQ032822/169}, please. We can see that, at
 21 23.00.03, those two NWAS officers have entered the
 22 station.
 23 At 23.00.02, NWAS Operations Manager Derek Poland
 24 arrives. Mr Poland was an extremely experienced
 25 employee of NWAS and also held the rank of senior

1 paramedic. He left his car and moved to speak to those
 2 in the ambulance which arrived at 22.58.37.
 3 At 23.00.24, GMP Inspector Hawksley entered Victoria
 4 Railway Station. Then, 14 seconds later at 23.00.38,
 5 three NWAS paramedics, who may have been the occupants
 6 of the ambulance which arrived at 22.58.37, are captured
 7 walking on Station Approach and entering
 8 Victoria Station 10 seconds later.
 9 We'll see {INQ032822/173}, please. There are those
 10 three paramedics who do not include Derek Poland, whom
 11 we have made reference to.
 12 {INQ032822/174} next, please. There is
 13 Patrick Ennis.
 14 Then {INQ032822/175}, please. There we see those
 15 three paramedics entering Victoria Railway Station and
 16 they're entering via the war memorial entrance.
 17 At 23.00.47, as in fact we have just seen, Advanced
 18 Paramedic Patrick Ennis is recorded speaking on his
 19 radio whilst standing just outside the City Room on the
 20 raised footbridge. Then 7 seconds later at 23.00.54,
 21 another NWAS ambulance is observed to pull up on
 22 Trinity Way near the Trinity Way link tunnel. The crew
 23 of this ambulance went on to assist Saffie -Rose and
 24 subsequently transported her to hospital.
 25 So in the final third of the first 30 minutes, the

1 first NWAS paramedic had entered the City Room, made
 2 contact with the GMP Bronze Commander, and had spoken to
 3 a representative of ETUK. He then left the City Room
 4 having spent approximately 5 minutes there, just as
 5 another paramedic and a doctor were arriving.
 6 By the conclusion of this period, 30 minutes after
 7 the explosion, there were a total of six NWAS paramedics
 8 at Victoria Railway Station, including an advanced
 9 paramedic, a senior paramedic, and a consultant
 10 paramedic, who took up the role of Bronze Commander, and
 11 also an NWAS MERIT doctor.
 12 A further ambulance also arrived at the end of this
 13 period, but both of those with that vehicle got no
 14 closer to the City Room than Trinity Way, as its
 15 occupants tended to and transported Saffie -Rose, who by
 16 then had been carried out of the Trinity Way link
 17 tunnel.
 18 Also, additional highly specialist firearms support
 19 in the form of three CTSFOs had arrived and entered the
 20 arena itself.
 21 We will turn next to the following 10 minutes,
 22 23.01.00 to 23.10.59.
 23 At 23.01.00, NWAS Consultant Paramedic Dan Smith can
 24 be seen meeting up on the station concourse with the
 25 three paramedics who had arrived seconds earlier.

1 Amongst these three was NWAS Operations Manager
 2 Matt Calderbank who was to undertake the role of loading
 3 officer. Very shortly thereafter this group was joined
 4 by NWAS Operations Manager Derek Poland and NWAS
 5 Advanced Paramedic Patrick Ennis. NWAS MERIT Doctor
 6 Michael Daley was also present.
 7 Could we have on the screen, please,
 8 {INQ032822/177}.
 9 Daniel Smith has a JESIP tabard in his right hand
 10 and he soon puts it on, and in fact he's the only
 11 commander to do so that night.
 12 We're seeing there that huddle of NWAS officers.
 13 Next, please, {INQ032822/179}. We see shortly after
 14 11 pm, further huddles of NWAS officers.
 15 {INQ032822/180}, please. A further image of
 16 Patrick Ennis in conversation at 23.01.34 with
 17 Operational Commander Daniel Smith, Dr Michael Daley,
 18 the MERIT doctor, and Derek Poland.
 19 At 23.01.37, four GMP CID officers can be seen
 20 walking up the staircase to the raised footbridge
 21 travelling towards the City Room.
 22 At 23.02.57, a number of GMP officers, including
 23 Inspector Hawksley and Sergeant McGowan, enter the
 24 City Room, and by 23.03.01, the conversation between
 25 Mr Ennis, Mr Smith and Mr Poland had concluded as at

1 this time the latter two were captured leaving Victoria
 2 Railway Station. Mr Ennis remained on the station
 3 concourse speaking to Dr Daley.
 4 {INQ032822/186}, please. There we see at 23.03.01,
 5 so 32 minutes after the explosion, NWAS Operational
 6 Commander Daniel Smith and his colleague Derek Poland
 7 exiting the station at the Station Approach.
 8 At 23.03.05, an injured person is visible on
 9 a stretcher in the City Room. They're subsequently
 10 moved out of the City Room on that stretcher 3 minutes
 11 later.
 12 At 23.03.24, another injured person is carried out
 13 of the City Room, this time on a makeshift stretcher.
 14 At 23.03.27, Mr Ennis and Dr Daley are recorded as
 15 speaking to one another on the station concourse. The
 16 conversation concludes seconds later at which point NWAS
 17 Advanced Paramedic Patrick Ennis begins to make his way
 18 back to the City Room.
 19 At 23.04.04, NWAS Consultant Paramedic and
 20 Operational Commander Dan Smith can be seen wearing an
 21 ambulance commander tabard.
 22 At 23.05.19, Patrick Ennis re-entered the City Room.
 23 Once in the City Room, Mr Ennis can be seen speaking to
 24 people and leaning over some of those who were lying
 25 prone on the floor.

1 23.05.17, a police officer can be seen approaching
 2 Mr Ennis and taking him to a place where there are
 3 a number of injured persons. Other footage reveals that
 4 it was Sergeant Hare who took Mr Ennis over to
 5 Georgina Callander.
 6 Over the subsequent minutes Mr Ennis can be seen
 7 speaking to police officers including Inspector Smith
 8 and ETUK medics. He's also captured leaning over some
 9 of those who were lying on the floor.
 10 At 23.06.21, the only stretcher which is deployed in
 11 the City Room that night is used to evacuate an injured
 12 person out into Victoria Railway Station.
 13 Next, at 23.06.57, three off-duty doctors,
 14 David Dolan, Vicky Wijratne and Matthew Burrows, can be
 15 seen arriving on the station concourse and speaking to
 16 Dan Smith, the operational commander. They're observed
 17 to leave the station a few seconds later and are seen to
 18 re-enter Victoria Railway Station approximately
 19 10 minutes after that.
 20 At 23.08.27, a wheelchair which had been abandoned
 21 on the raised footbridge was moved by an unknown person
 22 into the City Room and is used shortly thereafter to
 23 move an injured person out of that area.
 24 At 23.08.48, six more NWAS ambulances arrive on
 25 Station Approach and then at 23.09.58, at the end of

1 this further 10-minute period, six more GMP officers
 2 enter Victoria Railway Station. We'll have
 3 {INQ032822/224} on screen, please.
 4 So we've just dealt with the period 30 to 40 minutes
 5 following the explosion. Again, we'll seek to draw the
 6 strands together. In that period of 30 to 40 minutes
 7 following the explosion, NWAS Advanced Paramedic
 8 Patrick Ennis has spoken in person to the NWAS
 9 Bronze Commander outside the City Room and then returned
 10 to the City Room. By the end of this period, 40 minutes
 11 after the explosion, he is the only NWAS paramedic to
 12 have been into the City Room. At least eight ambulances
 13 had attended Victoria Railway Station together with NWAS
 14 employees in other vehicles. During this period the
 15 NWAS Bronze Commander, Consultant Paramedic Dan Smith,
 16 had established himself visibly as such. Three off-duty
 17 doctors had briefly entered Victoria Railway Station.
 18 The only deployment of a stretcher in the City Room had
 19 occurred and another injured person had been transported
 20 out of the City Room on a makeshift carrying platform.
 21 On the policing side, more police officers had
 22 arrived and entered the City Room, and six more firearms
 23 officers were on site during that period.
 24 We'll turn next to 40 to 50 minutes post-detonation,
 25 23.10.00 to 23.20.59.

1 CCTV captures GMP firearms officers conducting
 2 a check of the arena concourse during this period. Then
 3 at 23.14.04, there was a significant further development
 4 because at that time the NWAS Hazardous Area Response
 5 team, known as HART, paramedics Lea Vaughan and
 6 Christopher Hargreaves, entered Victoria Railway
 7 Station. They made their way directly to the City Room
 8 where they arrived 1 minute later. Once in the
 9 City Room they spoke to Patrick Ennis and then started
 10 to move between casualties.
 11 {INQ032822/249}, please. As we indicated, this is
 12 an important development in the events that will need to
 13 be studied closely during the course of the evidence.
 14 We have members of the Hazardous Area Response Team of
 15 NWAS arriving at 23.14.04.
 16 At 23.17.40, the evacuation of John Atkinson from
 17 the City Room begins as he is moved on a display board
 18 across the floor of the City Room towards the raised
 19 footbridge. That is therefore 46 minutes after the
 20 explosion has taken place. The issue of John Atkinson's
 21 survivability is, as we shall explain, probably not
 22 today but tomorrow, a significant issue for the inquiry
 23 to consider.
 24 At 23.17.54, the three off-duty doctors are seen on
 25 the station concourse together with Helen Mottram,

1 an NWS paramedic, who acted as triage officer in the
 2 casualty clearing station. Shortly after this,
 3 Mrs Mottram, the wife of Nicholas Mottram, can be seen
 4 giving triage instructions. By this stage there are
 5 a significant number of people, including the injured,
 6 other members of the public and paramedics within the
 7 station concourse.
 8 At 23.17.36, GMP Detective Inspector Neil Haywood
 9 enters Victoria Railway Station via Station Approach.
 10 He enters the City Room fewer than 3 minutes later. At
 11 23.19.28, the party moving John Atkinson on a display
 12 board are captured on the footbridge trying to get him
 13 to the lift. So in the period 40 to 50 minutes
 14 following the explosion, two more NWS paramedics
 15 entered the City Room, namely members of HART.
 16 On the station concourse a significant number of
 17 other paramedics, together with medical doctors, have
 18 established themselves attending to the injured who are
 19 there. The evacuation of John Atkinson from the
 20 City Room has begun and he has got as far as the raised
 21 footbridge during that period.
 22 GMP firearms officers are by now conducting
 23 a systematic sweep of the arena.
 24 We will turn then to the final 10 minutes of the
 25 hour after the explosion, 23.21.00 to 23.30.59.

1 At 23.22.18, an injured person, Paul Price, on
 2 a makeshift carrying platform, is carried across the
 3 station concourse. At the same time, up on the raised
 4 footbridge, a metal barrier has been obtained to be slid
 5 under the display board used to move John Atkinson. By
 6 23.24.25, John Atkinson can be seen to be carried to the
 7 area by the war memorial entrance of the Victoria
 8 Railway Station where he is placed and tended to by
 9 an NWS paramedic, Philip Keogh. He remains at that
 10 location for the next 24 minutes.
 11 At 23.24.04, GMP Chief Inspector Dexter, the ground
 12 assigned tactical firearms commander, is about to enter
 13 Victoria Railway Station. He enters the City Room just
 14 over a minute later and he's recorded using his mobile
 15 telephone shortly after this. So could we have on the
 16 screen, please, {INQ032822/297}?
 17 There is Chief Inspector Dexter from whom we'll hear
 18 evidence in the inquiry, the ground assigned tactical
 19 firearms commander, at 23.24, about to enter Victoria
 20 Railway Station.
 21 At 23.26.14, a party of police officers begin to
 22 carry Georgina Callander out of the City Room on
 23 a makeshift stretcher. At 23.26.49, three more
 24 paramedics are recorded as walking to Victoria Railway
 25 Station.

1 At 23.29.03, NWS HART paramedics, Lea Vaughan and
 2 Christopher Hargreaves are captured in conversation with
 3 Advanced Paramedic Patrick Ennis in the City Room.
 4 Then, at 23.29.12, Georgina Callander is carried out of
 5 Victoria Railway Station and on to Station Approach. As
 6 she is placed on the ground, she is attended to by three
 7 paramedics.
 8 At 23.30.33, Chief Inspector Dexter leaves the
 9 City Room and can be seen in the company of
 10 PC Richardson, the operational firearms commander or
 11 OFC. PC Richardson is no longer wearing his protective
 12 helmet at that stage and his principal firearm is
 13 hanging by its sling from his shoulder.
 14 We'll have {INQ032822/331} on the screen, please.
 15 So PC Richardson, in respects of whose identity, as
 16 everyone knows, a restriction order is in place for good
 17 reason, will give evidence during the course of the
 18 inquiry, and given his body language, we will need to
 19 explore with him during the course of evidence whether
 20 he believed at this stage, at 23.30.33, he was in a hot,
 21 warm or cold zone.
 22 So, as the hour after the explosion came to an end,
 23 both John Atkinson and Georgina Callander were carried
 24 down on to the station concourse. Also occurring during
 25 this period, the ground assigned tactical firearms

1 commander, Chief Inspector Mark Dexter, arrived in the
 2 City Room and spent approximately 5 minutes in it before
 3 leaving and meeting up with PC Richardson.
 4 PC Richardson's appearance may suggest that he no longer
 5 considered that there was an active threat in the
 6 immediate vicinity, although that, as with all matters,
 7 will need to be assessed during the course of the
 8 evidence.
 9 We will turn next in this part of our opening
 10 address to address the following 90 minutes. There are
 11 very few images that we can responsibly show in respect
 12 of this period.
 13 The second hour of the response began with crowd
 14 control barriers, such as the one used to carry
 15 John Atkinson, being brought into the City Room, and
 16 this can be seen at 23.32.12 and 23.32.14. Chief
 17 Inspector Dexter and Constable Richardson continued
 18 their journey from the City Room and arrived outside
 19 Victoria Railway Station at 23.32.56. Both can be seen
 20 using communication devices.
 21 At 23.34.08, a red tag with the number 1 is placed
 22 on John Atkinson who is still at this stage at the war
 23 memorial entrance to Victoria Railway Station. At
 24 23.38.28, Georgina Callander is lifted up on a spinal
 25 board and placed into an ambulance. First on to

1 a stretcher and then into the vehicle . She was then
2 taken to the Emergency Department of Manchester Royal
3 Infirmary .

4 At 23.40.32, the final person is evacuated from the
5 City Room on a makeshift stretcher comprising of
6 cardboard and a crowd control barrier . By 23.43.35,
7 a very large number of police officers can be seen to
8 have congregated in the City Room. Subsequently, they
9 disperse .

10 At 23.43.35, NWAS Emergency Medical Technician
11 Laura Worrall and NWAS Paramedic Michael Ruffles place
12 John Atkinson on a spinal board stretcher .

13 At 23.47.12 a BTP dog handler, PC Philip Healy, can
14 be seen entering the City Room with his police dog.
15 Then at 23.47.36, Chief Inspector Dexter and
16 Inspector Smith are recorded as speaking to each other
17 in the City Room.

18 At 23.47.50, so well over an hour after the
19 explosion , indeed well over an hour and 15 minutes,
20 chest compressions are started on John Atkinson, who is
21 still at that point in the war memorial entrance to
22 Victoria Railway Station. Chest compressions continue
23 as he is wheeled towards an ambulance.

24 At 23.51.42, a number of ETUK medics can be seen
25 leaving the City Room and making their way towards the

1 station concourse. Then at 23.56.11, BTP Chief
2 Inspector Andrea Graham is captured on the raised
3 footbridge making her way towards the City Room. She is
4 captured, at 00.00.58, just outside the City Room.

5 We'll have {INQ032822/421} on the screen, please.

6 Again, Chief Inspector Graham is an officer we will
7 hear from during the course of the inquiry . Could that
8 be taken from the screen , please?

9 At 23.57.15, NWAS Consultant Paramedic Dan Smith can
10 be seen taking off his commander's tabard. Within
11 5 minutes NWAS Deputy Director of Operations
12 Stephen Hynes, who's first identified at the scene at
13 23.50, is seen wearing a commander's tabard, having
14 relieved Mr Smith of his role as NWAS operational
15 commander.

16 {INQ032822/417}, please. Mr Hynes is arriving and
17 relieving Mr Smith of his role as operational commander.

18 At 00.03.52, BTP Chief Inspector Graham can be seen
19 walking across the City Room together with two other BTP
20 officers . She approaches GMP Inspector Smith.

21 Ten minutes later , at 00.13.52, Chief Inspector Graham
22 can be seen using her mobile telephone and then
23 3 minutes later , at 00.16.47, Chief Inspector Dexter
24 approaches NWAS Operational Commander Stephen Hynes.

25 At 00.19.13, an explosive ordnance officer enters

1 Victoria Railway Station . He and a colleague make their
2 way to the raised footbridge where they speak to Chief
3 Inspector Graham before entering the City Room and
4 making contact with Inspector Smith.

5 At 00.23.38, HART Paramedics Hargreaves and Vaughan
6 leave the City Room and make their way to the station
7 concourse. Then, 4 minutes later , at 00.27.43,
8 Detective Chief Superintendent Denise Worth, the GMP
9 duty senior investigating officer , entered Victoria
10 Railway Station and she is subsequently captured at
11 various points moving around the station and arena
12 complex, including spending time in the City Room.

13 At 00.31.55, Advanced Paramedic Patrick Ennis is
14 captured going up on the mezzanine area of the City Room
15 for the first time. At 00.37.02, Chief Inspector Dexter
16 is recorded speaking to the NWAS Operational Commander,
17 as he had become, Hynes on Station Approach.

18 Then at 00.37.08 is another significant development
19 because at that time, a GMFRS fire engine arrives on
20 Station Approach, the first to do so. A second GMFRS
21 vehicle follows close behind. These are followed by two
22 more fire engines seconds later . As will be apparent,
23 this was 2 hours and 6 minutes after the explosion , and
24 an important issue for the inquiry to investigate will
25 be how that came to pass and whether it made any

1 difference .

2 We'll have {INQ032822/466} on the screen, please.
3 00.37.08. The first engine of the Fire and Rescue
4 Service is seen to arrive .

5 At 00.37.37, GMFRS Station Manager, as he was then,
6 and NILO, Andy Berry, can be seen getting out of his
7 motor vehicle and shortly thereafter he speaks to the
8 NWAS operational commander, Hynes, and Ground Assigned
9 Tactical Firearms Officer Dexter.

10 By 00.41.51, Chief Inspector Dexter and Chief
11 Inspector Graham of respectively GMP and BTP can be seen
12 walking across the City Room. Chief Inspector Dexter
13 can then be seen speaking to GMP Inspector Smith, the
14 Bronze Commander.

15 At 00.46.06, Chief Inspector Dexter can be seen
16 giving a briefing to a large number of firearms officers
17 on the arena concourse side of the doors to the
18 City Room. During this time BTP Chief Inspector Graham
19 enters the same space as the briefing for a short time.
20 Outside on Station Approach, at 00.44.44, Patrick Ennis
21 is speaking to approximately ten GMFRS personnel.
22 Following this briefing the firefighters walk down
23 Station Approach towards Corporation Street .

24 Then at 00.48.02, GMFRS can be seen moving
25 stretchers along Station Approach towards the entrance

1 of Victoria Station . They can subsequently be seen
 2 assisting paramedics on the station concourse. The
 3 number of GMFRS personnel in the station increases as
 4 time passes .
 5 Could we have on the screen , please ,
 6 {INQ032822/504}? As will be apparent, this is by now
 7 2 hours and 18 minutes after the explosion . We see the
 8 firefighters pulling a number of empty stretchers along
 9 Station Approach and heading towards an entrance to the
 10 station .
 11 SIR JOHN SAUNDERS: Do you have to know where these
 12 stretchers come from? Are they fire engine --
 13 MR GREANEY: Again, we'll have an answer when we return. My
 14 understanding is that the answer to that question is
 15 yes .
 16 At 00.50.37, a large number of BTP and GMP officers
 17 make their way towards the City Room, which, at this
 18 time, has no more than a handful of officers in . Once
 19 in the City Room, they appear to be organised by
 20 Inspector Smith as they walk in a line around the very
 21 edge of the City Room before entering the arena
 22 concourse .
 23 At 00.59.33, GMFRS station manager and duty NILO
 24 Berry speaks to Chief Inspector Dexter. He had followed
 25 Dexter for a period waiting for him to end the call

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1 he was on .
 2 Shortly thereafter , at 01.00.45, Chief Inspector
 3 Graham approaches and speaks to GMP Chief
 4 Inspector Dexter .
 5 So in that period , which covers 90 minutes after the
 6 first hour , a number of key events are captured on the
 7 CCTV from the scene. These include the transportation
 8 of both Georgina Callander and John Atkinson from the
 9 scene to hospital prior to midnight, the removal of the
 10 last injured person from the City Room, meetings between
 11 commanders, a change of NNAS operational commander, the
 12 arrival of BTP Chief Inspector Graham shortly before
 13 midnight, the arrival of the GMP duty SIO at 00.27, and,
 14 at 00.37, the arrival on scene of GMFRS .
 15 Against that background, which we appreciate has
 16 included a good deal of detail , but necessary detail ,
 17 we will turn as the final part of our opening statement
 18 on chapter 10 to consider the preparedness and response
 19 of each of the emergency services .
 20 As we have indicated already , we will deal with the
 21 emergency services in the order in which they arrived on
 22 the scene, so British Transport Police , Emergency
 23 Training UK, station staff , Greater Manchester Police ,
 24 North West Ambulance Service, and Greater Manchester
 25 Fire and Rescue Service , and at the same time as we deal

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1 with GMFRS, we will deal with North West Fire Control .
 2 Before we embark upon this part of our opening
 3 statement, it is important that we acknowledge the
 4 pressure that those who responded to the attack at the
 5 Manchester Arena came under. It must, we acknowledge,
 6 have been enormous. Which of us who was not there and
 7 not required to make critical decisions in the agony of
 8 the moment can understand what that felt like? This
 9 process must understand that and our investigation must,
 10 counsel to the inquiry considers , not be used to vilify
 11 those who did their best on the night , but made mistakes
 12 or who could have done better .
 13 Still , what we must do is to probe deeply , although
 14 fairly , into the emergency response that night . If
 15 there were mistakes or failures , they will need to be
 16 revealed , not because our purpose is to criticise , but
 17 instead so that the bereaved families may know the truth
 18 and also so that real lessons may be learned and things
 19 made better in the future .
 20 First , we will deal with BTP and the preparedness of
 21 that organisation for a terrorist attack at the
 22 Manchester Arena and more generally .
 23 1. The Local Resilience Forum. As a category 1
 24 responder, BTP was a member of the Greater Manchester
 25 Resilience Forum. The records reveal that the meetings

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1 of GMRF were not regularly attended by a representative
 2 of BTP, with such a representative apparently being
 3 present at only three of the nine meetings prior to the
 4 attack. Given the resilience forum's focus on ensuring
 5 a multi-agency response, in the context of the extensive
 6 of cooperation and coordination which took place on
 7 22 May the inquiry will need to investigate BTP's
 8 attitude towards the resilience forum and whether that
 9 had any impact on the response on the night .
 10 2. Plans. BTP's response to major incidents is set
 11 out in its major incident manual. According to
 12 Assistant Chief Constable O'Callaghan, who has provided
 13 the BTP corporate statement, the edition which was
 14 current as at 22 May 2017 came into force in 2011. It
 15 was replaced a month after the attack .
 16 Because JESIP was not instituted , as we have
 17 observed already , until 2012 the BTP major incident
 18 manual at the time did not expressly embed JESIP
 19 principles . Furthermore, its focus is substantially
 20 upon the response to incidents on the railway network .
 21 In light of the extent of the multi-agency response
 22 on the night, it will be necessary for the inquiry to
 23 investigate whether any defects in BTP's documentation
 24 made a difference to the emergency response .
 25 Furthermore, BTP did not have a plan in place

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1 specific to the arena. By contrast, GMP did have such
 2 a plan. This was despite the fact that at the time of
 3 the attack, both GMP and BTP regarded BTP as having
 4 primacy over the arena.
 5 The absence of a BTP plan for the area over which
 6 BTP had primacy and whether this had any impact on the
 7 adequacy and effectiveness of the response will need to
 8 be considered by the inquiry in the context of its wider
 9 investigation of the issue of primacy, about which
 10 we have already made observations.
 11 3. Training. ACC O'Callaghan describes in the BTP
 12 corporate statement that since the College of Policing
 13 launched JESIP, training is provided across the ranks in
 14 both JESIP and major incidents. The inquiry intends to
 15 investigate, both at a corporate level but also at an
 16 individual level, the nature and extent of the training
 17 relevant to responding to an incident such as that which
 18 occurred on 22 May.
 19 4. Still dealing with preparedness, training
 20 exercises. Following the Paris attacks of 2015,
 21 Operation Sherman, a tabletop exercise, was run twice.
 22 The purpose of the exercise was to explore and test the
 23 resilience of Greater Manchester. On each occasion the
 24 scenario involved a marauding firearms terrorist attack.
 25 The first of these exercises took place in 2015. The

1 second took place in July 2016. The venue in the first
 2 scenario was the Trafford Centre, but the venue in the
 3 second, less than one year before Salman Abedi's attack,
 4 was Victoria Railway Station.
 5 The latter scenario involved a building intelligence
 6 picture culminating in reports of a shooting in the box
 7 office area of the Manchester Arena. In other words,
 8 the scenario envisaged a terrorist attack in the
 9 City Room. BTP was invited to attend and participate in
 10 Operation Sherman, this exercise. Given the chilling
 11 prescience of the second Operation Sherman scenario just
 12 10 months before the attack, the inquiry will
 13 investigate Operation Sherman very closely and the
 14 learning which was or was not derived from it. Indeed,
 15 the very fact that the terrorist attack was expressly
 16 envisaged and promoted as a suitable set of facts for
 17 a very substantial multi-agency exercise itself may be
 18 considered to speak volumes about how obvious a target
 19 for terrorists in 2017 the City Room was.
 20 BTP also participated in Exercise Red Kite in
 21 June 2016, a training exercise designed to test command
 22 and control preparedness for an MTFA. The exercise
 23 scenario included a declaration of Operation Plato.
 24 The inquiry will investigate these and all of BTP's
 25 involvement in relevant exercises together with what

1 learning was identified and whether that was effectively
 2 implemented prior to the attack.
 3 We will turn now to provide an overview of the BTP
 4 response to the attack. At the time of the explosion,
 5 there were four BTP officers, PC Bullough and PCSOs
 6 Morrey, Renshaw and Brown within the Victoria Railway
 7 Station complex. At that moment, the moment of the
 8 explosion, they were together, as a four, close to the
 9 war memorial entrance to the station. Immediately upon
 10 hearing the explosion, they began to make their way
 11 towards the City Room.
 12 At 22.32.19, PCSO Renshaw made a radio broadcast
 13 stating:
 14 "We need more people at Victoria: we just had a loud
 15 bang."
 16 As we've seen, the CCTV reveals that fewer than
 17 2 minutes after the detonation at 22.32.47, three of
 18 those officers entered the City Room. PC Bullough, who
 19 was the first to enter the City Room, describes in her
 20 statement having heard a loud bang. She says that she
 21 observed adults and children screaming and running away
 22 from the City Room and some appeared to be injured. In
 23 her statement, PC Bullough describes the City Room once
 24 she'd entered it in this way:
 25 "At this point I ran into the City Room and I can

1 only describe it as a war zone there. There were
 2 a number of casualties on the floor, blood everywhere,
 3 and the whole place was smoky and, in my words, was
 4 carnage. There were nuts and bolts scattered everywhere
 5 and the smell was a strong smell of gunpowder and
 6 burning material."
 7 At 22.33.50, PC Bullough broadcasted the following:
 8 "It's definitely a bomb. People injured. At least
 9 20 casualties."
 10 Police Sergeant Cawley, who was in his office at the
 11 nearby Peninsula Building, sent a radio message at
 12 22.33.09, stating that he had heard a bang from there
 13 and asking for an update.
 14 So far as requests for other agencies are concerned,
 15 at 22.32.54, there was a request by BTP for GMP, and at
 16 22.34.04, PC Bullough made the first of a number of
 17 requests for ambulances.
 18 At 22.35.00, just 4 minutes after the explosion,
 19 PCSO Morrey asked for as many resources as possible.
 20 At 22.44.25, Constable Roach nominated the Fish Dock
 21 car park as the rendezvous point or RVP. PC Roach was
 22 asked for a different RVP and he nominated the Sandpit
 23 on Deansgate.
 24 When PCSO Renshaw asked about RVPs he was told it
 25 was the Fish Dock at 22.53.23. At 22.58.28, there was

1 a discussion between PC Roach about the Fish Dock as the
 2 RVP.
 3 At 22.55.15, a full 24 minutes after the explosion ,
 4 PC Roach said to Control said :
 5 "You're going to hate me, where's our ambulances,
 6 please?"
 7 To which the controller replied :
 8 "We don't know. We're calling them again."
 9 As the CCTV evidence we have summarised already
 10 makes clear, within the first 10 minutes at least 12 BTP
 11 officers had reached or were in the immediate vicinity
 12 of the City Room. Those who entered offered assistance
 13 to the people they encountered. The inquiry might in
 14 due course conclude that in behaving as they did, they
 15 showed the very best of humanity, acting selflessly and
 16 without apparent regard for the danger they themselves
 17 might be in in order to help those who needed it.
 18 We now turn our focus away from BTP at the scene to
 19 consider what was happening within BTP elsewhere during
 20 this time and how that related to what was going on on
 21 the ground.
 22 We'll start with the control rooms. BTP has two
 23 control rooms, one in Birmingham and one in London.
 24 They are referred to as Force Control Room Birmingham,
 25 FCRB, and Force Control Room London, FCRL, respectively.

1 The senior duty officer , or SDO, who is in command of
 2 both control rooms, was based in London. On the night,
 3 the SDO was Chief Inspector Tony Lodge. Beneath the SDO
 4 in the command structure is the force incident manager,
 5 referred to as the FIM, who at the time of the attack
 6 was Inspector Ben Dawson, who was also based in London
 7 in the control room.
 8 As the FIM, it was Inspector Dawson's responsibility
 9 to take initial command of the incident as other roles
 10 of the command structure were populated.
 11 Inspector Dawson had joined BTP in 2006, and about
 12 a week before the attack, he had received refresher
 13 training covering major incidents , which had included
 14 learning further about JESIP. He had also been trained
 15 in tactical firearms command, in Operation Plato and in
 16 Bronze Command.
 17 The BTP computer system, known as Control Works,
 18 records Inspector Dawson, the FIM, as becoming aware of
 19 an unfolding incident at 22.33.52, so about 2 minutes or
 20 so after the explosion . Chief Inspector Lodge reports
 21 that Inspector Dawson then informed him of the incident .
 22 At 22.35.04, it 's recorded that the FIM was asking for
 23 an early update from the scene, his first recorded
 24 action as initial incident commander.
 25 That request included a request for a METHANE

1 report . A METHANE report, as we have explained, is an
 2 essential part of ensuring good situational awareness of
 3 any incident . It will be record that it 's an acronym
 4 with the M standing for major incident , which is
 5 intended to prompt the question , "Has a major incident
 6 been declared?"
 7 The purpose of the METHANE report is to obtain key
 8 information about an incident in a structured manner.
 9 This information can then be passed on to those who are
 10 responding including responders from other agencies .
 11 The request for a METHANE report was repeated at
 12 23.38.44. Inspector Dawson of BTP states that he
 13 considered himself declaring Operation Plato. He states
 14 he decided not to do so as it seemed to him that this
 15 was a single-person attack .
 16 The policing experts have considered this decision
 17 and they regard it as being reasonably open to
 18 Inspector Dawson to have taken that approach. We pause
 19 to observe that at the time BTP had no armed assets
 20 in the immediate Manchester area. The inquiry will
 21 examine in those circumstances what a declaration of
 22 Operation Plato by Inspector Dawson would really have
 23 meant in practice for BTP if called .
 24 At 22.39.14, the BTP incident log records that
 25 Inspector Dawson had declared a major incident for BTP.

1 At 22.39.23, PC Trow of BTP broadcast that there were
 2 about 60 casualties . That report, the report of 22.39,
 3 was passed on to NWS at 22.41.42. In the course of
 4 that call BTP informed NWS that they had declared it
 5 a major incident .
 6 At 22.44, Inspector Dawson updated the log with:
 7 "I require a METHANE report urgently."
 8 The log and radio traffic records that this request
 9 is repeated a number of times.
 10 At 22.58.13, Sergeant Cawley asked to be talked
 11 through the METHANE report process. Inspector Dawson
 12 did so and over the course of the ensuing minutes, each
 13 element of the METHANE report was addressed by
 14 Sergeant Cawley.
 15 Sir, we now, I hope, are going to listen to the BTP
 16 METHANE recording that occurred at 22.58, so 28 minutes
 17 after the explosion .
 18 (Audio played to the inquiry)
 19 We have just heard the force incident manager for
 20 BTP, Inspector Dawson, in the control room in London,
 21 receiving a METHANE report from Sergeant Cawley, who is
 22 on the ground in Manchester. As we indicated, the
 23 purpose of a METHANE report is to obtain key information
 24 about an incident in a structured manner so that that
 25 information can then be passed on to those responding,

1 including responders from other agencies.
 2 As we've just heard, as part of the METHANE report,
 3 PC Cawley stated, "It's our jurisdiction , confirmed".
 4 This may be a reference to the issue of primacy and
 5 we will need to explore that.
 6 Furthermore, as part of the METHANE report, at
 7 23.01.37 Sergeant Cawley stated that there were at least
 8 100 casualties and stated a need for ambulances.
 9 A number of entries in the BTP incident log
 10 immediately before and after the 2300 hours query
 11 whether BTP or GMP has jurisdiction, which again may be
 12 a reference to the question of primacy, as we said
 13 earlier today, an important issue for the inquiry to
 14 investigate .
 15 Between the requests for a METHANE report and the
 16 Force Control Room London receiving it, Chief Inspector
 17 Lodge spoke to the BTP divisional commander for the
 18 geographical area which includes the arena, known as
 19 C Division . That is a chief superintendent whose name
 20 is Allan Gregory. The log records the conversations
 21 having occurred at 22.53.43. The chief superintendent
 22 was in Birmingham at the time at a hotel a short
 23 distance from Force Control Room Birmingham.
 24 Shortly before 23.01.28, which is the time the
 25 conversation is logged, and whilst Inspector Dawson was

1 receiving the METHANE report, Chief Inspector Lodge, the
 2 SDO, was in contact with the on-call chief officer who
 3 that night was Assistant Chief Constable Robin Smith.
 4 At 23.16.46, the BTP incident log records a message
 5 from Chief Superintendent Gregory that Superintendent
 6 Kyle Gordon had been requested to attend from his home
 7 address. Superintendent Gordon was to become the BTP
 8 Bronze Commander, although, as we shall see, whether he
 9 performed any meaningful role in that capacity is
 10 a matter for investigation .
 11 At 23.18.12, the log records a message from the Fire
 12 and Rescue Service to the effect that their rendezvous
 13 point was Philips Park Fire Station and that they had no
 14 requests of BTP at that time.
 15 At 23.31.00, the command structure is recorded
 16 in the BTP incident log as confirmed as being
 17 Superintendent Gordon as Bronze Commander, Chief
 18 Superintendent Gregory as Silver Commander, and
 19 ACC Smith as Gold Commander.
 20 23.34.09. Chief Superintendent Gregory took over
 21 tactical command of the incident from Inspector Dawson,
 22 the FIM.
 23 Having reviewed in selective summary some of the key
 24 events which were taking place in Force Control Room
 25 London during the first hour, we will now consider the

1 actions of each of those identified in the command
 2 structure message before and after they formally took up
 3 their role .
 4 First , the BTP Gold Commander. ACC Smith was first
 5 notified of the incident in his capacity as on-call
 6 chief officer by Chief Inspector Lodge shortly before
 7 23.00. At that time he was at home in the south-east .
 8 ACC Smith has more than 30 years' experience as a police
 9 officer and joined BTP in 2016. Having spoken to Chief
 10 Superintendent Gregory, ACC Smith spoke to the BTP
 11 Chief Constable, and he was instructed to travel to
 12 Manchester. ACC Smith's records indicate that he was on
 13 the motorway by 00.37.
 14 By around 01.00, so 1 o'clock in the morning,
 15 ACC Smith had spoken to the GMP Gold Commander,
 16 ACC Ford. During this conversation it was agreed
 17 between them that GMP would lead the overall response to
 18 the incident .
 19 By 4 am, ACC Smith had reached GMP HQ in time to
 20 attend the first strategic coordinating group meeting
 21 which took place at 04.15. It was at this meeting that
 22 ACC Smith first learned that GMP had declared
 23 Operation Plato, so many hours after that had occurred.
 24 Why he did not learn this earlier is obviously an
 25 important issue for the inquiry to investigate .

1 Next, the BTP Silver Commander. For the first hour,
 2 this role was taken by Inspector Dawson. However,
 3 he was relieved , as we have said, by Chief
 4 Superintendent Gregory. Chief Superintendent Gregory
 5 was notified of the incident prior to 22.52. He had
 6 joined BTP in 1996 and had become the commander for
 7 C Division the year before the attack .
 8 He spoke to Superintendent Gordon before 23.15 and
 9 appointed him as Bronze Commander. The reasoning for
 10 this is recorded in his statement in the following
 11 terms:
 12 "It was important to have a senior commander on the
 13 scene in order to have an accurate picture of what was
 14 happening on the ground and how the situation was
 15 developing."
 16 So it was important to have a senior commander on
 17 the scene in order to have an accurate picture of what
 18 was happening on the ground and how the situation was
 19 developing .
 20 This is a decision which will be the subject of
 21 careful and close scrutiny by the inquiry . The choice
 22 of Superintendent Gordon, as we shall see, led to there
 23 being no nominated BTP Bronze Commander on the ground
 24 until after 1 am, despite the fact that BTP's internal
 25 contemporaneous records may record in the first hour

1 that they regarded themselves as having primacy, that is
2 to say that they were taking the lead over GMP in terms
3 of the policing response.

4 In the result , by the time that
5 Superintendent Gordon arrived at the scene, primacy had
6 been formally agreed to rest with GMP in the
7 conversation between ACC Smith and ACC Ford at around
8 1 am.

9 The inquiry will consider all of these facts in the
10 context of the response and, in particular , the degree
11 and extent of multi-agency cooperation in accordance
12 with JESIP and will establish whether, as part of any
13 multi-agency failure that there may have been, the
14 adequacy and effectiveness of the emergency response was
15 adversely affected .

16 At 23.34, Chief Superintendent Gregory is recorded
17 as taking Silver Command, relieving Inspector Dawson.
18 By midnight, Chief Superintendent Gregory had made
19 inquiries about Chief Inspector Graham, another
20 significant BTP officer in relation to the issue of
21 command and control.

22 Shortly after this inquiry , the log records that
23 Chief Inspector Graham was at the arena. As we saw in
24 the CCTV review, Chief Inspector Graham was captured on
25 the raised footbridge at 23.56. The Control Works entry

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1 at 00.02.07 records Chief Inspector Graham being briefed
2 as Bronze scene commander. Again, this is something
3 we'll return to when we summarise her actions in our
4 next and final section relating to BTP's actions on the
5 night.

6 Also, shortly after midnight, Chief Superintendent
7 Gregory attempted to contact GMP Silver. His records
8 indicate he was seeking to establish which force held
9 primacy and exchange contact details . The Control Works
10 log indicates that he was informed that he would be
11 called back. He states he tried at least once more
12 however, and notwithstanding this , it appears that the
13 BTP Silver Commander did not speak to the GMP
14 Silver Commander throughout the course of the critical
15 stage of the incident .

16 It was to take until nearly 1.20 the following
17 morning for the BTP systems even to record the name of
18 the GMP Silver Commander.

19 At 00.40, Chief Inspector Gregory contacted Chief
20 Inspector Sue Peters and asked her to go to
21 GMP Headquarters to act as liaison , representing BTP and
22 supporting GMP. Chief Inspector Peters is recorded as
23 arriving at GMP a little over an hour later .

24 Before we turn to deal with the role of the
25 Bronze Commander, it is worth noting that Chief

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1 Superintendent Gregory states that he was never made
2 aware that GMP had declared Operation Plato. This is
3 but one example, albeit a highly significant one, with
4 potential ramifications for the safety and well-being of
5 BTP officers and/or those that they were assisting , of
6 the interagency communication failure which is
7 criticised by the police experts and which the inquiry
8 will investigate .

9 Superintendent Gordon states that he was notified of
10 the incident at approximately 22.45 by
11 Inspector Merchant. He subsequently spoke to Chief
12 Superintendent Gregory and is recorded as having been
13 requested to attend the scene at just after 23.15.
14 Superintendent Gordon explains that his training for the
15 role of Bronze Command was called Initial Public Order
16 Commander, which he undertook in 2009, and in which he
17 received subsequent refresher training .

18 At the time, Superintendent Gordon was the head of
19 operations for C Division . He was based in Manchester
20 and was at his accommodation in Blackpool at the time
21 he was notified . He was not on duty or on call at the
22 time. The first telephone call he received was from
23 Inspector Merchant. This was a request for permission
24 to task operations department assets to the arena as
25 there may have been an explosion .

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1 Superintendent Gordon states that he was
2 subsequently spoken to by Chief Superintendent Gregory,
3 who instructed him to go to the scene and take up
4 Bronze Command. He states that because he was intending
5 to work on the way, he ordered a taxi , which drove him
6 from Blackpool to Manchester.

7 The Control Works records record that at 23.55.46,
8 Superintendent Gordon estimated his arrival on scene
9 would be about 30 minutes thereafter . An email from
10 Superintendent Gordon to Chief Superintendent Gregory at
11 00.19 stated that he was about 20 minutes out, but that
12 there might be diversions . In the event,
13 Superintendent Gordon did not arrive on scene until some
14 time after 1 am. In his witness statement,
15 Superintendent Gordon describes the taxi encountering
16 difficulties with road blocks and ultimately being
17 escorted through to the arena by a GMP officer.

18 Once at the scene, Superintendent Gordon reports
19 that he had difficulty identifying an individual in
20 charge. The Control Works log records that at 01.19.59
21 a report from the scene was requested by ACC Smith from
22 Superintendent Gordon. An entry from the same log timed
23 Superintendent Gordon as being on the scene at 01.23.56.
24 In his witness statement, Superintendent Gordon
25 suggested that he arrived sooner than this , although

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1 still after 1 am. We will need to establish , so far as
2 possible , his actual time of arrival and, moreover, what
3 he did once he arrived .

4 Whilst at the scene, Superintendent Gordon reports
5 that he met with Chief Inspector Graham and, after
6 checking on the welfare of officers , convened a briefing
7 inside the Beer House within Victoria Railway Station .
8 Superintendent Gordon was given an overview by Chief
9 Inspector Graham and was told about Operation Plato by
10 BTP Inspector Cooper.

11 At 01.57.37, Superintendent Gordon had provided
12 a situation report to ACC Smith. At around this time,
13 Superintendent Gordon was also informed that GMP had
14 primacy and he moved then to a liaison role . This was,
15 as will be obvious, long after Superintendent Gordon was
16 capable of having any meaningful role .

17 As such, it would seem that Superintendent Gordon
18 did not in fact ever act as BTP operational commander
19 for the policing response to the bombing. It would
20 appear that no one did, despite BTP appearing to assert
21 internally that it had primacy in the early stages .
22 Indeed, by the time Superintendent Gordon had arrived ,
23 the need for an immediate response had long since
24 passed. The inquiry will need to investigate this and
25 whether or not the absence of a BTP operational

1 commander affected the adequacy and effectiveness of the
2 emergency response. One part of this will be to
3 consider whether the decision to appoint Superintendent
4 Gordon was the correct one.

5 The GMP Bronze Commander was an inspector rank.
6 Chief Inspector Graham of BTP arrived over an hour
7 before Superintendent Gordon. She was trained in public
8 order Bronze Command and JESIP as well as major incident
9 and firearms and active shooter incidents . She already
10 had a good working relationship with the arena staff .
11 She has stated that she was informed about the attack at
12 about 22.40 by her husband after she had gone to bed.
13 She explains that she responded immediately and drove
14 straight to the Peninsula Building where she arrived at
15 approximately 23.10 in order to collect her uniform.
16 From there she went to Victoria Railway Station .

17 The policing experts are critical of Chief Inspector
18 Graham's actions in a number of respects. They take the
19 view that she was or ought to have been the BTP
20 Bronze Commander and that she failed to take any actions
21 in pursuit of that role with multi-agency communication
22 under JESIP forming a significant part of that.

23 Chief Inspector Graham has responded to these
24 criticisms in a further statement and her position is
25 emphatically that this was not her role , although she

1 also says that if it had been her role , it would not
2 have made any difference .

3 Consideration of these criticisms and the response
4 will form part of the inquiry 's overall investigation
5 into the command response by British Transport Police ,
6 whether it was deficient and, if it was, whether that
7 deficiency made any response [sic] to the adequacy and
8 effectiveness of the emergency response.

9 SIR JOHN SAUNDERS: Any difference, I think.

10 MR GREANEY: Any difference, quite right, sir .

11 We are turning next to deal with the opinions of the
12 experts. Would that be a convenient moment to break for
13 lunch?

14 SIR JOHN SAUNDERS: Right. We will break for an hour and
15 a quarter. 1.20, please. Thank you very much.
16 (12.03 pm)

(Lunch adjournment)

17 (1.20 pm)

18 SIR JOHN SAUNDERS: Mr Greaney.

19 MR GREANEY: I am going to ask that {INQ032822/36} from the
20 sequence of events we've been studying this morning be
21 put back on the screen, please.

22 This is an image timed at 22.36.13, and it shows two
23 BTP officers arriving into the station following the
24 arrival of several other officers before this. When
25

1 this image was shown on the screen, you asked where the
2 BTP vehicles had arrived at the station had come from.
3 The answer to that question is that they came from
4 a variety of locations : some came from Manchester
5 Piccadilly Railway Station and some were on mobile
6 patrol nearby.

7 SIR JOHN SAUNDERS: Thank you.

8 MR GREANEY: Next, could {INQ032822/504} be put on the
9 screen, please. This is an image timed at 00.48 hours.
10 It shows firefighters pulling empty stretchers along
11 Station Approach in the direction of the entrance to the
12 railway station .

13 When this image was shown, sir, you enquired which
14 organisation those stretchers belonged to. Our current
15 understanding, and this seems to be the understanding of
16 those CPs, core participants , who have a direct interest
17 in this issue, is that they are NWS stretchers, so
18 ambulance service stretchers .

19 SIR JOHN SAUNDERS: Thank you.

20 MR GREANEY: Sir, finally, before I return to the opening
21 statement on chapter 10, may we acknowledge that the
22 session this morning was dense with information and I'm
23 relieved that I was not the only one that found it heavy
24 going and indeed it has been relayed to me that some
25 members of the bereaved families found it a long session

1 albeit a valuable session from which they learnt .
2 We would like to assure everyone that the balance of the
3 opening today and tomorrow will be more narrative and
4 we will make certain that no session is for any longer
5 than 90 minutes.
6 SIR JOHN SAUNDERS: Mr Greaney, there's a lot of detail in
7 this inquiry . There are going to be sessions when
8 we are dealing with a lot of detail , so I'm afraid it 's
9 inevitable that will happen.
10 MR GREANEY: We respectfully agree, sir.
11 We're going to return to our opening statement on
12 the emergency response. As all will , I hope, recall ,
13 we were dealing with the response of British Transport
14 Police . We are going to turn next to summarise the
15 expert policing evidence so far as it relates to the
16 response of BTP.
17 As we've said already the inquiry instructed
18 Iain Sirrell , Ian Dickinson and Scott Wilson as policing
19 expert witnesses . They have jointly prepared the
20 following reports .
21 First, what they described as their report on
22 policing and multi-agency planning dated July 2019.
23 This report provided an overview of the national
24 policing arrangements that were in place in May 2017,
25 including how police forces were expected to plan,

1 prepare and respond to mass casualty incidents and
2 terrorist attacks .
3 Their second report, they entitled "An analysis of
4 the adequacy and effectiveness of the police response to
5 the Manchester Arena attack".
6 That report is dated May of this year. Part 1 of it
7 considered the preparedness of policing in
8 Greater Manchester to deal with mass casualty incidents
9 and terrorist attacks . Part 2 reviewed how this
10 preparation was put into practice during the emergency
11 response of the police on the night of the attack. The
12 report was amended in August of this year in light of
13 observations made by core participants , and the policing
14 experts explained those amendments in an addendum report
15 dated 3 August.
16 The policing experts described the overall conduct
17 of BTP on 22 May as "extremely good."
18 The courageous conduct of those officers who entered
19 the City Room to provide treatment was, they thought,
20 quite outstanding and worthy of proper recognition .
21 However, the experts also identified areas for
22 improvement. Their main findings in relation to British
23 Transport Police may be summarised as follows.
24 Primacy. The policing primacy of BTP for
25 Manchester Arena is based solely on its ownership by

1 Network Rail, but BTP does not specialise in the
2 policing of large entertainment facilities .
3 Accordingly, in the view of the experts, its routine
4 provision of policing at the arena does not assure the
5 safety of the public . This, consider the experts, would
6 be better served by Greater Manchester Police.
7 Multi-agency preparations . The GMRF brings together
8 local agencies with responsibility for emergency
9 preparation , planning and response, as we have
10 identified already . The experts query whether BTP is
11 adequately represented in the GMRF, both in terms of
12 seniority and consistent participation in meetings. BTP
13 officers were present , as we have explained , at only
14 three of the nine meetings in the 2 years
15 before May 2017 and a Chief Inspector attended only once
16 in 2 years .
17 Preparation and planning . BTP did not maintain any
18 emergency plan for the arena, nor does it appear that
19 BTP officers were aware of the GMP contingency plan.
20 The experts remark that this is surprising given that
21 BTP had primacy for the arena and Victoria Station .
22 The BTP major incident manual, which was in place on
23 22 May, was, in the view of the experts , out of date.
24 Although it was largely fit for purpose, there were some
25 inadequacies , including insufficient detail about

1 information management and shared situational awareness .
2 Communications and Airwave. Although there were
3 difficulties in maintaining the audio recording
4 capability around the time of the attack, this did not
5 affect the operational response. However, there was no
6 attempt to integrate communications between BTP and GMP
7 at the arena. The experts observe that this was
8 a serious issue because of the potential danger in the
9 arena scene. They add:
10 " If there had been an imminent threat the BTP
11 officers would have been isolated and unaware of
12 directions or tactics communicated to keep them or the
13 public around them safe."
14 Emergency response. As we all heard this morning,
15 a METHANE report was prepared approximately 30 minutes
16 after the explosion and then passed to the BTP control
17 room in Birmingham, but BTP did not share its METHANE
18 assessment with any other agency.
19 Police and multi-agency command. Although BTP
20 declared a major incident at 22.39 hours, it did not
21 communicate this to GMP. The experts observe that this
22 was a significant issue which restricted a shared
23 understanding of the situation . All other responding
24 agencies could have been made aware of the declaration
25 so that they could take the necessary action .

1 Finally , BTP command. The senior BTP officer at the
 2 scene was Chief Inspector Andrea Graham, whose movements
 3 and actions we've considered already. Rather than
 4 engaging in any multi-agency command, in the opinion of
 5 the experts she acted independently and had only minimal
 6 contact with GMP commanders. The BTP strategic
 7 commander appointed a Chief Superintendent in Birmingham
 8 as the tactical commander and a superintendent in
 9 Blackpool as operational commander. The latter had no
 10 police radio or vehicle and took 2 hours at least to
 11 arrive at the scene.

12 The experts found in summary that none of the three
 13 levels of BTP command appeared to exert any multi-agency
 14 or effective scene command. All of this will require
 15 consideration by the inquiry . It is important to
 16 restate that, as we have already observed, the inquiry
 17 has made no prejudgments and it will be for the chairman
 18 to resolve the issues raised by the experts once all of
 19 the evidence has been heard.

20 We are next turning to the lessons that BTP has
 21 described itself as having learned .

22 ACC Sean O'Callaghan has provided the lessons
 23 learned statement on behalf of BTP. It is dated
 24 8 June 2020. This sets out the changes that have been
 25 made as a result of BTP's inquiries into its own

1 performance on 22 May.

2 The change described in that statement can be
 3 summarised as follows. BTP and SMG now meet monthly to
 4 review arena events. The meeting reports are
 5 incorporated into BTP's risk assessments for the
 6 policing provision . Formal risk assessments are
 7 conducted for each arena event. The allocation of
 8 officers to arena events is now governed by a four- tier
 9 system of risk evaluation in which increased risk is met
 10 with increased levels of command and control.

11 Sergeants now share the same shifts as the officers
 12 they are supervising for arena events. The briefing to
 13 officers provides a detailed review of the risk level
 14 and any key information or intelligence . All briefings
 15 now contain a counter- terrorism awareness element.

16 BTP's armed policing capability has been extended to
 17 cover Manchester and other areas of the UK, thereby
 18 enhancing its protective security arrangements.
 19 A national position of Superintendent "Protect and
 20 Prepare" has been created, whose role includes the
 21 introduction of detailed electronically stored emergency
 22 plans and BTP officers are now issued with additional
 23 first aid equipment, including multiple bandage
 24 dressings , burn dressings , and face masks to assist with
 25 mouth-to-mouth resuscitation . The role of this inquiry

1 will be to consider whether those are all of the lessons
 2 that needed to be learnt by British Transport Police .

3 Joining the threads together, the inquiry legal team
 4 considers that the principal issues for consideration
 5 in relation to BTP are as follows .

6 1. Was BTP prepared? This will include
 7 consideration of the involvement of BTP in the Local
 8 Resilience Forum, what planning took place and what
 9 exercising was undertaken by BTP. The lack of
 10 a site- specific arena plan, for example, will be
 11 something which is examined along with all other
 12 relevant matters of preparation .

13 2. Primacy. The freehold for the arena and
 14 City Room was owned by Network Rail. As a result, the
 15 City Room was within the jurisdiction of BTP. Because
 16 of this, and for reasons which the inquiry will consider
 17 in detail , both BTP and GMP regarded the starting point
 18 to be that BTP had primacy in relation to incidents that
 19 occurred in the City Room. The inquiry will investigate
 20 the impact of this, both on the preparedness of BTP for
 21 an attack such as occurred on 22 May, and the response
 22 of BTP to it.

23 As to the latter of these, there exist important
 24 questions as to whether what GMP and BTP at a corporate
 25 and individual level considered primacy meant and how it

1 operated in practice had any material impact on the
 2 effectiveness of the response on the night of the
 3 attack. Beyond this, the inquiry legal team foresees
 4 the possibility that the understanding gained from
 5 a close analysis of the issue of primacy on 22 May may
 6 have wider implications for other similar sites around
 7 the United Kingdom.

8 3. JESIP and inter-agency communication. The
 9 policing experts raise concern about the lack of
 10 integration into the multi-agency response on the 22nd
 11 by BTP. Hand in glove with this , and but one example,
 12 was the fact that the BTP METHANE report was not passed
 13 on to any other agency nor does it appear that an
 14 adequate system of communication between BTP and GMP was
 15 ever established during the critical phase of the
 16 response.

17 The inquiry will investigate these matters and
 18 consider the extent to which all or any of them made
 19 a difference . Of course, communication is a two-way
 20 street , and examination of JESIP and inter-agency
 21 communication must therefore be considered by reference
 22 to all emergency responders and not just BTP.

23 4. Sufficiency of equipment and training of BTP
 24 officers . Only three paramedics operated in the
 25 City Room: Patrick Ennis from 22.50 and Lea Vaughan and

1 Christopher Hargreaves of the HART team from 23.15.
 2 Only one stretcher was used on a single occasion in the
 3 evacuation of the injured from the City Room. BTP
 4 officers , among others, brought first aid kits into the
 5 City Room. In the absence of paramedics administering
 6 medical treatment in the City Room, BTP officers sought
 7 along with others to provide treatment, staunch
 8 bleeding , administer CPR and operate defibrillators .
 9 A number of people were transported by, among others,
 10 police officers from the City Room on makeshift carrying
 11 platforms .

12 There are a number of references within the witness
 13 statements obtained from police officers in relation to
 14 the adequacy of their training for the situation they
 15 were confronted with and the availability of equipment
 16 in the City Room. The inquiry will investigate the
 17 concerns which are raised in relation to the adequacy of
 18 first aid training and equipment in the City Room and
 19 consider the impact of the behaviour of the other
 20 emergency responders in this context.

21 5. Overall effectiveness of BTP command and
 22 control . The lack of a Bronze Commander for BTP during
 23 the most critical part of the incident and the actions
 24 of the Silver and Gold Commanders are all matters which
 25 the inquiry will consider through the prism of what

1 might be done better and whether any failings that might
 2 be identified had an impact on the adequacy and
 3 effectiveness of the overall response of the emergency
 4 services .

5 These are all significant issues bearing upon BTP's
 6 response and upon the overall response, but we will
 7 leave those issues for now and turn next to address the
 8 role of Emergency Training UK on the night of the
 9 bombing.

10 We are able to deal with this fairly shortly ,
 11 although that does not mean, of course, that the role of
 12 ETUK demands other than a most careful examination
 13 during the course of the oral evidence hearings.

14 ETUK was the company contracted by SMG, the venue
 15 operator, to provide first aid services at the arena on
 16 the night of the attack . On 22 May, there were 14 ETUK
 17 workers providing medical support at the arena. Two of
 18 these workers were emergency medical technicians ,
 19 referred to as EMTs, and 12 were first-aiders . We will
 20 need to look at the meaning of those terms during the
 21 course of the evidence, but it will suffice for now to
 22 make clear that EMTs were more qualified than
 23 first -aiders , although EMTs are certainly not so highly
 24 trained as paramedics.

25 Following the explosion , members of ETUK were among

1 the first responders to enter the City Room. We've
 2 addressed already , when providing our overview earlier
 3 today, the times of arrival of these people into the
 4 City Room, but we will summarise the position again now
 5 briefly in order to provide context.

6 The first ETUK staff member arrived in the City Room
 7 at around 22.34, so 3 minutes after the explosion . Four
 8 further ETUK staff members reached the City Room within
 9 the first 10 minutes of the explosion and a fifth
 10 entered seconds later . A sixth member of ETUK staff,
 11 Ryan Billington , who now happens to work for NWAS,
 12 entered the City Room at 22.42. He is later captured on
 13 CCTV speaking to Advanced Paramedic Patrick Ennis at
 14 22.58.44, following the arrival of Mr Ennis into the
 15 City Room.

16 Ryan Billington recalls that, upon entering the
 17 City Room, he, that is to say Ryan Billington , sent
 18 a radio message which included the words to the effect
 19 of, "The priority is to stop catastrophic bleeding and
 20 open airways: if there is no pulse they are to be
 21 treated as deceased and move on to the next patient ."

22 He recalls also that Patrick Ennis confirmed to him
 23 that there should be no CPR given to patients in cardiac
 24 arrest . When we come to consider the case of
 25 John Atkinson, the advice to prioritise the stopping of

1 catastrophic bleeding will need to be kept squarely in
 2 mind.

3 Furthermore, the evidence indicates that ultimately ,
 4 all but three of the 14 ETUK staff entered the City Room
 5 during the response to the attack and played some role
 6 in triaging and/or treating victims . Moreover, some of
 7 the ETUK staff had significant contact with several of
 8 the deceased, as we shall see during our analysis of
 9 chapter 12, the experience of each individual deceased.

10 The role of ETUK has been assessed by the ambulance
 11 experts , Michael Herriot and Christian Cooper. They
 12 have considered the contract between SMG and ETUK, the
 13 communication between ETUK and NWAS, the roles, training
 14 and experience of the ETUK staff, and the planning and
 15 risk assessments undertaken by ETUK.

16 The experts comment that to the best of their
 17 knowledge and understanding, there had been no
 18 independent assessment of the adequacy of ETUK to
 19 undertake the range of tasks and clinical services for
 20 which they were contracted by SMG prior to 22 May. The
 21 correctness of this and, if correct , its significance
 22 will need to be assessed by the inquiry .

23 In their report the experts refer to the Purple
 24 Guide to Health, Safety and Welfare At Music and Other
 25 Events, which we'll call "the Purple Guide". The Purple

1 Guide aims to assist and inform event organisers so as
 2 to enable them to manage health and safety at events.
 3 The Purple Guide stipulates that medical providers must
 4 recognise that they may have to provide an initial
 5 response to a major incident, requiring them to supply
 6 intelligence upon which the decision to declare a major
 7 incident is capable of being made by the emergency
 8 service representatives overseeing the event.
 9 The inquiry will wish, and indeed need, to assess
 10 the performance of ETUK by reference to that benchmark
 11 of the Purple Guide.
 12 In their addendum report the experts express the
 13 following relevant views so far as ETUK is concerned.
 14 First, the experts have been unable to locate any
 15 material to demonstrate there was a meaningful working
 16 relationship in respect of risk assessment and planning
 17 between ETUK and NWS, even though both organisations
 18 had attended a number of multi-agency planning group
 19 meetings. The requirement for communication between
 20 ETUK and NWS was well-recognised, both in the Purple
 21 Guide and also in the arena plans, but this approach was
 22 not, in the view of the experts, followed on 22 May,
 23 leading to NWS having a much lower level of situational
 24 awareness than could and, we will explore, should have
 25 been the case.

1 Second, although ETUK could not be expected to
 2 manage the response to a major incident, early
 3 communication with NWS via 999 would have been
 4 expected, say the experts. This would have allowed ETUK
 5 to report the incident and pass a METHANE message in
 6 order to give information about the scale of the
 7 incident, but this did not happen.
 8 Third, the experts conclude that the provision of
 9 a level of basic organisation and a structured handover
 10 would have been a reasonable expectation, but this did
 11 not occur so far as ETUK was concerned.
 12 Turning to the preparedness and clinical expertise
 13 of the ETUK responders, the ambulance experts know that
 14 there is evidence that those injured were attended to by
 15 members of ETUK staff on a number of occasions, but that
 16 triage was not undertaken as stipulated in standard
 17 procedures, although the experts do acknowledge that the
 18 actions of the ETUK staff were what might be expected of
 19 personnel with no specific training or experience in
 20 major incident medical response.
 21 The experts conclude that:
 22 "With the possible exception of first-aiders with
 23 any background or experience in emergency ambulance or
 24 pre-hospital medical response it is unlikely that the
 25 first-aiders at the arena would have been prepared for

1 the level of trauma and distress that they encountered
 2 on 22 May."
 3 Drawing on the Purple Guide, the experts express the
 4 view that the ETUK staff holding only a first aid at
 5 work qualification were inadequate to undertake duties
 6 at the arena. In that regard the inquiry will wish to
 7 note that very many of the ETUK staff have stated that
 8 this was indeed the level of qualification that they
 9 had. The significance of that will need to be assessed.
 10 Against that background, the inquiry will need to
 11 consider, we suggest, the following issues in relation
 12 to ETUK.
 13 The adequacy of the policies and guidelines of ETUK.
 14 The adequacy of the service ETUK was contracted to
 15 provide by the event organiser and, in particular,
 16 whether this was safe.
 17 The ETUK and SMG risk assessment process and
 18 planning prior to the Ariana Grande concert and whether
 19 this was appropriate.
 20 The adequacy of the equipment available to ETUK.
 21 Coordination between NWS and ETUK prior to the
 22 night of the attack.
 23 The training and experience of ETUK workers and
 24 indeed their qualification level.
 25 And finally, the treatment and care provided by ETUK

1 staff on the night of the attack along with the
 2 performance of ETUK as an organisation and its
 3 coordination with other emergency responders.
 4 We will turn next in addressing the emergency
 5 response to the station staff. Again, without seeking
 6 to diminish their role or the need for the inquiry to
 7 scrutinise it closely, their involvement can be dealt
 8 with shortly in this opening statement.
 9 We've already dealt with the involvement of the
 10 station staff during our overview, but once more we'll
 11 summarise it so that there is an appropriate degree of
 12 focus at this stage of our opening statement.
 13 Travel Safe officers Philip Clegg, Reece Mackay and
 14 Neil Pentony reacted quickly to the explosion and began
 15 to make their way to the City Room. Owen Sanderson was
 16 the Northern Rail station supervisor on the night of
 17 22 May and appears to have been the on-duty team leader
 18 and Bronze Commander on site. He heard the noise of the
 19 explosion along with something on the arena radio about
 20 an explosion, he activated the station alarm and then
 21 made his way to the City Room with two colleagues. He
 22 collected the major incident bag which contained first
 23 aid equipment and took that to the City Room.
 24 Mr Sanderson is seen on the station CCTV at 22.39.54
 25 with another member of the station staff and they're

1 both seen to be carrying large NHS first aid kit bags.
 2 These bags are then taken to the City Room, arriving at
 3 22.40.23.
 4 The station CCTV also captures an unidentified
 5 member of Northern Rail staff on the raised footbridge
 6 moving towards the City Room carrying a defibrillator at
 7 22.39.30. Footage also captures several members of
 8 Northern Rail staff helping casualties in the City Room,
 9 unidentified Northern Rail staff are also shown on the
 10 CCTV assisting John Atkinson as he is evacuated from
 11 that area.
 12 In terms of relevant expert evidence, the ambulance
 13 experts refer to evidence provided by station staff and
 14 others within the City Room stating, as we have already
 15 said:
 16 "Fortunately, members of the public, police, rail
 17 and arena staff remained with the severely injured and
 18 gave whatever care and support that they could until
 19 patients were in the care of ambulance and medical
 20 staff."
 21 In their addendum report, the experts comment on the
 22 care provided by volunteers, including station staff.
 23 They state:
 24 "We are unable to comment on how effective such
 25 treatment was but note that the reassurance given

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1 through their attendance has been commented on
 2 positively."
 3 Whilst the statements appear to indicate that
 4 patients were visited by various first-aiders on
 5 a number of occasions and triage was not undertaken as
 6 stipulated in standard procedures, their actions were
 7 all that could be expected of personnel with no specific
 8 training or experience in major incident medical
 9 response.
 10 Philip Jones, the crime reduction manager at
 11 Northern, will be called during chapter 7, which, as we
 12 all now know, deals with the security arrangements
 13 at the arena. But he will be recalled in chapter 10 to
 14 deal with the policy, planning and procedures that
 15 Northern had in place for a terrorist attack and the
 16 training that had been undertaken. He will also deal
 17 with equipment, including the acquisition of trauma
 18 packs and the obtaining of a number of stretchers for
 19 Victoria Station.
 20 Mr Jones also addresses the lessons learned by
 21 Northern. In short, counter-terrorism training sessions
 22 have now been given to staff and Northern has also
 23 engaged with the resilience forum.
 24 The following issues will need to be considered by
 25 the inquiry in relation to the response of the railway

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1 staff on the night: the planning and preparedness of
 2 Network Rail and Northern for a terrorist attack; the
 3 plans of those organisations and whether those plans
 4 reflected the material possibility of a terrorist attack
 5 at Manchester Arena railway station and/or the arena;
 6 communication between Northern Rail and other emergency
 7 responders; the availability of first aid equipment at
 8 Victoria Station; and the care and treatment provided by
 9 railway staff.
 10 We are going to turn next to Greater Manchester
 11 Police. Plainly, this will take longer than the last
 12 two organisations that we've dealt with. We will begin
 13 with GMP's preparedness for a terrorist attack.
 14 First, the Local Resilience Forum. As a category 1
 15 responder, GMP was involved in the GMRF. As with BTP,
 16 the policing experts have raised a query about the
 17 seniority and consistency of participation in the
 18 resilience forum meetings by GMP personnel. Given the
 19 issues surrounding multi-agency response which arise
 20 in relation to 22 May, the inquiry will investigate this
 21 among other aspects of GMP's relationship with the
 22 resilience forum.
 23 Second, plans. As we have made plain, GMP had
 24 a major incident plan. The plan itself was in the view
 25 of the experts fit for purpose and had been updated to

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1 include JESIP. However, as it happened on the night,
 2 a major incident was not declared by GMP until 1 am on
 3 the morning of the 23rd. Unlike BTP, and
 4 notwithstanding the issue as to primacy, GMP did
 5 maintain a contingency plan for the arena. However,
 6 in the view of the experts, it was out of date and in
 7 need of review. In particular, it had not been updated
 8 to include JESIP. The reasons for this will need to be
 9 explored during the oral evidence hearings, including
 10 consideration of whether this was a systemic problem for
 11 GMP.
 12 GMP has contended that because the major incident
 13 plan did include JESIP, it was not necessary to update
 14 subsidiary plans. The potential difficulty with this
 15 line of reasoning may be that the major incident
 16 planning was not activated during the most important
 17 phase of the response on the night of the bombing.
 18 GMP's approach will be a matter for the inquiry to
 19 explore during the course of the evidence.
 20 Third, training. Detective Chief
 21 Constable Pilling's statement sets out that generalist
 22 officers may have had an awareness of multi-agency and
 23 joint working but that specific training sessions for
 24 all inspectors, chief inspectors and superintendents
 25 were introduced in 2014 with a mandatory JESIP

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1 e-learning package implemented in 2015/2016.
 2 The inquiry will investigate the detail of JESIP
 3 training with DCC Pilling and individual officers given
 4 how events developed on the night. This will be in the
 5 context of the conclusions of Operation Iron,
 6 a force-wide review of GMP in March 2017, which
 7 concluded that most staff were unaware of JESIP.
 8 Operation Iron recommended a training programme to
 9 reinforce JESIP principles, and the inquiry will need to
 10 examine how GMP responded to the conclusions of
 11 Operation Iron.
 12 SIR JOHN SAUNDERS: Just before you go on, I think it's
 13 Deputy Chief Constable Pilling; I think you called him
 14 detective. I'm only saying that because just in case
 15 anyone is reporting any of this and to make sure it's
 16 accurate.
 17 MR GREANEY: That's my slip. It is certainly Deputy
 18 Chief Constable Pilling. Thank you for the correction,
 19 sir.
 20 Fourth, training exercises. The policing experts
 21 conclude that in 2017 GMP played a prominent and active
 22 role in training exercises and that GMP appeared to have
 23 recognised the importance of this, despite the cost.
 24 For present purposes, it is necessary that we mention
 25 only two of the large number of relevant exercises that

1 GMP undertook in the period prior to the attack. They
 2 have both been mentioned already but it is relevant to
 3 mention them in the context of our examination of GMP's
 4 response on the night also.
 5 In May 2016, GMP participated in Exercise Winchester
 6 Accord. Exercise Winchester Accord was, as we have
 7 said, a live multi-agency scenario involving an MTFA
 8 at the Trafford Centre. The College of Policing debrief
 9 document notes the following issues which arose.
 10 A lack of police tactical command and presence
 11 at the forward command post at the scene. A lack of
 12 communication with teams on the ground. An inability to
 13 make contact with the GMP force duty officer or FTO and
 14 that additional support for the FTO would have helped.
 15 They further identified confusion between the
 16 tactical firearms commander, the TFC, and the ground
 17 assigned tactical firearms commander, the GATFC, along
 18 with the delay in declaring the warm zone, and low
 19 awareness of terminology in the operational control
 20 room.
 21 During did the exercise, there was a 2.5-hour delay
 22 in GMFRS resources being deployed to the scene. Given
 23 that to a greater or lesser extent all of these issues
 24 arose in some form or another on 22 May 2017, the
 25 inquiry will investigate the degree to which GMP

1 implemented effective learning from Exercise Winchester
 2 Accord and also whether other agencies involved in that
 3 exercise did so.
 4 The second exercise to mention at this stage is
 5 Exercise Sherman, which we've introduced already when
 6 dealing with BTP. As we have said, in this tabletop
 7 exercise in July 2016, the scenario was a terrorist
 8 attack at Manchester Victoria Railway Station including
 9 fatalities in the City Room. GMP was one of the
 10 organisations giving a presentation to the delegates.
 11 The inquiry will seek to understand what learning GMP
 12 derived from its participation in this event,
 13 particularly that the presentation it gave was about its
 14 role in a multi-agency response to something strikingly
 15 similar to that which eventuated on the night of 22 May.
 16 That is all we propose to say about preparedness.
 17 We will turn from that topic to deal with GMP's response
 18 on the night.
 19 First, the command structure. The role of force
 20 duty officer, or FDO, on the night of 22 May was
 21 undertaken by Inspector Dale Sexton. He was the first
 22 GMP commander to assume such a role in relation to the
 23 attack. As the initial commander, he automatically
 24 assumed both the Silver, or tactical, and Gold, or
 25 strategic, Command role until others took up those

1 positions.
 2 The FDO is also the initial tactical firearms
 3 commander, the ITFC, in the event that firearms are
 4 deployed.
 5 At 22.39, the GMP Night Silver Commander,
 6 Superintendent Arif Nawaz was notified of an explosion
 7 at the arena by Ian Randall, who occupied the role of
 8 force duty supervisor, or FDS, the FDS being the FDO's
 9 direct support. At that point assume the Nawaz became
 10 the Silver Commander. It is a Silver Commander's role
 11 to activate emergency plans and formulate a tactical
 12 plan. Superintendent Nawaz spoke to Inspector Sexton at
 13 22.50, during which conversation he was told that
 14 10 people had been killed by a terrorist and that
 15 Operation Plato had been declared. Indeed, as we know,
 16 it had been declared just minutes earlier.
 17 At 22.52, Superintendent Nawaz notified Assistant
 18 Chief Constable Debbie Ford, who was the on-call duty
 19 strategic commander. At this point ACC Ford assumed
 20 overall command for the incident in the role of Gold,
 21 or strategic, Commander. As it was a firearms incident,
 22 ACC Ford also became the strategic firearms commander,
 23 or SFC, as well.
 24 ACC Ford travelled to and arrived at
 25 GMP Headquarters at 23.18. At 22.45, Chief Inspector

1 Mark Dexter was notified by a colleague that
 2 Operation Plato had been declared in relation to the
 3 arena. This, it would appear, was a product of an
 4 informal prior agreement he had with colleagues that he
 5 wanted to be notified of any serious event whatever the
 6 circumstances; he was not on duty at the time.

7 Chief Inspector Dexter decided to self-deploy to the
 8 scene and assume the role of ground assigned tactical
 9 firearms commander. This is one of two tactical command
 10 firearms role based, as the name would imply, at the
 11 scene. The other tactical firearms role, the tactical
 12 firearms commander, taking over from the FDO in their
 13 ITFC role, is based remotely.

14 Pausing for a moment, we do appreciate that some of
 15 these descriptions of role may be confusing and many
 16 sound one like the other. We have sought to be as clear
 17 as we can in developing our opening of facts and we will
 18 continue to seek to do so, and in any event we are
 19 confident that the bereaved families and others will
 20 become most familiar with all of these terms over the
 21 course of the evidence.

22 Chief Inspector Dexter communicated his intentions
 23 at 22.58. He arrived on scene at 23.23 and, as we heard
 24 when reviewing the CCTV, entered Victoria Railway
 25 Station 1 minute later. The on-duty tactical firearms

1 commander was Chief Inspector Rachel Buckle. She was
 2 notified of what had occurred at around 22.45. In the
 3 event she did not take over from Inspector Sexton as the
 4 tactical firearms commander. The reason for this was
 5 that her superior, Temporary Superintendent
 6 Craig Thompson, a specialised tactical firearms
 7 commander, was notified by Chief Inspector Dexter and
 8 took this role, deploying to GMP Headquarters.

9 At 00.15, Inspector Sexton handed over the TFC role
 10 to Temporary Superintendent Craig Thompson. In terms of
 11 the operational Bronze Command, these roles were taken
 12 up by Inspector Michael Smith for the unarmed officers
 13 and PC Richardson as operational firearms commander.
 14 PC Richardson arrived at the arena at 22.39,
 15 Inspector Smith arrived at 22.45.

16 At approximately midnight, Superintendent Nawaz was
 17 replaced as incident Silver Commander by Temporary
 18 Superintendent Chris Hill, who had become aware of the
 19 incident through social media whilst at home and who had
 20 been directed by ACC Ford to take over the position.
 21 Why this occurred will need to be explored.

22 Having set out in summary form the command structure
 23 which was established on the night by GMP, we turn now
 24 to look in more detail at the three principal areas in
 25 which GMP operated on the night: the operations

1 communications branch or OCB, at the scene, and at
 2 headquarters.

3 First, GMP in the operations communications branch.
 4 Information is gathered and processed by GMP through the
 5 operations communications branch, which is distributed
 6 across more than one site in the Greater Manchester
 7 area. Within the OCB, in May 2017, were two operational
 8 control rooms or OCRs, which were dedicated to the
 9 management of radio channels as well as providing
 10 a telephone call handling centre. Posted to the OCB are
 11 the force duty officers, as we have said, the FDOs, who
 12 are of police inspector rank and have responsibility for
 13 the initial management of any incident. They are
 14 supported by a force duty supervisor, the FDS.

15 As we have heard, on the evening of 22 May, the FDO
 16 was Inspector Sexton, who at the time had 26 years of
 17 service, 16 years in the rank of inspector, and had been
 18 trained in Operation Plato and in JESIP. He had been
 19 an FDO since 2014. The FDS, force duty supervisor, was
 20 Ian Randall, a member of police support staff. He had
 21 worked for GMP since 1996 and been an FDS since 2013.
 22 Subsequently, at the time the first call came in, the
 23 two people who between them were taking initial control
 24 and management of the incident on behalf of GMP were
 25 very experienced.

1 Beneath the FDO and FDS were a number of others,
 2 including call handlers and command and control
 3 operators. One such operator who was to play
 4 an important part in what was to come was police support
 5 staff member David Myerscough. He had not received any
 6 formal training in Operation Plato and had received only
 7 30 minutes of e-learning in relation to JESIP as his
 8 ordinary role did not require this.

9 Inspector Sexton explains in his witness statement
 10 that 22 May had started out as a quiet night. The most
 11 significant occurrence that Inspector Sexton remarks
 12 upon was a police pursuit which was handled by an
 13 operator under his supervision.

14 The first notification Inspector Sexton had of the
 15 attack is recorded at 22.34.09. This was as a result of
 16 a force-wide incident number, or an FWIN, which was
 17 displayed on Inspector Sexton's computer screen. He
 18 noted that there were reports of an explosion at the
 19 arena and recalls being told by Mr Randall that there
 20 was an Ariana Grande concert on that night at that
 21 location. His initial belief was that it was a hoax, so
 22 unusual did the report seem to him, and regrettably so
 23 common, it would seem, such calls are.

24 However, upon receipt of a second report and still
 25 unsure of what sort of incident he was dealing with,

1 Inspector Sexton reports that as a precaution he ordered
 2 Armed Response Vehicles to the scene.
 3 As we have explained at an earlier stage in our
 4 opening statement the first Armed Response Vehicle is
 5 seen on CCTV to arrive at Victoria Railway Station at
 6 22.41.39, just over 5 minutes after the FWIN entry with
 7 the first report of an explosion. In fact,
 8 PC Richardson reports over the radio to Inspector Sexton
 9 that he's outside the arena at 22.39.50, so about
 10 8 minutes after the explosion has occurred.
 11 At the time PC Richardson was radioing from the
 12 arena, Ian Randall was contacting Superintendent Nawaz,
 13 the Night Silver. We'll return to Superintendent Nawaz
 14 when we consider the role of GMP Headquarters on the
 15 night. Very quickly after the initial report, more and
 16 more reports started to come in to the OCB, some of
 17 these included reports of gunshots. Inspector Sexton
 18 contacted Sergeant Paul Lawton, who was a TFC tactical
 19 adviser. Sergeant Lawton's function was to provide
 20 advice as to the best firearms tactic. An emergency
 21 search tactic was agreed upon. This is a high-level
 22 response and instructs armed officers to enter, search
 23 for and neutralise any ongoing threat. Inspector Sexton
 24 states that the reports of gunshots informed this
 25 decision.

1 Inspector Sexton granted firearms authority and he
 2 then assumed the role of ITFC. The significance of the
 3 emergency search tactic for anyone who might be injured
 4 is that it is an instruction to armed officers to focus
 5 on threat neutralisation over everything else, meaning
 6 that such officers do not stop to provide medical care
 7 to anyone.
 8 Inspector Sexton describes in his statement that he
 9 understood the consequences of this decision and that it
 10 was, to quote him, a really hard decision for him to
 11 make. The inquiry will need to consider that decision,
 12 but our current understanding is that the policing
 13 experts do not consider that Inspector Sexton should be
 14 criticised for these actions.
 15 In terms of the unarmed GMP response, 3 minutes
 16 after the first FWIN entry relating to the arena,
 17 Inspector Smith had contacted the OCB and nominated
 18 an RVP. An RVP is a critical part of a multi-agency
 19 response as it permits co-location of emergency services
 20 at or very near the scene. From this, situational
 21 awareness can develop, risk assessments can be shared,
 22 and a coordinated response considered. In other words,
 23 establishing an effective RVP is a key part of JESIP.
 24 The precise location of the RVP declared by
 25 Inspector Smith is something the inquiry will explore.

1 His reference point was the cathedral, although what he
 2 said and what he meant may be open to interpretation.
 3 Whatever the precise location, what is clear is that
 4 this RVP was not used. Whether it should have been and
 5 whether this would have made a difference to the
 6 adequacy and effectiveness of the emergency response are
 7 matters to be explored by the inquiry.
 8 In the course of what was to come, a number of RVPs
 9 were declared at different times and the overall
 10 approach to RVPs across the emergency service response
 11 is a matter which demands investigation.
 12 For now we will stay with Inspector Sexton who, at
 13 22.46, activated his dictaphone. One of the first
 14 things it captures is that 1 minute later, at 22.47, he
 15 declared Operation Plato. Operation Plato had already
 16 been referred to at this stage by PC Moore, a firearms
 17 officer on the ground. However, the formal declaration
 18 could only be made at this stage by Inspector Sexton.
 19 He did so and set in train events which were a direct
 20 consequence of that declaration.
 21 That declaration of Operation Plato will necessarily
 22 be the subject of the closest scrutiny during this
 23 inquiry. That scrutiny of the Operation Plato
 24 declaration begins with the reasons behind declaring it.
 25 In contrast to Inspector Sexton, his BTP equivalent

1 decided not to declare Operation Plato. What
 2 information Inspector Sexton had when he made that
 3 declaration and whether it was within the reasonable
 4 range of options open to him are matters to be
 5 investigated. The policing experts' opinion is that
 6 both GMP and BTP's decisions are supportable, although
 7 the lack of a contemporaneous record of
 8 Inspector Sexton's reasoning is also something that they
 9 comment upon.
 10 Once Plato had been declared, policy required that
 11 zones be applied and for the declaration to be
 12 communicated to other emergency services as a joint
 13 response is required under the joint operating
 14 principles which were developed for this very scenario.
 15 Indeed, the third joint operating principle requires all
 16 other interested organisations to be notified.
 17 At the time of the attack, the relevant edition of
 18 the joint operating principle, or JOPs, was the third,
 19 which had been published in January 2016. This document
 20 and its implications will be the subject of detailed
 21 consideration in the course of the oral evidence
 22 hearings.
 23 Once Operation Plato had been declared, the policing
 24 experts' view is that Inspector Sexton quickly became
 25 overwhelmed. This is something which in their view was

1 entirely predictable given the training exercises which
 2 had gone before. Particular note should be taken of the
 3 outcome of Winchester Accord to which we have referred .
 4 Inspector Sexton’s own view is that it was necessary for
 5 him to prioritise his ITFC, so firearms role , in
 6 preference to the FDO role, as he lacked capacity to
 7 address, as he describes them, the requirements of
 8 a major incident .

9 One of the key issues the inquiry will investigate
 10 in relation to both GMP but also in relation to the
 11 wider emergency service response is the extent to which
 12 Inspector Sexton becoming overwhelmed had an impact on
 13 that response. In his statement, Inspector Sexton says
 14 he became aware only later , for example, that the Fire
 15 and Rescue Service NILO had tried to contact him but
 16 that contact had not occurred because he had been busy
 17 concentrating on managing the threat in his firearms
 18 commander role. The inquiry will need to consider and
 19 determine whether these are precisely the lessons that
 20 should have been learned from Exercise Winchester
 21 Accord.

22 So far as Inspector Sexton’s approach to
 23 Operation Plato zoning is concerned, he says that he
 24 regarded the scene as a hot zone, which caused him to
 25 conclude that he should not send further unprotected

1 personnel there. Indeed he states that he considered
 2 that he was dealing with an area which was at very high
 3 risk of further attack. He goes on to say in his first
 4 statement that despite this, he did not openly declare
 5 his view that the immediate vicinity of the scene was
 6 a hot zone to GMFRS or NWAS, as he knew this would
 7 hinder the emergency response.

8 The hot zone, as defined by Operation Plato, is, as
 9 we have stated earlier , an area of live terrorist
 10 activity in which only armed police should operate.
 11 Inspector Sexton also states that he did consider
 12 seeking to remove all unarmed personnel from this area
 13 but he could not justify this to himself because of the
 14 need to treat and evacuate casualties . He describes
 15 having taken a calculated risks that the armed officers
 16 who were present would afford adequate protection in the
 17 event of further firearms attack. But he knew that in
 18 taking this decision , he was going against national
 19 guidance.

20 Inspector Sexton states that his decision -making as
 21 set out included consideration of the Fire and Rescue
 22 Service. He knew that they were at Philips Park Fire
 23 Station. He states he was not minded to draw them in
 24 because he did not want to add to the risk .

25 Clearly , these were all highly significant decisions

1 in the context of what took place on 22 May and the
 2 inquiry will examine in detail Inspector Sexton’s
 3 thought processes and, moreover, its consequences.

4 As the incident progressed , further reports about
 5 the arena and surrounding area were coming in to
 6 Inspector Sexton. These included a report of a gunshot
 7 wound, a report of a second perpetrator, a report of
 8 gunshots at Oldham Hospital, and a suspicious package at
 9 North Manchester General Hospital. It will be important
 10 not to judge decision -making with the benefit of
 11 hindsight but to look at what was known at the time.
 12 The importance of that cannot be overstated , and
 13 in relation to this , just as in relation to other issues
 14 that we dealt with yesterday , we invite all not to jump
 15 to conclusions .

16 So far as Operation Plato is concerned, it will be
 17 necessary to consider not only the decision to activate
 18 it but also how this was communicated, what it would
 19 have meant to those who had not been taught about it , or
 20 not adequately, and whether it should have been
 21 withdrawn earlier than when it came to an end, which was
 22 not until around midnight.

23 The impact of all of these matters will be
 24 considered by the inquiry in assessing the effectiveness
 25 and adequacy of the emergency response on 22 May 2017.

1 At 22.53, Inspector Sexton directed an operation
 2 response request to be made. This has the effect of
 3 notifying all divisions of GMP, so all areas of GMP,
 4 that there is a need for more specialist and
 5 non- specialist resources . At 22.58, Inspector Sexton
 6 attempted to contact NWAS in relation to
 7 Operation Plato, but he was unsuccessful . The inquiry
 8 will need to explore why that was so.

9 At 23.10, Inspector Sexton states :

10 "I had to release Ian Randall to go to force
 11 headquarters and start setting up Silver Control."

12 Mr Randall’s departure from the OCR is something
 13 which the policing experts have commented upon. It is
 14 their opinion that this aggravated the difficulties that
 15 Inspector Sexton was already facing . The role of the
 16 FDS was taken up by Sergeant Andy Core and his
 17 contribution as a support to Inspector Sexton, as
 18 Mr Randall’s replacement, is something the inquiry will
 19 investigate .

20 The inquiry will also consider whether Mr Randall’s
 21 departure was justified and the extent to which it had
 22 an impact, if at all , on the adequacy and effectiveness
 23 of GMP’s response.

24 Associated with the FDO and FDS roles that night was
 25 police support staff member David Myerscough, and we’ve

1 mentioned him already. In circumstances that the
 2 inquiry will explore, he came to be answering the FDO
 3 telephone line. He was manifestly not qualified to do
 4 so, although through no fault of his own. In his own
 5 words:
 6 "I was in a situation which I wasn't trained for and
 7 lacked relevant experience for."
 8 The inquiry will examine the extent of the impact of
 9 the role Mr Myerscough ended up playing on the
 10 performance of the OCB, but to give just one example of
 11 a difficulty faced by Mr Myerscough, shortly before
 12 midnight he spoke to the Fire and Rescue Service Station
 13 Manager, SM, Andy Berry, on the FDO line. The
 14 discussion was about forward control points.
 15 Mr Myerscough, after a substantial delay, came back with
 16 an RVP, which was dismissed by SM Berry. After further
 17 delay and obviously relaying what he'd been told,
 18 Mr Myerscough offered another location, which was also
 19 rejected by SM Berry. The conversation was plainly
 20 unsatisfactory and, it seems to counsel to the inquiry,
 21 the very antithesis of promoting the joined-up approach
 22 which was required in the circumstances and which JESIP
 23 dictated.
 24 At 23.27 Inspector Sexton spoke to
 25 Chief Inspector Dexter who was at that time, as will be

1 recalled, now at the arena and in the City Room. The
 2 discussion was around deploying further firearms
 3 officers to Piccadilly Railway Station in case of
 4 a second attack. Armed officers were deployed there.
 5 A further conversation took place at 23.53 between
 6 Chief Inspector Dexter and Inspector Sexton in order to
 7 define their roles. As midnight passed Inspector Sexton
 8 explains that he assessed that the threat might be
 9 diminishing and he handed over the TFC role to
 10 Superintendent Thompson at quarter past midnight.
 11 So we turn away now from what has been a selective
 12 summary of events in the OCR during the first hour and
 13 we'll return to what was happening at the arena.
 14 We've covered already in detail when we considered
 15 the CCTV evidence the order in which GMP officers
 16 arrived at the scene. In summary, the first firearms
 17 officers arrived just 10 minutes after the explosion and
 18 the GMP Bronze Commander, Inspector Smith, was on scene
 19 from 22.44.41. A significant number of other GMP
 20 officers, at least 30 in total, had arrived within
 21 20 minutes of the attack, and many of those carried
 22 first aid kits.
 23 Armed officers took up defensive positions on either
 24 side of the City Room with some engaging in a search of
 25 the arena. The unarmed officers focused their presence

1 in the City Room with some seeking to establish
 2 a cordon. There are available, and the inquiry will
 3 hear from, multiple perspectives from within the cohort
 4 of GMP officers who arrived at the scene as to what they
 5 saw and what they did. We make clear that the inquiry
 6 legal team regards all of these witnesses as having
 7 an important part to play in this process. We also
 8 acknowledge again, specifically in relation to GMP
 9 officers, as it is GMP's response we are currently
 10 considering, that bravery, kindness and selflessness was
 11 in abundant display from those who went into the
 12 City Room to help the people who had been devastated by
 13 the blast.
 14 For the purposes of this opening, however, we focus
 15 on command and confine ourselves to three short
 16 perspectives, namely those of PC Richardson, the
 17 operational firearms commander, OFC as we have said,
 18 Inspector Smith, the Bronze Commander, and
 19 Chief Inspector Dexter, the ground assigned tactical
 20 firearms commander or GATFC.
 21 First then, PC Richardson, who reports to the FDO
 22 that at 22.39 he's outside the arena and trying to
 23 ascertain what has occurred. He had been on duty that
 24 night, heard reports of an explosion and gunshots, and
 25 volunteered to undertake the operations firearms

1 commander role. Upon arrival at the arena, he states
 2 that things appeared calm. He heard the emergency
 3 search order. He describes a smell similar to cordite
 4 as he approached the City Room and being met by a stream
 5 of people going the opposite way as he walked around the
 6 arena concourse in the City Room.
 7 By 22.53, PC Richardson was reporting to
 8 Inspector Sexton from inside the arena complex that it
 9 appeared that a nail or shrapnel bomb had been detonated
 10 and that the male responsible was, in his words,
 11 "a mess". He states that there was nothing to suggest
 12 anyone further and asks about an explosives dog. He
 13 goes on to say to Inspector Sexton at 22.54, 23 minutes
 14 after the explosion:
 15 "We just need more ambo staff, paramedics, anyone
 16 that they can get hold of, please."
 17 At just after 23.04, PC Richardson reports to
 18 Inspector Sexton that there were a number of civilian
 19 staff who were obviously not first aid trained but who
 20 were doing the best they could. PC Richardson says:
 21 "If you can get anyone who can come in and basically
 22 extract anyone who can stand or walk."
 23 PC Richardson describes in his statement directing
 24 firearms officers to search and secure the scene. He
 25 remained in the City Room providing armed overwatch. In

1 due course, shortly before 23.30, Chief Inspector Dexter
2 arrived on scene and assumed on-scene command of the
3 firearms assets.

4 Before we deal with Chief Inspector Dexter, we will
5 deal with the non-armed Bronze Commander at the scene,
6 Inspector Smith. He had been an inspector since 2008,
7 a Bronze Commander since 2010, and had received JESIP
8 training in 2014. He became aware of the incident at
9 22.35 via the FWIN that we have referred to. Whilst
10 en route at 23.36 he declared the RVP which he stated
11 was:

12 "The cathedral, you know, there's a parking area
13 outside the cathedral."

14 CCTV records him arriving at Victoria Railway
15 Station at 22.44.57. He made his way to the City Room
16 via the raised footbridge, entering at 22.47.51.

17 He states that walking to the City Room was:

18 "A shock to the senses."

19 However, he states that in his mind, from the moment
20 he stepped into the City Room, it was safe. He
21 acknowledges that he could not exclude an attacker
22 elsewhere in the building but realised that the firearms
23 officers were on hand and dealing with that possibility.
24 He also thought a second device was unlikely and this is
25 an important piece of evidence.

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1 Shortly after he arrived at the City Room,
2 Inspector Smith spoke to Advanced Paramedic Patrick
3 Ennis of NWAS. At the time he thought that Mr Ennis was
4 the NWAS Bronze Commander. Inspector Smith states he
5 believes that asked Mr Ennis to identify to officers
6 priorities for the removal of casualties from the
7 City Room. As Bronze Commander, Inspector Smith
8 requested GMP and NWAS support. In his statement he
9 acknowledges that he did not ask for the Fire and Rescue
10 Service as it did not accord with his experience of when
11 the Fire Service might assist. However, he goes on to
12 state that with hindsight, the Fire and Rescue Service
13 may have provided assistance with moving casualties and
14 may have had stretchers to do so.

15 He states that at the time the absence of GMFRS did
16 not concern him and that he believed that the evacuation
17 of casualties was "going well in difficult
18 circumstances".

19 At 23.05, Inspector Smith contacted the OCR and
20 informed them he believed he had located the body of the
21 bomber. In relation to Operation Plato, Inspector Smith
22 says that although difficult to say now, he probably did
23 not know about hot, warm and cold zones, although he was
24 aware of that by the time he gave his statement. He
25 also does not recall having any Operation Plato training

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1 before the incident or having taken part in any
2 Operation Plato exercise. However, he states that even
3 if he had been aware of Operation Plato earlier, which
4 is something he believes he was told about by
5 Chief Inspector Dexter, he does not believe it would
6 have altered his response as he did not feel that this
7 was a marauding terrorist attack.

8 The last of the on-scene commanders we will consider
9 briefly at this stage is indeed Chief Inspector Dexter.
10 As we have said, he arrived at the arena at 23.24. By
11 this point he had self-deployed from home, spoken to
12 Superintendent Thompson, and appointed himself as the
13 ground assigned tactical firearms commander. Issues
14 which the inquiry will explore surrounding
15 Chief Inspector Dexter's role on the night will include:
16 his approach to Operation Plato; whether his actions
17 were in accordance with JESIP principles in relation to
18 matters such as huddles, at which information is shared
19 between agencies; the use of the forward command point
20 and his decision-making process and recording thereof.
21 Like Inspector Sexton, Chief Inspector Dexter used
22 a dictaphone which provides a valuable source of audio
23 evidence, which will assist the inquiry to understand
24 what took place and why.

25 The inquiry will also examine the effect on

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1 Chief Inspector Dexter and upon GMP's response more
2 generally of the fact that there was no Silver or
3 tactical commander of unarmed officers only at the
4 scene. This was a responsibility which could have been
5 taken up by Superintendent Nawaz, who instead went to
6 GMP Headquarters, which will be the issue to which we
7 next turn.

8 Sir, again, I'm aware that we've been going for
9 75 minutes. We've been through a lot of information.
10 This maybe an appropriate moment for a break. Before we
11 take one, can I indicate, it's occurred to me as we've
12 been going through the course of today, given the number
13 of roles and acronyms, it would be helpful to see if
14 we can agree a list of roles, acronyms and who performed
15 those roles that can be uploaded to the inquiry website.
16 SIR JOHN SAUNDERS: I think that that would be very helpful.
17 Just in preparation for this case, I have found the
18 number of acronyms extremely confusing on occasion, so
19 it would certainly help me.

20 How long would you like to have a break for now?

21 MR GREANEY: If it's convenient to everyone, can we have
22 a break of 15 or no more than 20 minutes so we can reach
23 the point that we need to reach today to finish
24 tomorrow?

25 SIR JOHN SAUNDERS: Okay. 2.55. If we can make it prompt,

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1 we'll do the 20 rather than 15.
 2 (2.35 pm)
 3 (A short break)
 4 (2.55 pm)
 5 MR GREANEY: We have dealt with the actions of GMP staff in
 6 the operations communications branch and at the scene
 7 and we're turning now to deal with GMP at headquarters.
 8 The Silver Commander for the period covering the
 9 first hour and slightly beyond was Superintendent Nawaz.
 10 He did not go to the scene, but instead travelled to
 11 GMP Headquarters. The inquiry will need to examine that
 12 decision in some detail. This was indisputably a major
 13 incident. As such, it seems to be the case that the GMP
 14 major incident plan should have been activated. The
 15 major incident plan directs that the tactical commander
 16 attends the scene. This is so for a number of reasons,
 17 which the inquiry will explore.
 18 It will be important for the inquiry to consider
 19 whether or not the GMP tactical commander going to GMP
 20 HQ rather than the scene improved or hampered the
 21 response of GMP and/or other emergency services. This
 22 will include consideration of whether a tactical
 23 commander concerned exclusively with unarmed assets
 24 at the scene would have improved the emergency response.
 25 Chief Inspector Dexter, who took up the tactical

1 command on the ground for the firearms assets has stated
 2 that he did not consider himself to also be in charge of
 3 the unarmed officers. This accords with the view of the
 4 policing experts and also with the view of
 5 Inspector Sexton.
 6 However, GMP has suggested that this was indeed
 7 Chief Inspector Dexter's role and that, as such, there
 8 was no need for an unarmed tactical commander at the
 9 scene. Which perspective is correct, whether both may
 10 be correct, and whether it made any difference to the
 11 adequacy and effectiveness of the emergency response are
 12 all matters which the inquiry will explore.
 13 As part of resolving the dispute between GMP and the
 14 policing experts, it will be necessary to establish why
 15 it was that Superintendent Nawaz did not go to the
 16 scene. Superintendent Nawaz joined GMP in 2000. He had
 17 undertaken training as a Bronze Commander in 2012,
 18 received JESIP training in 2014, and qualified as
 19 a Silver Commander in 2015. He was in his office across
 20 the road from GMP Headquarters at the time he received
 21 the call from the FDS, Mr Randall. In response, he
 22 states he sought to access GMP's arena contingency plan.
 23 Following his initial contact with Mr Randall at
 24 22.39, at 22.50 Superintendent Nawaz was called by
 25 Inspector Sexton, who confirmed that there were 10 dead

1 and that he had declared Operation Plato as it was
 2 a terrorist attack. In a witness statement
 3 Superintendent Nawaz states that he decided not to
 4 declare a major incident as Operation Plato was
 5 underway. However, he also states that at the time he
 6 had no knowledge of what Operation Plato was and had to
 7 ask Inspector Sexton. He states that he did not
 8 appreciate that Operation Plato related to a specific
 9 type of terrorist attack.
 10 By contrast, Inspector Sexton, who was responsible
 11 for the Operation Plato declaration, states that he
 12 expected major incident protocols to be followed whilst
 13 he got on with managing the firearms side of the
 14 incident. The inquiry will need to investigate this
 15 mismatch of understanding, the extent to which it
 16 contributed to no major incident being declared by GMP
 17 until 1 am the following day, and whether the lack of an
 18 early declaration of a major incident, with the actions
 19 which ought to flow from that, had any effect on the
 20 adequacy and effectiveness of the emergency response
 21 overall.
 22 In his most recent witness statement prepared
 23 following the policing expert report, which highlights
 24 this issue, Superintendent Nawaz has provided further
 25 detail about his account of events of when he was first

1 notified. He states that he has been reminded that
 2 he was intending to go to the scene and started to get
 3 ready to do so. However, in the light of the
 4 information imparted by Inspector Sexton, he decided to
 5 brief ACC Ford, who was the on-call Gold Commander
 6 before he set off. He did so at 22.52.
 7 Superintendent Nawaz states that in that
 8 conversation, ACC Ford asked him to set up Silver at
 9 GMP HQ and this made sense to him and so he changed his
 10 plan to go to the scene and went instead to
 11 headquarters.
 12 It appears that Superintendent Nawaz was the first
 13 to arrive in the Silver room. At 23.00 he contacted FDS
 14 from the Silver room. He states that shortly after he
 15 arrived, others also began to arrive. 23.20, he briefed
 16 ACC Ford in person in her role as Gold Commander.
 17 Superintendent Nawaz was relieved of Silver Command at
 18 about midnight by Temporary Superintendent Hill on the
 19 instruction of ACC Ford. He stayed on in support of
 20 Temporary Superintendent Hill rather than revert back to
 21 Night Silver as this role was now taken by Chief
 22 Superintendent Evans.
 23 The policing experts are not only critical of the
 24 fact that Superintendent Nawaz did not attend the scene
 25 but also criticise what they consider was a lack of any

1 real practical decision-making by him during the period
 2 he was the Silver Command. The inquiry will examine
 3 whether this criticism is justified and whether, if
 4 it is, it made any difference to the adequacy and
 5 effectiveness of the emergency response. This will
 6 necessarily involve consideration of the extent of
 7 Superintendent Nawaz's understanding of Operation Plato
 8 on the night, something which he states bore upon why
 9 it would have been irresponsible for him to make any
 10 unilateral decisions in relation to a plan.

11 The final GMP commander to introduce at this stage
 12 is Assistant Chief Constable Debbie Ford. We shall do
 13 so only briefly. ACC Ford was an officer of 23 years'
 14 service, who had completed the Gold Commander's course
 15 in 2014 and a strategic firearms commander course in
 16 2015. She had passed the strategic command course in
 17 2016 and a multi-agency Gold incident commander's course
 18 in October 2016. She had also obtained a specialist
 19 strategic firearms commander qualification 10 days
 20 before the attack.

21 As we have said, she received notice of the incident
 22 at 22.52 when she was awoken by Superintendent Nawaz's
 23 call. She states she was initially very shocked and
 24 found it difficult to comprehend what she was being
 25 told. She explains that her instruction to

1 Superintendent Nawaz was to get more information from
 2 the FDO and to open up the Gold and Silver rooms. She
 3 then devised a strategy, got dressed, made a number of
 4 calls, including to the Chief Constable and the head of
 5 the North West Counter-terrorism Unit,
 6 Chief Superintendent Russ Jackson, as he was at that
 7 stage, before making her way to the GMP headquarters.
 8 She states that she was not able to get through to the
 9 FDO whilst travelling.

10 At 23.15, Temporary Superintendent Hill contacted
 11 her, volunteering to be the Silver Commander, which
 12 offer she accepted. At 23.20, she received her briefing
 13 from Superintendent Nawaz from which point she remained
 14 at GMP Headquarters until the conclusion of the
 15 incident. Temporary Superintendent Hill sought to
 16 activate the Casualty Bureau but encountered
 17 difficulties because of the telephone system. In the
 18 event the Casualty Bureau was active by 1 am.

19 At 01.16, ACC Ford confirmed that GMP had primacy in
 20 her conversation with ACC Smith of BTP, a decision to
 21 which we've made reference when dealing with BTP.

22 01.29, ACC Ford asked Detective Superintendent Chadwick
 23 to activate the Greater Manchester Mass Fatalities Plan.

24 Finally, so far as this selective summary of actions
 25 by ACC Ford is concerned, we note that it was not until

1 some time after the period upon which we are focused,
 2 namely at 04.15, that the first strategic coordinating
 3 group meeting took place, which brought together for the
 4 first time the strategic leads of all of the emergency
 5 responders. Whether this is something that should have
 6 occurred sooner and what effect that might have had will
 7 be investigated.

8 Overall, the policing experts consider that ACC Ford
 9 performed her strategic command adequately and to
 10 a standard which would be expected of an officer of her
 11 seniority. However, they also express the view that as
 12 senior GMP commander, she is ultimately accountable for
 13 the significant flaws in the GMP response. In the
 14 policing experts' view, these flaws include but are not
 15 limited to: the non-timely activation of emergency
 16 plans, particularly the major incident plan; lack of
 17 verification that Operation Plato activation and
 18 continuation was appropriate; and lack of multi-agency
 19 arrangements.

20 The inquiry will investigate whether these
 21 criticisms are justified and, if they are, what impact
 22 they had on the effectiveness or adequacy of the
 23 emergency response.

24 As we have mentioned a number of times, the inquiry
 25 has instructed Iain Sirrell, Ian Dickinson and

1 Scott Wilson as policing experts. We have made clear
 2 the scope of their instructions both so far as BTP and
 3 GMP are concerned and we will not repeat them. The
 4 policing experts described the overall conduct of GMP on
 5 22 May as extremely good. The courteous conduct of
 6 those officers who entered the City Room to provide
 7 treatment was, they say, quite outstanding and worthy of
 8 proper recognition. GMP had an excellent armed
 9 capability in 2017 and all armed and unarmed officers
 10 were suitably qualified and competent in their command
 11 roles.

12 Furthermore, the experts express the view that the
 13 North West Counter-terrorism Unit hosted by GMP was
 14 first class and enjoyed a highly effective relationship
 15 with national counter-terrorism policing.

16 However, the experts also identified areas for
 17 improvement. Their main findings can be summarised as
 18 follows.

19 1. Multi-agency preparations. In May 2016, GMP
 20 participated in Exercise Winchester Accord. This was,
 21 as we have said, a live multi-agency scenario involving
 22 an MTFA at the Trafford Centre. A number of issues
 23 arose from the exercise, as we referred to earlier,
 24 including a lack of police tactical command and presence
 25 at the forward command post, a lack of communication

1 with teams on the ground, an inability to make contact
2 with the GMP FDO, delay in declaring the warm zone, and
3 low awareness of terminology in the operational control
4 room.

5 The policing experts found that the same problems
6 were manifest in the response to the arena attack and
7 that accordingly, and we quote them:

8 "... significant and substantial lessons learned had
9 not been carried through into organisational change by
10 GMP."

11 The experts also queried whether GMP is adequately
12 represented in the resilience forum, both in terms of
13 seniority and consistent participation in meetings.

14 2. GMP preparation and planning. The GMP plans and
15 arrangements for DVI, Casualty Bureau and mass
16 casualties were, the experts say, extremely good, as
17 they were adequately resourced, trained and exercised.
18 In 2017, a well-developed major incident plan was in
19 place. However, the experts concluded that the GMP
20 contingency plan for the arena was inadequate and out of
21 date, which was likely, they thought, to have made
22 a significant difference to the multi-agency emergency
23 response. GMP did not activate the relevant emergency
24 plans, mass casualties or DVI, or did not implement them
25 effectively until hours after the attack.

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1 3. Marauding terrorist firearms attack and
2 Operation Plato. GMP had invested in training and
3 exercising to ensure an effective response by the armed
4 units attending an Operation Plato incident. However,
5 knowledge and understanding of Operation Plato was not
6 well-demonstrated in the view of the experts during the
7 arena attack.

8 4. Communications and Airwave. The distributed
9 communications capability was held over four sites.
10 This was, thought the experts, a significant weakness as
11 staff could not readily be transferred between roles and
12 information exchange between the sites was difficult.
13 The Airwave communications capability was compromised by
14 the fact that GMP staff were not effectively utilised.
15 Furthermore, there was no attempt to integrate
16 communications between BTP and GMP at the arena, which
17 was a serious issue due to the potential ongoing
18 dangers, as we have explained.

19 The lack of tri-service communication within the
20 GMP FCM culminated in a failure of JESIP in terms of
21 shared situational and risk assessment.

22 5. Emergency response. GMP did not prepare
23 a METHANE report and did not exert firm control of
24 resources. The deployment and command of
25 Operation Plato at the scene was not adequately

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1 addressed and the scene command lacked multi-agency
2 cohesion and no formal FCP was established. A major
3 incident was not declared by GMP until 1 am on 23 May
4 and notification to the local authority was
5 significantly delayed in the view of the experts. There
6 was, moreover, an absence of tactical police command of
7 the arena scene until midnight and, the experts say, it
8 was wholly inappropriate that the unarmed scene command
9 was left in the hands of inspectors who were neither
10 trained nor experienced in tactical command.

11 As we have been at pains to emphasise throughout
12 today, whether these opinions are correct will be for
13 the chairman to decide in the light of all of the
14 evidence.

15 We turn next to lessons learned. Deputy
16 Chief Constable Ian Pilling of GMP has provided
17 a statement on behalf of that police force dated
18 31 March of this year. He explains that a lengthy
19 debrief process took place after the arena attack. This
20 produced 576 recommendations, which included complex and
21 significant suggestions about policy, training,
22 resources and command structure. An accompanying
23 spreadsheet sets out the changes made as a result of the
24 debrief process. Some of those changes may be
25 summarised as follows.

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1 Force command resilience has been enhanced by the
2 introduction of seven force critical incident managers,
3 or FCIMs, who provide 24/7 cover and an increased number
4 of qualified specialist firearms commanders.

5 The major incident plan has been updated. The SCC
6 activation plan has been reviewed and national
7 Operation Plato guidance has been revised to include
8 a new graded response proportionate to the particular
9 threat. Officers of inspector rank and above now
10 receive an additional four-hour multi-agency JESIP
11 workshop covering major incident response. A review of
12 the situational briefing document was conducted,
13 resulting in a new national template which is used by
14 Counter-terrorism Policing North West.

15 It is now embedded practice for the FDO on duty to
16 perform a radio check with NNAS and GMFRS three times
17 a day. A dedicated telephone line now ensures that the
18 FDO can be contacted by other agencies during a major
19 incident. A protocol involving the use of action cards
20 in control rooms to instigate METHANE messages has also
21 now been established.

22 Against that background, what are the issues or the
23 key issues that the inquiry will need to consider so far
24 as GMP is concerned? The inquiry legal team consider
25 that the following principal issues arise for

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1 consideration .
 2 1. Was GMP adequately prepared? This will involve
 3 consideration by the inquiry of the effectiveness of:
 4 the Local Resilience Forum; the adequacy of the
 5 preparation of generic and specific plans and other
 6 documents such as the GMP major incident plan and the
 7 Manchester Arena contingency plan, which underpinned, or
 8 should have underpinned, the response to the attack; the
 9 inclusion , development and embedding the principles of
 10 joint working in accordance with JESIP; the use or
 11 otherwise by GMP of Resilience Direct , a platform for
 12 sharing documents between agencies in relation to
 13 multi-agency planning and response; the extent to which
 14 there were relevant and effective exercises prior to the
 15 attack; and whether learning derived from such exercises
 16 was effectively translated by GMP into improved
 17 practices .
 18 2. Primacy. As with BTP, the issue of primacy
 19 arises also for GMP. Whether the fact that BTP had
 20 primacy made any difference to either GMP's preparedness
 21 or its response on the night will need to be
 22 investigated .
 23 3. Major incident declaration and Silver Command.
 24 GMP did not declare the attack to be a major incident
 25 until , as we have emphasised, approximately 1 am on

1 23 May. The inquiry will investigate whether or not the
 2 delay in this declaration had any impact on the
 3 effectiveness of the response. As part of this , the
 4 inquiry will investigate the reasons behind the
 5 Silver Commander not attending the scene and whether it
 6 had any impact, whether positively or negatively , on the
 7 adequacy and effectiveness of the response by GMP and
 8 the other emergency services .
 9 Further, and related to the declaration of a major
 10 incident , is the METHANE message. In short, no METHANE
 11 message, as we currently understand the evidence , was
 12 prepared by GMP at any stage. Whether the declaration
 13 of a major incident at an early stage would have led to
 14 this being sought by the commanders as per GMP's major
 15 incident plan and whether, had one been provided,
 16 it would have contributed in a positive way to GMP's
 17 response and the response of others had it subsequently
 18 been shared are also matters which will be investigated .
 19 4. Operation Plato. Both GMP and BTP considered
 20 declaring Operation Plato. GMP did declare
 21 Operation Plato at an early stage; BTP did not. The
 22 inquiry will therefore consider GMP's decision to
 23 declare Operation Plato, how that decision was
 24 implemented, the understanding within GMP and beyond
 25 about what it meant, the approach to the dissemination

1 of the fact that Operation Plato had been declared by
 2 GMP, and the timing and manner of its ending.
 3 5. JESIP. Experience has taught that when
 4 emergency responders work together in response to events
 5 such as that which occurred on 22 May, the best possible
 6 outcome is achieved. As such, the inquiry will
 7 investigate , as it will for other responders, the degree
 8 to which GMP operated in accordance with JESIP. The
 9 inquiry will examine this through each of the JESIP
 10 principles for joint working, namely GMP's approach to
 11 co-location , communication, coordination, joint
 12 understanding of risk , and shared situational awareness.
 13 Across these principles , the following issues
 14 arising from 22 May among others fall to be considered:
 15 how RVPs were or were not used by GMP to promote
 16 co-location ; the effectiveness and inclusiveness of
 17 on-scene huddles between commanders; the approach to
 18 sharing of information by GMP such as the declaration of
 19 Operation Plato; the timing and use of the strategic
 20 coordination group to promote coordination ; how
 21 information was shared by GMP, including through the use
 22 of the Airwave system so as to ensure that , among
 23 others, GMFRS understood the risks and how those risks
 24 were being controlled ; and the lack of use of METHANE to
 25 establish shared situational awareness.

1 6. Sufficiency of equipment and training of GMP
 2 officers . As with BTP, the inquiry will investigate the
 3 same issue for GMP in relation to the equipment that was
 4 actually available and the training in its use. This in
 5 turn will feed into the inquiry's investigation into the
 6 extent to which the absence of other emergency services
 7 to a greater or lesser degree had an impact upon those
 8 affected by the blast .
 9 7. Communication. We've touched on this a number
 10 of times. For GMP, as with other category 1 responders,
 11 it is a topic which crosses all areas of preparedness
 12 and response. It includes matters such as inter-agency
 13 communication on things such as Operation Plato, METHANE
 14 messages, whether the JESIP principles were embedded and
 15 observed, and use of the Airwave system. It also covers
 16 the use of social media by both GMP and the public
 17 in relation to which the inquiry has obtained an expert
 18 report which will be spoken to during chapter 10, but
 19 which we will not develop in more detail at this stage.
 20 8. The overall effectiveness of GMP command and
 21 control . The issues which arise do so in the context of
 22 every level of GMP command: operational, tactical and
 23 strategic , both armed and unarmed. The inquiry will
 24 consider what each of the individuals who occupied those
 25 roles did and did not do, focusing on those areas in

1 particular in which the above issues arise and the
2 inquiry will consider the extent to which their
3 performance had an impact upon the adequacy and
4 effectiveness of GMP's response.

5 We will turn next to address the response of the
6 North West Ambulance Service to the bombing. That
7 service, NWAS, was formed in 2006 to provide the
8 ambulance service for the North-west of England,
9 including Greater Manchester, and by the date of the
10 arena attack employed well over 5,000 personnel and
11 operated from over 100 ambulance stations and other
12 locations.

13 The ambulance experts explain that NWAS was
14 responsible for the command and control of all health
15 assets and the NHS responders at the scene of the arena
16 attack and:

17 "... had the primary responsibility for the
18 management of casualties at the Manchester Arena and the
19 surrounding area."

20 That means that the role of NWAS on 22 May included
21 the triage and treatment of those requiring
22 life-supporting medical intervention and also the
23 transportation of the injured, many of whom were
24 suffering from serious trauma, to the most appropriate
25 receiving hospitals across the Greater Manchester area.

1 Self-evidently, therefore, it will be important for
2 the inquiry to develop a clear understanding of the
3 nature, extent and effectiveness of the response of NWAS
4 on the night.

5 At this stage, in seeking to outline the areas of
6 evidence and issues that we will be concerned with
7 during the oral evidence hearings, we will deal first
8 with the preparedness of NWAS for a terrorist attack,
9 second with the actual response of NWAS on the night,
10 third with the conclusions of the experts, fourth with
11 the lessons NWAS has learned, and finally with the
12 principal issues for the inquiry so far as NWAS is
13 concerned. This is, of course, the approach we've
14 adopted in dealing with the other emergency services.

15 First, preparedness and the Local Resilience Forum.
16 In the view of the experts, NWAS has performed
17 a proportionate role within GMRF, the resilience forum,
18 and had done so prior to 22 May. Accordingly, there is
19 no need to say any more about this aspect of
20 preparedness, save that the underpinning evidence for
21 that conclusion, as with all of the conclusions of the
22 experts, will plainly need to be examined.

23 Second, plans. The ambulance experts confirm that
24 NWAS had a wide range of emergency plans and procedures
25 in place and they consider that the organisation was

1 compliant with the national standards for emergency
2 preparedness at the time of the attack. Indeed, the
3 view of the experts is that this had been demonstrated
4 through two particular processes, namely an emergency
5 preparedness response and resilience, EPRR, annual
6 assurance process, and that had been verified by
7 NHS England and a JESIP assurance visit.

8 Many of the plans of NWAS stress the need for
9 a coordinated multi-agency response to identifiable
10 risks and, as we have observed already, the
11 Manchester Arena attack cried out for just such
12 a response. It is right to observe NWAS did not have an
13 up-to-date site-specific plan for a major incident
14 at the arena, a location the experts describe as a large
15 venue with substantial potential for a major incident.

16 Notwithstanding this, the experts conclude that in
17 terms of emergency plans, NWAS was well-prepared for
18 a response to an incident such as the attack on 22 May.

19 Third, training and training exercises. The
20 ambulance experts consider that training for NWAS
21 commanders was well-established and that the overall
22 level of training and exercising undertaken in both
23 a single and multi-agency setting was comprehensive and
24 demonstrated a high level of commitment. Specialist
25 training, particularly to support the requirements of

1 the Hazardous Area Response Teams, was also embedded and
2 included multi-agency training and exercising in respect
3 of a terrorist attack.

4 In common with other service-specific experts
5 however, the ambulance experts consider that important
6 lessons were not learned by NWAS from those exercises.
7 As will already be apparent therefore, a significant
8 issue for the inquiry to address is how in the future
9 the emergency services not only identify the lessons to
10 be learned from exercises but also implement those
11 lessons and improve.

12 In short, therefore, so far as preparedness is
13 concerned, there are grounds for believing that NWAS was
14 in a good state of preparedness for a terrorist attack.
15 If that is correct, but the evidence nonetheless shows
16 that there were shortcomings in the response of NWAS on
17 the night, the inquiry will need to consider how that
18 has come about and what may be done to prevent
19 recurrence.

20 We will turn against that background to consider in
21 brief summary the actual response of NWAS on the night
22 of the attack, but before we do so may we give
23 a specific warning that we will shortly, within, I would
24 have thought 5 minutes, be playing a 999 call made by
25 Ronald Blake very shortly after the explosion. At the

1 time it is quite clear that Mr Blake was with
 2 John Atkinson and therefore this recording may be
 3 particularly distressing for them. This is a matter
 4 I have discussed with counsel for Mr Atkinson, or his
 5 family, rather, before we started this session.
 6 SIR JOHN SAUNDERS: Thank you.
 7 MR COOPER: I am grateful to Mr Greaney for raising the
 8 matter with me. We have communicated with the bereaved
 9 of John Atkinson and I should inform you they have
 10 chosen not to listen to this section of the hearing.
 11 We are grateful for the sensitivity displayed.
 12 SIR JOHN SAUNDERS: I'm grateful to you both. Thank you
 13 very much.
 14 MR GREANEY: Within seconds of the detonation, at 22.31.52,
 15 a member of the public made an 8-minute 6-second call to
 16 999, although only the first 4.5 minutes involve
 17 conversation between the caller and control room
 18 operator.
 19 The call was made by Ronald Blake, who is known as
 20 Ron, from whom we'll hear or expect to hear in
 21 chapter 12. Mr Blake was a member of the public,
 22 present at the arena to pick up his daughter who had
 23 attended the concert. Mr Blake tended to and comforted
 24 John Atkinson, a stranger to him, for just short of
 25 an hour until paramedics took over. Mr Blake's conduct

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1 showed, in our view, the best of our community.
 2 In his 999 call, Mr Blake made clear that there were
 3 many injured people within the City Room. He referred
 4 to an explosion and gave detailed information concerning
 5 his location. He made plain that people were in need of
 6 urgent life-saving medical attention, and referred to
 7 one such person who was undoubtedly John Atkinson, who
 8 he said was "really injured with blood pumping from his
 9 leg".
 10 Travel Safe Officer Philip Clegg briefly spoke on
 11 the call, and Confirmed that there had been an explosion
 12 and to specify its location, but explained that he could
 13 not stay on the call because he had to help people.
 14 We are going to play that 999 call. We make plain
 15 that it is capable of causing distress, not just to the
 16 family of Mr Atkinson, but to any person and
 17 particularly the bereaved families. Therefore we will
 18 wait for a short time to allow anyone who wishes to to
 19 leave the room they are in or turn off their feed to do
 20 so. We'll be playing the first 4.5 minutes of the
 21 recording and so we suggest that anyone who leaves
 22 a room or turns off a feed returns to the room and turns
 23 on the feed in about 5 or 6 minutes.
 24 Mr Lopez, I'm going to ask you to find
 25 {INQ019523/1}. In a moment I'll invite you to play from

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1 the beginning up until 4:32. The reason we don't play
 2 beyond 4:32 is because thereafter it is possible to hear
 3 muffled sounds of Mr Blake speaking to John Atkinson,
 4 but there is no further conversation with the control
 5 room operator.
 6 So would you play that recording now, please,
 7 Mr Lopez?
 8 (Audio played to the inquiry)
 9 As we indicated, all that can be heard thereafter
 10 are sounds of assistance being provided by Mr Blake.
 11 Within literally seconds of the explosion,
 12 information was provided via a 999 call that there had
 13 been an explosion in the City Room and that what was
 14 developing was a mass casualty incident requiring, it
 15 may be suggested, a multi-agency response, the
 16 activation of major incident plans and the deployment of
 17 appropriate and sufficient assets and resources.
 18 In his call Mr Blake made clear that many people
 19 within the City Room were in urgent need of medical
 20 attention, and it may be suggested that this was
 21 a situation in which NWSAS ought to have responded
 22 speedily and treated those who were injured where they
 23 had fallen or evacuate them. Whether that is right and,
 24 if so, whether NWSAS discharged its duties adequately
 25 will be for the inquiry to establish.

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1 We will turn in a moment to remind everyone of the
 2 critical timings so far as the arrival of NWSAS staff
 3 at the arena is concerned and their actions thereafter,
 4 but first it will be helpful to identify the NWSAS
 5 command structure on the night as we did with BTP and
 6 GMP.
 7 Neil Barnes was the NWSAS Gold Commander on the night
 8 of the bombing. He was also the NWSAS deputy director of
 9 quality. He was made aware of the bombing at 22.40. He
 10 mobilised later after the NWSAS national NILO and
 11 tactical adviser, Steve Taylor, informed him of the need
 12 to go to GMP HQ and that is where he went. Following
 13 his arrival at GMP he commenced his decision log at
 14 00.35. By this time all patients had been evacuated
 15 from the City Room and all of the 22 deceased had been
 16 declared dead. The inquiry will therefore need to
 17 consider the contribution that he made to the emergency
 18 response, if any.
 19 Annemarie Rooney is the NWSAS sector commander for
 20 central Manchester and also holds a role as a tactical
 21 commander. She was the NWSAS Silver Commander on the
 22 night of the bombing. She was informed of the bombing
 23 at 22.38 by the duty manager of the NWSAS emergency
 24 operations centre, which was known as EOC and her name
 25 is Nicola Pratt. In discussion with Nicola Pratt,

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1 Annemarie Rooney asked the attendance at the arena of
 2 the Hazardous Area Response Team, a specialist ambulance
 3 team trained and equipped to work in hazardous areas.
 4 She also informed Nicola Pratt that the EOC needed to
 5 make reference to their Operation Plato cards because
 6 the information available at that early stage indicated
 7 that a marauding terrorist firearms incident might be
 8 underway.

9 However, she, Annemarie Rooney, was subsequently
 10 informed by Nicola Pratt that this was not an MTFA and
 11 instead EOC staff were using the major incident action
 12 cards.

13 Annemarie Rooney travelled to GMP Headquarters
 14 arriving at 23.12. Having arrived there she describes
 15 being informed by Superintendent Nawaz and ACC Ford that
 16 what had occurred was not a shooting incident. However,
 17 at 00.18, she was informed by GMP tactical commander
 18 Chris Hill that Operation Plato had been declared at
 19 22.47, just over 90 minutes earlier. She was surprised
 20 and confused by this, as on more than one occasion she
 21 had been told by GMP at headquarters that there was no
 22 active shooter.

23 As we have made plain, whether Operation Plato was
 24 correctly declared and, if so, whether it remained in
 25 place for too long, are issues for the inquiry to

1 consider and the evidence of this witness will bear upon
 2 that.

3 Daniel Smith is a consultant paramedic with NWAS and
 4 alongside that position held the role of tactical
 5 commander. He performed the role of Bronze Commander on
 6 the night of the bombing. He mobilised following a call
 7 at 22.41 from Annemarie Rooney and went to the scene.
 8 He set up a casualty clearing station on the station
 9 concourse, an area across the bridge from the City Room
 10 and down the stairs near the entrances from Station
 11 Approach. In his witness statement Daniel Smith
 12 explains that this was a deliberate decision because he
 13 considered that it would not have been safe to position
 14 the casualty clearing station nearer the City Room.

15 Daniel Smith also spoke to Patrick Ennis, who, as we
 16 have observed already, was the first paramedic on the
 17 scene. Patrick Ennis told Mr Smith that there were many
 18 casualties and deceased in the City Room. However, the
 19 Bronze Commander, Mr Smith, did not enter that area
 20 himself. Daniel Smith recalls that at 2300 hours the
 21 HART team arrived, although in fact that occurred about
 22 15 minutes later. As we have made plain this was the
 23 team that was trained and equipped to operate in
 24 a hazardous area.

25 Mr Smith was advised that two members of that team

1 had volunteered to enter the City Room. He said that
 2 whilst he couldn't guarantee their safety, he was, as he
 3 puts it, "fairly happy" that an MTFA was not underway
 4 and the presence of "vast" numbers of firearms officers
 5 was sufficient to ensure safety.

6 Later, at 23.55, NWAS Deputy Director of Operations
 7 Steve Hynes arrived and took over as Bronze Operational
 8 Commander from Mr Smith. As will be obvious, this was
 9 at a late stage of events and the principal involvement
 10 of Mr Hynes was at 00.15 when he asked Chief Fire
 11 Officer O'Reilly in a phone call for the attendance of
 12 12 trauma-trained firefighters and a commander. In the
 13 course of the evidence, the inquiry will need to examine
 14 the decision-making of Daniel Smith and, if it concludes
 15 that mistakes were made, consider why that was,
 16 including whether he was adequately trained for the role
 17 he was required to perform that night.

18 Would you bear with me one moment, please?

19 (Pause)

20 Having identified the NWAS command structure,
 21 we will return to the chronology so far as NWAS is
 22 concerned. We will not be dealing with every time
 23 in that chronology, just those that seem to us to be of
 24 particular relevance.

25 NWAS Advanced Paramedic Patrick Ennis must have

1 arrived at the scene at about 22.46 because at that time
 2 he passed the following message to NWAS control:

3 "Yeah. It's a major incident so stand by. We had
 4 reports of a nail bomb possibly with shooting incident.
 5 Apparently it's 6 and 8 casualties all appear walking
 6 wounded currently but I can't confirm the number. I've
 7 got no major incident command post set up but for the
 8 time being I could do with at least four emergency
 9 ambulances. It's a bit chaotic but the best access
 10 would appear to be -- I'm just trying to think, but the
 11 best access would be from Cross Street, liaising at
 12 Victoria Station."

13 By this time, as we've observed, the EOC had spoken
 14 to Annemarie Rooney, Tactical and Silver Commander, who
 15 had requested escalation to Gold Command and instructed
 16 the deployment of HART.

17 The reality is that control at this time, 22.46,
 18 knew full well that the incident was not restricted to
 19 six or eight casualties who were all walking wounded.
 20 Furthermore, Patrick Ennis was himself quickly to
 21 discover that this was not the case and that the
 22 situation was much, much worse.

23 At 22.49.53, Patrick Ennis is captured on Station
 24 Approach approaching the war memorial entrance. He
 25 entered Victoria Railway Station 30 seconds later and

1 was captured speaking on his radio as he did so. This
2 was the first involvement of any officer of NWS at the
3 scene.

4 It is important to point out that, as we currently
5 understand the evidence, neither the attendance at the
6 scene of Patrick Ennis nor his entry to the City Room
7 were at the direction of an NWS commander or as part of
8 the implementation of a jointly agreed plan between the
9 emergency services. Instead it seems that he had
10 self-deployed having been made aware of the incident and
11 had followed a police car to the scene.

12 At 22.50.55, Patrick Ennis was recorded in
13 conversation with a number of GMP officers on the
14 station concourse. It was by now nearly 20 minutes
15 after the explosion. There was only one paramedic at
16 Victoria Railway Station and he had not yet entered the
17 City Room or treated a single casualty, and indeed had
18 attended voluntarily and not due to instruction.

19 The inquiry will need to consider whether that
20 represents a reasonable level of response by an
21 ambulance service.

22 Between 22.51.38 and 22.52.59, Patrick Ennis made
23 his way to the City Room via the raised footbridge.
24 In the course of this journey he stopped briefly by some
25 injured persons who were on the raised footbridge

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1 receiving treatment from others. Mr Ennis met up with
2 GMP Inspector Smith at the raised footbridge entrance to
3 the City Room at 22.53.01, then he entered the
4 City Room.

5 When he gives evidence, we will need to consider
6 with Advanced Paramedic Ennis his actions once in that
7 area. We will want to understand, among other matters,
8 whether, as seems likely, he developed situational
9 awareness, namely that there was no marauding terrorist
10 within the room, that there were dead, dying and injured
11 people in the room, the latter in need of urgent medical
12 attention, that no stretchers were available even though
13 many of those injured could not walk, that there was
14 a need for dressings and tourniquets to stem bleeding,
15 that first aid and CPR efforts were taking place in the
16 absence of paramedics and doctors, provided by police
17 officers, security staff, members of the public, and
18 ETUK, who had limited supplies and, for the most part,
19 no medical training.

20 So we will want to explore with him whether he
21 developed situational awareness of all of those matters
22 together with the fact that the police officers present
23 in particular were asking when the ambulances and
24 paramedics would arrive.

25 If such situational awareness was developed, the

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1 inquiry will want to understand what was done by NWS in
2 response.

3 At 22.59.57, Patrick Ennis is recorded leaving the
4 City Room via the raised footbridge. At about this time
5 Daniel Smith, the NWS Bronze Commander, and NWS
6 doctor, indeed MERIT doctor, Michael Daley, were
7 arriving.

8 At 23.05.19, Patrick Ennis is shown on the CCTV
9 footage returning to the City Room and again it will be
10 necessary to consider with him his actions once back
11 in that area.

12 However, what is clear is that by 23.11, 40 minutes
13 after the explosion, Patrick Ennis was the only NWS
14 paramedic to have been into the City Room. As we have
15 observed, the inquiry will need to consider whether that
16 represents a reasonable level of response by an
17 ambulance service.

18 At 23.14.04, NWS HART paramedics Lea Vaughan and
19 Christopher Hargreaves entered Victoria Railway Station.
20 The CCTV indicates they made their way directly to the
21 City Room where they arrived 1 minute later. As we have
22 observed, the evidence indicates that they volunteered
23 to go into that area. Once in the City Room, they spoke
24 to Patrick Ennis and then started to move between
25 casualties. They were the only HART paramedics to enter

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1 the City Room and the inquiry will need to consider why
2 that was so given that other HART paramedics were
3 present in the station and they were, as we have said
4 now a number of times, trained and equipped to enter
5 a hazardous environment, even assuming that by 23.15 the
6 City Room could properly have been described as such.

7 So only three NWS paramedics ever entered the
8 City Room. An important issue for the inquiry to
9 consider is why that was and whether it is a reasonable
10 thing to have occurred.

11 NWS suggests that it behaved reasonably, but if
12 that's not right, we'll need to assess what went wrong
13 and what impact that had upon the treatment of those who
14 had been injured in the explosion.

15 We will turn next to the opinion of the ambulance
16 experts. We've already introduced the ambulance
17 experts, Michael Herriot and Christian Cooper. Their
18 overview report is dated 6 August, their principal
19 report addressing the performance of NWS is dated May
20 this year, and their report in response to the questions
21 of core participants is dated 5 August, so just last
22 month. They have also, of course, contributed to the
23 joint report of all of the emergency services experts
24 instructed by the chairman.

25 The views of the ambulance experts can readily be

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1 summarised. First, in their third report, in answer to
 2 a question posed by NNAS, the experts state:
 3 "We fully acknowledge the commitment of the
 4 ambulance personnel and recognise that the response to
 5 this incident would have been exceptionally challenging
 6 for all concerned. However, we cannot state that the
 7 overall response by NNAS was adequate in all the
 8 circumstances because aspects of the response were less
 9 than adequate."
 10 However, they say:
 11 "We would assess the overall response of NNAS as
 12 mostly good and mostly compliant with exceptions. There
 13 were some failings and missed opportunities which means
 14 that the response was less than adequate in certain
 15 specific aspects."
 16 It will be necessary for the inquiry to consider
 17 whether that assessment is accurate or whether it may be
 18 overly favourable given the nature and extent of the
 19 criticisms made by ambulance experts, which we will next
 20 turn to, and indeed in the light of the overall
 21 evidence.
 22 Second, the experts consider that the necessary
 23 lessons from the training exercises that should have
 24 been learned were not learned.
 25 Third, the experts consider that a number of

1 important roles, including ambulance safety officer,
 2 were not established, despite being specified in the
 3 NNAS Major Incident Response Plan and action cards.
 4 Furthermore, commanders could also have given greater
 5 overall direction to ambulance crews.
 6 Fourth, only two members of a larger HART team were
 7 deployed into the City Room. Other members of the team
 8 remained outside. We have identified this potential
 9 failure already.
 10 Fifth, mass casualty vehicles that form part of the
 11 national capability for incidents such as the arena
 12 attack were not deployed and other incident-support
 13 assets were not used effectively. Furthermore, no
 14 stretchers or bulk medical supplies were deployed into
 15 the City Room despite being available within NNAS.
 16 Sixth, and very importantly, effective inter-agency
 17 communication was hampered because no formal forward
 18 control point was established at the scene and the JESIP
 19 model was not used as indicated in the NNAS plans. As
 20 the experts more generally describe, the declaration of
 21 Operation Plato was not communicated effectively and
 22 inter-agency meetings were delayed. Information sharing
 23 between the emergency services, assert the ambulance
 24 experts, was confused at times and could have been more
 25 efficient.

1 Seventh and much less importantly in the overall
 2 scale of things, the experts consider that the treatment
 3 of those with minor injuries could have been better.
 4 Eighth, and finally, communication, the experts
 5 consider, between NNAS and ETUK could have been
 6 improved.
 7 Many of these criticisms are accepted by NNAS,
 8 although with some qualifications, but we will need to
 9 explore that in the evidence. As with all the experts,
 10 the inquiry will need to probe the live evidence in the
 11 hearing in order to see whether the ambulance experts
 12 have got it right or whether they've gone too far or
 13 indeed not gone far enough in their conclusions.
 14 We will turn next to the lessons learned by NNAS.
 15 Gerard Blezard, director of operations of NNAS, has
 16 provided a lessons learned statement on behalf of that
 17 organisation. That statement sets out the lessons that
 18 NNAS describes having learned as follows.
 19 Mr Blezard emphasises in his statement that NNAS
 20 takes its obligation to learn lessons from all incidents
 21 seriously and draws attention to the following that has
 22 been done.
 23 New Major Incident Response Plan cards have been
 24 developed. NNAS has introduced an operational order for
 25 the arena, the purpose of this is to support the Major

1 Incident Response Plan. NNAS representatives also now
 2 attend multi-agency meetings of the arena that take
 3 place three times a year.
 4 Steps have been taken to ensure that all members of
 5 the NNAS command and control structure are adequately
 6 trained.
 7 Guidance has been issued to ensure NNAS officers do
 8 not self-deploy to the scene.
 9 Senior staff have been educated in functional roles.
 10 The EOC now has a substantive resilience manager.
 11 NNAS now has a policy for dealing with marauding
 12 terrorist attacks.
 13 Changes have been made to the EOC action cards and
 14 steps are being taken to ensure that NNAS engages in
 15 multi-agency major incident training exercises.
 16 JESIP training has been undertaken. Communications
 17 have been improved. Steps have been taken to improve
 18 knowledge amongst operational staff and commanders about
 19 the equipment carried within NNAS vehicles.
 20 Tabards have been issued so particular NNAS staff
 21 can be identified at the scene of an incident and triage
 22 packs have been updated.
 23 All of these changes and others identified by NNAS
 24 will need, as in the case of all of the emergency
 25 services, to be scrutinised in the evidence so as to

1 ensure that there can be confidence that NWAS will rise
2 to the challenge if another major incident occurs in the
3 geographical area for which it is responsible if it did
4 not do so on this occasion.

5 What we have said so far has identified the issues
6 and the helpful response, may we say, of NWAS to the
7 expert report. That means that many of the issues are
8 unlikely to be controversial. We can therefore identify
9 the issues that arise in relation to NWAS in simple
10 terms.

11 Was NWAS adequately prepared for a terrorist attack
12 on a major target such as the Manchester Arena?

13 Did NWAS follow its own plans?

14 What is the significance of the rule against
15 self-deployment which has now been reinforced? If it
16 had been applied strictly on the night of the bombing
17 would it have made things better or worse and, if worse,
18 what does it mean for the new NWAS policy?

19 Were roles properly allocated by NWAS on the night
20 of the bombing?

21 Did NWAS comply with JESIP? Did NWAS work
22 effectively with its partner agencies? How did the NWAS
23 command structure perform on the night?

24 Why did so few paramedics enter the City Room,
25 including HART paramedics?

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1 Was sufficient equipment available at the scene and,
2 if so, was it properly deployed? If not, why not?

3 Do the decisions about the setting-up of the
4 casualty clearing station and the casualty clearing
5 point bear scrutiny?

6 And overall, as in the case of all of the emergency
7 services, how did NWAS perform on the night?

8 That is all we propose to say about NWAS in the
9 course of addressing chapter 10. We are going to move
10 next to the performance of GMFRS and NWFC, which will
11 take some time, and it may therefore be that this would
12 be an appropriate time to break for the evening.

13 SIR JOHN SAUNDERS: Are we on schedule to finish the opening
14 tomorrow?

15 MR GREANEY: We are, sir, yes, although it will be in the
16 afternoon tomorrow.

17 Mr de la Poer would like to draw something to my
18 attention, so before you rise, would you give me one
19 moment, please?

(Pause)

21 We have had what has been described to me as a very
22 forceful request by NWAS that it should be pointed out
23 that the Ronald Blake call was received not by their
24 operator but by the GMP operator, and we are happy to
25 say that, although we don't believe that we specified

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1 that it was received by the NWAS operator. Nonetheless,
2 the position is now clear.

3 There is one final matter that will need to be dealt
4 with by Mr de la Poer and it will need to be dealt with
5 with the YouTube feed having been cut. We'll wait for
6 someone to indicate that that has been done.

(Pause)

8 Essentially what is going to happen is an
9 application is going to be made for a restriction order
10 in relation to a couple of words in the Ronald Blake
11 recording which should have been redacted before it was
12 played. I don't imagine it will be remotely
13 controversial.

14 SIR JOHN SAUNDERS: Will it have already been broadcast?

15 MR GREANEY: It may already have been broadcast, yes. I'm
16 not quite sure how long ago we played the recording, but
17 almost certainly more than 10 minutes ago.

18 SIR JOHN SAUNDERS: I think this is going out at the same
19 time. I don't think there's any delay, is there?

20 MR GREANEY: There is the 10-minute delay to the YouTube
21 feed.

22 SIR JOHN SAUNDERS: Right.

(Pause)

Application by MR DE LA POER

24 MR DE LA POER: I see from Mr Suter that we're no longer

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1 broadcasting on YouTube. The position is this, that
2 about 10 or 15 minutes ago, as you'll recall, the 999
3 call from Ronald Blake was played. That had been edited
4 to remove six words within it, in which Mr Blake makes
5 a reference to a RESTRICTION ORDER
6 RESTRICTION ORDER. It was considered that that was wholly
7 irrelevant and an intrusion RESTRICTION ORDER,
8 and an unnecessary one at that.

9 So it is that I apply to you for a restriction order
10 in relation to those words from the recording so that
11 when that 999 call is published in the way that it is
12 ordinarily published, those words will not be contained
13 within it. I know that steps will be taken in relation
14 to the YouTube recording. It may be, although it has
15 been broadcast, that whatever is subsequently published
16 by YouTube can have that removed. But that is beyond
17 my -- I see Mr Suter agreeing with that, so it may be
18 that when people come back to that session, those words
19 will be able to be removed by the order.

20 May I just deal with the formalities unless you have
21 any questions for me at this stage.

22 SIR JOHN SAUNDERS: I have to say I didn't notice what was
23 said. I didn't hear it.

24 MR DE LA POER: Those that have taken considerable care to
25 ensure that they were removed were disappointed to hear

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1 that they were played. I'm not casting aspersions there
 2 and we will need to investigate why that happened. I'm
 3 sure it was human error at some point, but we seek to
 4 put it right.
 5 So can I just --
 6 MR COOPER: I wonder if I can just approach my learned
 7 friend and see those words again so I'm sure exactly
 8 what he is referring to.
 9 SIR JOHN SAUNDERS: You may need to turn the microphones off
 10 if you're going to talk to him secretly.
 11 (Pause)
 12 MR DE LA POER: Yes, sir. If I may, I'll deal with the
 13 formalities and then I can read out the words so there's
 14 absolutely no ambiguity about what your order applies
 15 to. The formalities are --
 16 SIR JOHN SAUNDERS: Just stopping for a moment, do you
 17 actually need to read them out or can you write them
 18 down? It seems to me if there's an interference with
 19 privacy, then it's clearly an Article 8 right, so it can
 20 be written down for my benefit.
 21 MR DE LA POER: Absolutely. As I say, they are just six
 22 words and my learned friend who represents
 23 John Atkinson's family has seen them. He knows what
 24 we are referring to.
 25 So the application is under section 19.3(b) and 4(b)

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1 in which you, sir, as chairman, have the power to make
 2 a restriction order that you consider to be conducive to
 3 the inquiry fulfilling its terms of reference or which
 4 may be necessary in the public interest having regard in
 5 particular to the matters mentioned in subsection 4. We
 6 draw your attention particularly to subsection 4(b),
 7 which is:
 8 "Any risk of harm or damage that could be avoided or
 9 reduced by such a restriction."
 10 SIR JOHN SAUNDERS: Does anyone have any observations to
 11 make about the requested order?
 12 MR COOPER: No, sir. I have seen the words in question.
 13 We have no objection.
 14 SIR JOHN SAUNDERS: Anyone else? Thank you. I am satisfied
 15 from what you have told me that the matters that are
 16 sought to be removed are not relevant to the inquiry or
 17 to anything. They are also matters **RESTRICTION ORDER**
 18 **RESTRICTION ORDER** which should not normally be
 19 broadcast, **RESTRICTION ORDER**
 20 **RO**, so I agree to that order being made.
 21 MR DE LA POER: Thank you.
 22 SIR JOHN SAUNDERS: So that's it for today?
 23 MR GREANEY: There is nothing else to deal with today, no.
 24 SIR JOHN SAUNDERS: Thank you. 9 o'clock tomorrow.
 25 Thank you very much.

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1 (4.06 pm)
 2 (The inquiry adjourned until 9.00 am
 3 on Wednesday, 9 September 2020)

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