OPUS2

Manchester Arena Inquiry

Day 12

September 29, 2020

Opus 2 - Official Court Reporters

Phone: +44 (0)20 3008 5900

Email: transcripts@opus2.com

Website: https://www.opus2.com

1 Tuesday, 29 September 2020
2 (9.30 am)
3 SIR JOHN SAUNDERS: Mr Greaney.
4 MR GREANEY: Sir, good morning. First today we're going to
5 hear from Mr O'Connor on behalf of SMG Europe Holdings
6 Limited, who, as he will no doubt explain, is the
7 company that operates the arena.
8 SIR JOHN SAUNDERS: Thank you.
9 Opening statement by MR O'CONNOR
10 MR O'CONNOR: Sir, as you know, and as Mr Greaney has just
11 indicated, I represent SMG Europe Holdings Limited,
12 normally referred to simply as SMG, which is the company
13 that operates the Manchester Arena. I'm instructed by
14 John Gollaglee and Poppy Williams of DLA Piper
15 Solicitors.
16 May I start, as we started our written opening, by
17 expressing SMG's sincere sympathies to the families and
18 friends of the 22 people who died in the attack.
19 Although we have not been present in the hearing room
20 for the last 2 weeks, we've been following the pen
21 portrait evidence closely, as I'm sure have all the
22 organisational core participants.
23 Sir, the evidence that you have heard over the last
24 2 weeks has allowed us a brief glimpse into the
25 personalities of each of the 22 people who were murdered

1 by Salman and Hashem Abedi, as well as at least some
2 understanding of the terrible losses sustained by their
3 families. It has been, if we may say so, a fitting
4 start to the oral evidence stage of your inquiry's
5 proceedings.
6 Sir, there are always lessons to be learned from any
7 event as catastrophic as the terrible night of
8 22 May 2017. We are sure that, looking back over the
9 events of that night, you will identify many such
10 lessons.
11 We heard what Mr Cooper said yesterday about
12 organisations failing to learn lessons in the wake of
13 terrorist attacks. On behalf of SMG, let me speak
14 frankly. We know that SMG didn't get everything right
15 that night and we want to learn from what happened.
16 SMG's process of review commenced internally
17 immediately after the attack. That exercise is still
18 ongoing and SMG regards this inquiry as an important
19 part of it. SMG has cooperated and will continue to
20 cooperate with this inquiry, not only to respect the
21 process and to help the families obtain the answers that
22 they seek, but also to ensure that the inquiry's
23 analysis of what went wrong and the recommendations that
24 it makes are as well-informed and as thorough as
25 possible.

1 And if the inquiry does highlight further changes
2 that SMG could do for the better it will of course look
3 urgently at implementing those changes not only at the
4 arena but, as appropriate, across all its venues.
5 The arena is not only physically located at the
6 heart of the city of Manchester, we know that it also
7 occupies a place at the heart of the cultural life of
8 the city and in the lives of many of those who live and
9 work in Manchester and the north-west. It has been
10 a Manchester institution for 25 years. SMG values the
11 special regard that so many people have for its flagship
12 venue and is determined to respect and to honour that
13 regard.
14 It is also true, of course, that the
15 Manchester Arena will now always be linked with the
16 terrible events of the night of 22 May 2017. SMG
17 continues to engage with the families of the deceased
18 and indeed all those affected by the events of that
19 night. The latter category includes SMG's staff, many
20 of whom were deeply affected by what they experienced
21 and all of whom now work in a place that holds painful
22 memories.
23 In the broadest of terms, there are two areas of
24 SMG's conduct that the inquiry will wish to investigate.
25 First, SMG's preparations prior to the attack, the

1 systems that it had in place, in particular relating to
2 security and, second, the response of SMG's staff to the
3 attack. These matters are addressed in our written
4 opening submissions which you have and which will be
5 published on the inquiry website.
6 This morning I propose to summarise what we submit
7 are the key points from SMG's perspective of those two
8 matters. I will attempt to identify the questions that
9 we submit the inquiry should address and I will make
10 some remarks about how the inquiry should focus its
11 investigation and the way in which it should approach
12 the evidence.
13 Before I do so, sir, I propose to say a little about
14 the factual context, the arena itself, SMG and the
15 City Room.
16 As Mr Greaney rightly observed in the course of his
17 opening, the arena is one of the largest and busiest
18 indoor arenas in Europe. It opened in 1995 and has
19 a maximum capacity of 21,000. In recent years it has
20 hosted each year in excess of 1 million visitors
21 attending over 100 shows. It is one of several tenants
22 of the Victoria Exchange Complex and in fact sits above
23 the Manchester Victoria station.
24 It is already apparent, we suggest, that the arena's
25 status as one of several tenants within the

1 Victoria Exchange Complex and its proximity to the
2 station provide the factual context for many of the
3 issues that you will need to consider in the arena
4 security chapter, most obviously issues relating to the
5 City Room, to which I will turn in a moment, and the
6 series of issues concerning primacy as between BTP and
7 GMP.
8 As we've explained in our written opening, SMG is
9 a venue and event management company that operates on an
10 international basis. It currently operates a total of
11 11 arenas and other venues in Europe and is involved in
12 projects in the Middle East and Asia. It is also worth
13 emphasising that for all the international scale of SMG
14 as a company, the arena is actually run on a day-to-day
15 basis by a fairly small group of people.
16 In early 2017 there were fewer than 40 full-time SMG
17 staff engaged with running the arena. Of course,
18 actually putting on shows at the arena required far more
19 people and SMG itself engaged a large number of
20 occasional food and beverage staff on an event-by-event
21 basis and SMG contracted with ShowSec to provide
22 security and stewarding staff. On the night of
23 22 May 2017, there were some 164 ShowSec staff on duty
24 at the arena, a number that was not untypical.
25 To those who are familiar with the arena, ShowSec

1 staff are those wearing the yellow and black tops --
2 indeed one sees those tops at many other venues because
3 ShowSec is a market leader in the UK security industry,
4 operating at hundreds of events, festivals and venues
5 across the country.
6 ShowSec has provided security services at the arena
7 since it opened in 1995 and the company has an intimate
8 knowledge of the workings of the arena, and the wide
9 experience that ShowSec has of security issues at other
10 venues is highly valued by SMG.
11 SMG and ShowSec staff at the arena work very closely
12 together, both in preparation for and in putting on
13 events. ShowSec staff are an integral part of the
14 operation of the arena. They attend the weekly building
15 meetings held to discuss upcoming events, they attend
16 the multi-agency planning meetings held at the arena,
17 they sit on the arena health and safety committee, and
18 they also play a key role both in devising and in
19 undertaking tabletop training exercises.
20 At every event the SMG duty manager attends the
21 ShowSec supervisors' briefing and the ShowSec held of
22 security is stationed with the duty manager in the
23 Sierra Control Room.
24 ShowSec's work at the arena goes well beyond
25 security and crowd management. They have an office

1 at the arena and take a leading role in joint
2 SMG/ShowSec staff training. They also advise on
3 strategic issues, including, we say, counter-terrorism
4 measures, a subject to which I will return.
5 The inquiry will naturally focus on security
6 arrangements in the City Room, where Salman Abedi
7 exploded his bomb. It is therefore important that the
8 special nature of that space is understood from the
9 outset. The City Room is not part of the arena. Whilst
10 it is understandable that visitors sometimes refer to it
11 as the foyer, that term is misleading. SMG's lease of
12 the arena has never included the City Room.
13 The boundary of the area leased by SMG is at the
14 arena doors that separate the arena concourse from the
15 City Room. Putting it simply, the City Room was
16 a public space.
17 Even when a show was on at the arena, SMG did not
18 control the City Room. It's also used by many others
19 for a variety of different purposes. Most importantly,
20 perhaps, it afforded public access between
21 Victoria Station, Trinity Way and other parts of the
22 Victoria Exchange complex.
23 In 2013 the station was redeveloped, including the
24 erection of the bridge from the station concourse to the
25 City Room. The main purpose of that exercise was to

1 increase rail revenue by shutting off a previous access
2 route straight on to the station platforms and to make
3 people pass through the ticket barriers instead.
4 Maintaining a public access right of way through the
5 City Room was essential to this new scheme. The
6 City Room was also used for accessing the call centre,
7 the NCP car park and the go-karting track, also located
8 in the Victoria Exchange Complex. In addition, as
9 you will hear in evidence, until December 2016 there had
10 been a McDonald's restaurant in the City Room.
11 The City Room was at the heart of the
12 Victoria Exchange complex. It was used by different
13 organisations, one of which was SMG, for different
14 purposes. The ability of the public to pass through the
15 City Room at all times was regarded as critical. In
16 short, sir, the City Room was a complicated space, and
17 those complications are of obvious importance because
18 they form the factual context for consideration of the
19 security arrangements there at the time of the attack.
20 Sir, I would now like to deal with two points that
21 are raised in the security experts' reports. There's no
22 real dispute about these points so I can take them
23 briefly. The first, and it flows directly from what
24 I've just been saying about the City Room, is the
25 question of responsibility for security in the arena and

1 in the City Room.
2 SMG's position, which we have set out at
3 paragraphs 40 and 41 of our written opening, is, we
4 hope, clear and straightforward. SMG was responsible
5 for security in the arena itself. SMG also had
6 a responsibility with others for security in the
7 City Room.
8 As to the first part of that formulation, the arena
9 was and is a private entertainment venue. As the
10 operator of that venue, SMG of course owes all the usual
11 duties to take care for the safety of everyone, staff,
12 contractors, performers and visitors who enter it. And
13 as for the second, we do accept that SMG had
14 a responsibility for security in the City Room at the
15 time of the attack. It had a responsibility for the
16 safety of those leaving the concert. More generally,
17 SMG was contracted to provide facilities management
18 services, which included 24-hour security, across the
19 Victoria Exchange Complex, including the City Room.
20 We want to be clear, sir. We accept that SMG had
21 those responsibilities on the night of the attack and
22 that those responsibilities included looking out for
23 suspicious individuals who might pose a threat. At the
24 time of the attack, those responsibilities were being
25 discharged by the ShowSec stewards and supervisors

1 stationed in and around the City Room itself and also
2 the staff who were on duty in the control rooms at the
3 arena.
4 The reference to others sharing this responsibility
5 in the City Room is a reference to the police. Because
6 the City Room, in contrast to the arena itself, was
7 a public space that was not controlled by SMG, we do not
8 accept that SMG had sole responsibility for security
9 there. The police also had such responsibilities. As
10 the inquiry will hear, BTP officers had been
11 specifically tasked with patrolling the City Room on the
12 night of the attack. They too, we suggest, had
13 a responsibility for looking out for suspicious
14 individuals who might pose a threat.
15 We hope SMG's position is clear. This is
16 an important issue but not a contentious one. It may
17 have acquired an unnecessary prominence by a remark in
18 an early draft of the security experts' report, now
19 withdrawn, that SMG staff did not appear to understand
20 that they were responsible for security at the arena.
21 On that note, sir, you will have seen the concern
22 we have expressed at paragraph 32 of our written opening
23 about the evaluation and indeed the determination of
24 factual issues that appears in the security experts'
25 reports. It is a cardinal principle that the role of an

1 expert witness must be limited to providing their
2 opinion on agreed or set facts. It is absolutely not
3 their role, because, sir, it is your role, to involve
4 themselves in selecting, evaluating or determining
5 factual evidence given by others.
6 We do have a serious concern, sir, that there are
7 large parts of the security experts' reports that
8 transgress this rule. We are sure that when they come
9 to give oral evidence, the experts' evidence will be
10 confined to its proper limits.
11 I mentioned I would deal with two matters. The
12 second of those is of equal importance. It concerns the
13 written risk assessments that SMG prepared, addressing
14 the terrorism-related risks to the arena. There are two
15 such documents to which we have referred at paragraph 75
16 of our written opening.
17 Again, we want to be straightforward about this. We
18 accept that there were shortcomings with these
19 documents. We accept that the written documents did not
20 sufficiently address threat, vulnerability and impact.
21 We also accept that they were not being reviewed with
22 the appropriate frequency at the time of the attack. In
23 fact, neither of these documents was being used as part
24 of the day-to-day process of terrorism risk assessment
25 at the arena in the period running up to the attack.

1 Sir, in the course of his opening statement
2 yesterday Mr Cooper urged you to consider the
3 consequences of flawed risk assessment. We agree. The
4 inquiry should certainly consider the implications of
5 our concession regarding the shortcomings in SMG's
6 written risk assessment processes so far as the risk of
7 terrorism was concerned, and we urge you to do so in
8 a careful and considered manner.
9 Just because a written risk assessment process was
10 not as it should have been, it does not follow either
11 that there was no exercise in assessing risk or, most
12 importantly, that the security arrangements in place
13 were deficient. Both points, we say, require analysis.
14 For example, having in one part of their report
15 criticised the risk assessment process, the experts
16 subsequently criticise the security measures for not
17 being based on a sound risk assessment process. That,
18 with respect, adds nothing. The adequacy of the
19 security measures is a free-standing matter which we say
20 you must consider independently of the documented
21 process that led to them being in place.
22 We suggest that there are two questions that flow
23 from the concession that we have made regarding SMG's
24 written risk assessment. First, notwithstanding
25 the shortcomings in its written risk assessment process,

1 did SMG nonetheless engage in a process of engaging and
2 managing the risks of a terrorism attack? Second, were
3 the security arrangements in place on the night of the
4 attack appropriate?
5 As to the first of those questions, sir, we say that
6 the admitted inadequacies in SMG's written risk
7 assessment are far from being the end of the story.
8 Whatever the shortcomings with the document, at the time
9 of the attack SMG did have a system, albeit one that
10 wasn't paper based, for assessing terrorism-related
11 risks to the arena and for putting in place appropriate
12 mitigations.
13 Because SMG did not then have internal
14 counter-terrorism expertise, that system necessarily
15 involved expert advice and guidance received by others.
16 We invite the inquiry to approach this issue as a matter
17 of substance, not form.
18 The experts refer to the need for a risk assessment
19 process to generate what they describe as a "baseline
20 set of security measures". We suggest that the evidence
21 will show that at the time of the attack, there was
22 indeed a baseline set of security measures at the arena,
23 a baseline that had been developed through 25 years'
24 practice and experience and which was under continuous
25 review.

1 The baseline measures were those that were at that
2 time considered generally appropriate to mitigate
3 terrorism risk events in the absence of any reason to
4 adopt enhanced measures, for example police intelligence
5 of a specific threat. It was those baseline measures
6 that were in place on the night of the attack.
7 The baseline was informed and reviewed by means of
8 regular discussions with and input from the Greater
9 Manchester Police counter-terrorism security advisers,
10 John Archibald and Ken Upham, by SMG's very regular
11 interactions with British Transport Police, by
12 discussions with and advice from ShowSec, and also by
13 SMG's own internal learning from National
14 Counter-terrorism Security Office guidance training and
15 desktop exercises.
16 By means of these processes, the continuing security
17 risks, including terrorism risks, were the subject of
18 regular assessment and, over time, the baseline security
19 procedures at the arena were adapted accordingly. For
20 higher-risk events or where there was specific
21 intelligence, that baseline would be enhanced.
22 It will be very clear, sir, from that summary that
23 prior to the attack reliance on the expertise of others
24 was a core feature of SMG's counter-terrorism risk
25 assessing process. The simple reason for this, as

1 I have said, is that SMG did not then have, as it does
2 now, internal expertise in counter-terrorism. We submit
3 that that was not in itself a shortcoming. The inquiry
4 will hear evidence that it was not at that time common
5 practice in the industry for entertainment venues such
6 as the arena to employ full-time specialist security
7 advisers.
8 You will have seen, sir, the letter from Lucy Noble,
9 the chair of the National Arenas Association, which
10 states:
11 "Most venues did not have an in-house security
12 expert to assess counter-terrorism and security
13 measures. Venues would liaise with their local CTSA for
14 specialised counter-terrorism advice."
15 Pursuing the question of industry practice for
16 a moment, we have referred in our written opening
17 submissions, at paragraphs 22 and 23, to the flexibility
18 of approach that an inquiry enjoys in contrast to
19 a civil or criminal trial. We've suggested that you are
20 free to approach matters more flexibly and your
21 conclusions are likely to be the richer for that. You
22 can measure the conduct of those involved by reference
23 to a range or a combination of standards and we have
24 emphasised that at least one of the standards you should
25 have in mind when assessing SMG's performance is that of

1 contemporary industry practice.
2 In the course of his opening Mr Greaney referred to
3 the security experts' overall conclusion relating to
4 industry practice. That conclusion is striking and it
5 bears repeating. The experts said:
6 "We have not seen evidence that the security
7 operation that was in place at Manchester Arena was
8 dramatically out of step with the operations being used
9 at most other comparable venues."
10 When you come to consider the criticisms that have
11 been made of the practice at the arena at the time of
12 the attack you will need, we suggest, to have that
13 conclusion at the front of your mind: the practices
14 at the arena were in line with contemporaneous practices
15 at other comparable venues around the country.
16 Returning, sir, to SMG's practical risk assessment
17 process, I have mentioned a number of sources that SMG
18 drew on for specialist advice and guidance with regard
19 to counter-terrorism measures. Let me say a few words
20 about each.
21 Certainly the most important regular external
22 security advice that SMG received prior to the attack
23 was from the counter-terrorism security adviser or CTSA
24 from Greater Manchester Police, Ken Upham. Sir, there
25 will be some important findings for you to make about

1 the content of the advice that he gave to SMG and their
2 response to that advice. As you know, there are issues
3 on the evidence, both as to the scope of the advice that
4 a CTSA such as Mr Upham would normally give to SMG and
5 as to the advice that he actually gave.
6 In a sentence, SMG says that it relied upon the
7 specialist advice from Mr Upham and the consistent
8 advice that SMG had received both from him and indeed
9 from his predecessor at GMP prior to the attack, which
10 was that the counter-terrorism security measures in
11 place at the arena were appropriate.
12 Sir, there will be much oral evidence on these
13 issues, including from Mr Upham himself and from
14 Miriam Stone, head of events at the arena, and
15 Mr Upham's point of contact there. It will not be
16 helpful for me to anticipate the detail of that evidence
17 now, but I simply wish to make a few points that I hope
18 will assist the inquiry in approaching these issues.
19 First, we wish to emphasise the high level of
20 expertise held by CTSAs and the respect with which they
21 are regarded. In giving oral evidence to the London
22 Bridge Inquest, Deputy Assistant Commissioner
23 Lucy D'Orsi, from whom you will hear yourself, described
24 CTSAs as "the highest qualified counter-terrorism
25 security advisers in the country".

1 Although the use of the protective security
2 improvement assessment tool, known as the PSIA, used by
3 CTSAs is one element of their work, it is apparent from
4 the evidence before the inquiry that what DAC D'Orsi
5 describes as the bespoke security advice that CTSAs
6 provide to venues such as the arena is and was intended
7 to be more broadly based than merely completing the PSIA
8 spreadsheet. As we shall see, that is a point of some
9 significance.
10 Ken Upham took over as the CTSA with responsibility
11 for the arena in 2014. Between 2014 and 2017 he became
12 well-acquainted with the arena and those who work there.
13 His main point of contact, as I said, was Miriam Stone.
14 It is apparent from Miriam Stone's evidence that the
15 six-monthly PSIA meetings were lengthy and in-depth, the
16 PSIA scores were high and increased over the period,
17 although Mr Upham did recommend certain changes to the
18 security arrangements.
19 SMG took considerable comfort, understandably you
20 may think, from being told that their PSIA scores were
21 high and getting higher. At the final PSIA audit before
22 Salman Abedi attacked using a suicide bomb known as
23 a person-borne improvised explosive device, or PBIED,
24 Ken Upham awarded the arena a score of 92.6% for
25 resilience against a PBIED attack.

1 It is also significant we suggest that Ken Upham did
2 not only come to the arena to undertake regular PSIA
3 visits, Miriam Stone's evidence is that he was also in
4 the habit of popping in informally and, on at least one
5 occasion, he attended a meeting there at her request
6 specifically to discuss whether security measures at the
7 arena should be increased following the Charlie Hebdo
8 shooting in Paris. That was in January 2015. Later
9 that year, Miriam Stone had a similar conversation with
10 him after the Bataclan attack.
11 On both occasions she says Mr Upham stated that
12 he was happy with the security arrangements that were in
13 place. I mention that the January 2015 meeting took
14 place at Miriam Stone's request, a request she made by
15 e-mail. We suggest that that email and the subsequent
16 meeting are of considerable importance in understanding
17 SMG's relationship with Ken Upham and the advice he gave
18 them. I'm therefore going to ask that the email is
19 brought up on the screen. It is {INQ025133/2} and
20 {INQ025133/3} we need.
21 Sir, the email to which I refer you starts right at
22 the bottom of page 2 and you can see that Miriam Stone
23 is emailing both Ken Upham and also a man called
24 Chris Smith from BTP for information and advice. She
25 starts by wishing them a happy New Year and, if we can

1 go to the next page, we can see the request that she
2 makes. She says:
3 "I am sure you have probably been inundated with
4 requests for advice and information about the goings-on
5 in Paris [that is the Charlie Hebdo shooting] and the
6 knock-on effects here."
7 But she says she is going to ask them for advice
8 anyway. She refers to the fact that the arena has been
9 looking at its operations, making sure they're filling
10 as many gaps as they can, using the survey from Ken,
11 that's the PSIA survey, as a starting point.
12 She refers to the fact that security measures have
13 been changed with increased access control staffing.
14 She then refers to a tabletop exercise they had done
15 in the month or so before that, before the email, just
16 before Christmas. You can see what she says about that.
17 It's the next paragraph I want to draw your
18 attention to, sir. She says:
19 "We do want to make sure that we are up to date with
20 everything we are supposed to know and doing everything
21 we can. If there is anything you can tell us, we would
22 greatly appreciate it."
23 Then she says:
24 "If there's anything you can tell us that requires
25 levels of secrecy."

1 She refers to the fact that James Allen, the general
2 manager of the arena, is a member of something called
3 the Counter-terrorism Business Sentinel Strategic Group,
4 members of which are entitled to see confidential
5 material.
6 Thank you very much.
7 Sir, that is only one email, of course, but you may
8 conclude that it demonstrates both the sense of
9 responsibility that SMG felt for the safety of visitors
10 at the arena and the reliance that they properly placed
11 on experts to advise them in this regard, advice that,
12 as this email shows, was proactively sought.
13 You will also note that there was no mention in the
14 email of the PSIA system. Miriam Stone was not asking
15 Mr Upham to undertake another PSIA audit, but rather
16 asking him and Mr Smith from BTP to advise SMG as to
17 whether we are up to date with everything and doing
18 everything we can. You will hear about the meeting that
19 followed.
20 Miriam Stone's evidence, as I have said, is that
21 Mr Upham told her he was happy with the security
22 arrangements that were in place.
23 Because the inquiry will naturally focus on the
24 City Room, we also draw attention to Miriam Stone's
25 recollection of discussing the security arrangements

1 there with Ken Upham. Her evidence, as we say, is
2 striking. Ken Upham understood how the City Room was
3 used at events but never raised any concerns with the
4 security arrangements there. And Miriam Stone is also
5 very clear about the reliance that SMG placed upon
6 Ken Upham. They did rely on him. Indeed she describes
7 Mr Upham, as:
8 "Our most important source of guidance and advice on
9 counter-terrorism matters."
10 She also says that she is sure that Mr Upham knew
11 that SMG did not have any internal expert
12 counter-terrorism advice at the time and so he must have
13 known that they were relying on him.
14 Taking a step back from the detail of the evidence,
15 and in doing so I should add that Mr Upham disputes at
16 least some of the account I have just given, we make the
17 following three broad points about the questions that
18 the inquiry must resolve here.
19 First, it appears to be common ground that the CTSAs
20 perform an advisory function and that those who receive
21 their advice, such as SMG, are entitled to rely on it.
22 Second, there may be some debate about the breadth of
23 the advice that NaCTSO and police colleagues would
24 expect a CTSA to give. As I have said, DAC D'Orsi
25 refers to CTSAs giving bespoke advice to venues going

1 beyond matters raised in the PSIA form; GMP appear to
2 take a narrower view.
3 However, and this is the third point, that debate
4 may in truth be rather an arid one. Miriam Stone was
5 not to know the niceties of CTSA internal guidance or
6 practice. If Ken Upham did give her the type of broad
7 assurance that she says he did, and that of course will
8 be a matter for you to determine, then given his
9 expertise and status it cannot sensibly be suggested, we
10 say, that she was not entitled to rely on what he said.
11 Sir, there were two other external organisations to
12 which SMG looked for CT advice, BTP and ShowSec. I can
13 take them more shortly. You will hear that the arena's
14 location on top of Victoria Station meant that SMG staff
15 had a uniquely close relationship with the British
16 Transport Police. Miriam Stone's evidence is that the
17 arena staff were in contact with BTP in one form or
18 another on an almost daily basis. As you've heard
19 in the course of Mr Greaney's opening, BTP officers
20 undertook routine patrols at the time of events,
21 attended the arena's multi-agency planning meetings, and
22 were often called to attend incidents at the arena. One
23 of the consequences of that close relationship was that
24 BTP officers had a good practical understanding,
25 established over 25 years, of how the arena worked.

1 Although formal counter-terrorism advice was
2 provided by Ken Upham, Miriam Stone states that SMG did
3 discuss counter-terrorism matters with contacts at BTP.
4 In July 2015, BTP investigated a possible hostile
5 reconnaissance of the arena that SMG had reported taking
6 place during a Jehovah's Witness event. BTP took this
7 incident seriously and, for the following two events, as
8 a precaution, a BTP superintendent named Eddie Wiley
9 attended the arena and at in the Sierra Control Room.
10 Later that year, after the Bataclan attacks in
11 Paris, Miriam Stone discussed the arena's security
12 arrangements with Eddie Wiley as she also did, as I have
13 said, with Ken Upham.
14 Mr Wiley has no recollection of that conversation,
15 but Miriam Stone recorded it in a contemporaneous
16 document circulated within SMG. I ask if we can bring
17 that document up on screen. It is {INQ001444/1}. Sir,
18 if we can perhaps zoom in on the fifth paragraph down,
19 I think, which starts:
20 "Our police superintendent (Pennine Sub-divisional
21 Commander of British Transport Police) [that is
22 Eddie Wiley], with whom we have a very healthy
23 relationship, is happy that what we do here is as good
24 as it can be. He is confident that we are doing as much
25 as we can to achieve the best and safest situation for

our guests, staff, artists, et cetera, and is not asking us to do anything further."

As you'll see, there is then a reference to the high PSIA scores the arena had received:

"The arena has been subject to an anti-terrorism building security audit by Greater Manchester Police who carried out the same audit of all the larger venues and centres from which it came out very well."

Thirdly, sir, ShowSec, the arena's security contractors to whom I have already referred. The evidence of SMG witnesses is that they also provided SMG with counter-terrorism advice. To be clear, sir, we do not suggest that ShowSec had the level of counter-terrorism expertise enjoyed by the CTSAs, nor of course did they have access to the type of classified intelligence that the police were privy too. Nonetheless we say that the evidence will show that ShowSec did have, perhaps unsurprisingly for a security company, specialist knowledge in the counter-terrorism field and it did share that knowledge with SMG.

As to its specialist knowledge, you will take your own view of course, but you may consider that ShowSec's corporate expertise in this area is readily apparent from the counter-terrorism training courses it produced, the counter-terrorism awareness document for the arena

that it drafted, and so on.

As to whether ShowSec staff at the arena shared their specialist knowledge with SMG, ShowSec say that they had not contracted with SMG to provide counter-terrorism advice. There's a dispute about that. We say that these services were included within the contract, but in any event, sir, as we put it in our written opening, you are conducting a public inquiry, not a trial in the Chancery Division. Your focus, we suggest, should not be on the contents of a document covering a number of venues across the UK and signed several years before the attack, but rather on the evidence as to what was actually taking place.

Both James Allen, the manager of the arena, and Miriam Stone will say that in the period prior to the attack, they regarded ShowSec as specialists in counter-terrorism security and sought and received their advice on such matters.

Given the increased concern about security in the wake of the Charlie Hebdo and Bataclan attacks, you may think it would have been surprising if SMG had not sought advice from their security providers. Nonetheless, the ShowSec witnesses do not accept that there were any discussions about counter-terrorism. It will be a matter, sir, for you to resolve.

In conclusion on the question of practical risk assessing, whatever the shortcomings of SMG's written process of counter-terrorism risk assessment, SMG did nonetheless engage in an ongoing and proactive exercise of assessing and responding to the risks from terrorism. In keeping with what was then the general practice in the industry, SMG did not at that time have internal expert security expertise and this exercise therefore necessarily involved SMG seeking advice from other organisations.

You will hear the evidence, sir. We suggest it will show that SMG was the very opposite of complacent. It sought assurance from experts, in particular from Greater Manchester Police, regarding its security arrangements, and the message that SMG received back from all directions was that the arrangements in place were appropriate.

That is all I propose to say about risk assessment. As I suggested earlier, risk assessment is not an end in itself but a means to an end. Here, the purpose of the risk-assessing process that I have described was to ensure that an appropriate set of counter-terrorism mitigations was in place at the arena both in terms of physical measures and also associated procedures.

The question for the inquiry is whether the

mitigations in place on the night of the attack were in fact appropriate and it is to that issue I now turn.

Sir, I say "security arrangements on the night of the attack", but you will be aware that our submission is that your focus should in fact be narrower than that; this is the causation issue that we have developed in our written opening at paragraphs 14 to 21. Putting the point shortly, we say that the function of this inquiry, as in effect a substitute set of inquests, is to establish the circumstances in which Salman Abedi's 22 victims were killed. That requires the inquiry to focus on issues that are of at least potential causative relevance to the deaths. Where it is clear that an issue has no such causative relevance, it cannot be said to form part of the circumstances of the deaths and should not be investigated.

We have given the question of access controls at the arena as an example of such a matter. Whatever uncertainty there may have been previously, the CCTV evidence that is now available makes it abundantly clear that Salman Abedi never made any attempt to enter the arena on the night of the attack. He wasn't even in the City Room during the ingress period. He detonated his bomb at the end of the show when concertgoers had begun to exit the arena. Indeed, the view of the experts

1 is that he deliberately avoided approaching the entrance
2 to the arena.
3 Sir, in our written opening, we raised the question
4 as to whether, strictly speaking, this issue was within
5 the inquiry's terms of reference. It is not, however,
6 a point we will press. We have heard what Mr Greaney
7 had to say on this topic in his opening statement and
8 the submissions made by Mr Cooper and Mr Atkinson
9 yesterday. We are also mindful of the importance of
10 this issue to many of the families, in particular,
11 of course, Figen Murray. What we do say, and finally on
12 this topic, is that the inquiry should focus its
13 attention on causative matters and, if it does
14 investigate issues that are of limited causative value,
15 it should do so in a proportionate way.
16 Sir, I will briefly make two points regarding
17 physical security measures and in particular
18 walk-through metal detectors, WTMDs, as one sometimes
19 sees them described in the documents.
20 First, sir, we had understood from the security
21 experts' initial report their view to be that, at
22 a minimum, the physical security arrangements on the
23 night should have involved the closure of the City Room
24 and the use of walk-through metal detectors for all
25 those attending the concert. In their initial report

1 they describe this, not inaccurately, as an entirely
2 different regime.
3 As you will have noted, we address this contention
4 in our written opening at paragraphs 83 to 94. We
5 pointed out, among other things, that none of the
6 security experts with whom SMG liaised prior to the
7 attack had ever suggested that such a regime was
8 necessary and that walk-through metal detectors were
9 very little used in the industry prior to the attack;
10 things have changed since.
11 However, having read the experts' final report,
12 it is now not at all clear that the experts continue to
13 hold this position. They no longer refer to the need
14 for walk-through metal detectors or an extended
15 perimeter or indeed an entirely different regime. Sir,
16 this is a matter we will need to explore with the
17 experts, but we suggest that this change of position, if
18 that is what it is, is of some significance.
19 It's important not only for consideration of ingress
20 arrangements but also, and in light of what we've said
21 about causation, more importantly with regard to egress.
22 The experts' previous view, as we understood it, was
23 that the City Room should have been closed for the
24 duration of the event. That proposition has clear
25 causative connection to the deaths. If the City Room

1 was closed, Salman Abedi could never have gone in,
2 waited and then exploded his bomb when and where he did.
3 Although, as we have pointed out, one cannot take that
4 point too far. The assumption must be that if the
5 City Room was closed, Salman Abedi would simply have
6 detonated his bomb in the middle of the crowd that had
7 gathered on the edge of whatever a different perimeter
8 was.
9 But if there is no force in the idea that the
10 City Room ought to have been closed on the night, and
11 that is certainly our position, then the focus switches
12 to what, if anything, should have been done differently
13 in the City Room. Perhaps the single most important
14 question is: should someone have reported a concern
15 about him to the Sierra Control Room?
16 Sir, I will return to those matters, which we
17 suggest will be of the utmost importance to this part of
18 your inquiry in a moment. Before I do so, I want
19 briefly to deal with a second point concerning metal
20 detectors.
21 There is a suggestion in the final version of the
22 experts' report, a suggestion that is repeated in one of
23 Ken Upham's witness statements and indeed in other
24 places, that in 2016 SMG were actually considering
25 installing walk-through metal detectors for routine use

1 at the arena but decided against it. Sir, this
2 suggestion appears to have stemmed from a simple
3 misunderstanding about a particular document and I hope
4 it's helpful if I clear it up now.
5 The document in question is an email exchange
6 between James Allen and two ShowSec staff in April 2016,
7 which attached a copy of the stewarding review that had
8 recently been conducted at the arena by Miriam Stone.
9 The review and the email refer to the possible
10 introduction of something called fixed scanners at the
11 arena and it is this that has led to the talk of
12 walk-through metal detectors.
13 In fact, the scanners under discussion were not
14 walk-through metal detectors at all, they were ticket
15 scanners similar to automated ticket barriers at train
16 stations. These ticket scanners were in use at a venue
17 in Germany, which led to the discussion about
18 introducing them in Manchester. Before leaving this
19 point, I would like to read the passage of the
20 stewarding review that discusses these scanners.
21 Miriam Stone stated as follows:
22 "It would in theory, and with consultation with the
23 City Council, be possible to automate entry to the venue
24 using fixed scanners. However, I think this is
25 something we should resist strongly, particularly in the

light of heightened security awareness. Currently all bags are checked into the building and every single customer has some level of interaction with a human being. Aside from the better customer experience, this allows staff to pick up potential issues of intoxication or suspicious behaviour as well as reassuring the public that we are in control of the venue. The visible staffing on the doors is a deterrent, as was seen in Paris in 2015, where the stadium bombing was unsuccessful as the perpetrator saw that they would not be able to get past the external doors. From recent conversations, the police would resist this automation and potentially make formal objections as this specific activity is covered in the PSIA guidance and scoring." {INQ015823/7}

You may conclude, sir, that this passage provides a helpful insight into the way in which SMG weighed cost savings against security. SMG is a business and like any business, it must be profitable in order to survive. Indeed, the purpose of this stewarding review was to consider whether savings could be made. It is, of course, legitimate to ask in such a situation whether the business has prioritised safety over profit. We know that that is a concern of the families here. It was a concern expressed yesterday by Mr Cooper and by

Mr Welch.

This passage, we suggest, demonstrates SMG's approach, which was to reject cost-saving measures when they compromised security. I would add that this passage is further evidence of the ongoing practical risk assessment process to which I referred earlier. Here, Miriam Stone is deploying her understanding of the terrorist risk gained from CTSA and others to ensure that there was no reduction of security measures.

I now turn to the issue of looking out for and reporting suspicious behaviour in the City Room. We readily accept that this is a core issue which the inquiry will wish to probe in some depth. In a sentence, SMG's position is that at the time of the attack it believed and had good reason to believe that there was an effective system in place for looking out for and reporting suspicious behaviour.

We have set out some fairly detailed points in support of that proposition at paragraphs 99 to 109 of our written opening statement. By way of summary now, I would like to underline what we suggest are five key matters.

First, training. There is, sir, a great deal of evidence about the various training exercises undertaken both by SMG and by ShowSec staff, some of it together,

some of it separately, some external, some internal, and so on. Going back to what I was saying earlier about causation, you may think that what really matters at least for these purposes is to consider whether staff at the arena, in particular ShowSec staff, whose role included looking out for and reporting suspicious behaviour during events, were sufficiently trained to know what they should be looking out for and what to do if they did see anything of concern.

The experts have added a further consideration, that of confidence. They have made the fair point that staff can be trained to report suspicious behaviour but at the same time lack the confidence or motivation to make such a report, perhaps because they're worried about the consequences of doing so.

This issue, again, sir, is the subject of detailed evidence before you. Miriam Stone has addressed this point in clear terms. We have quoted a page from her statement in our written opening in which she states that she personally encouraged staff to report anything suspicious or concerning, that they should always make a report if they're in any doubt and no one would shout at them if the arena ending up reporting things to the police all the time.

She added:

"To my knowledge, none of the managers at the arena has ever responded negatively to staff making reports. The culture was, and is, that if you see something, you call it in."

The experts have reviewed all this evidence and have drawn conclusions that you may think are of some significance. In their final report they've stated:

"We have not seen evidence that staff lacked confidence to report incidents immediately for fear of criticism from management. In our opinion SMG and ShowSec security staff had sufficient training, confidence, empowerment and support to report suspicious activity."

Sir, the second point I make, again from SMG's particular perspective, is in the period running up to the attack there had been several examples of ShowSec staff making reports of suspicious individuals.

Again this, is all set out in the evidence and you will hear that there were in fact two such incidents only 4 days before the attack. The point is an obvious one. These incidents gave SMG every reason to believe that the system was working.

Third, sir, is the question of counter-terrorism awareness in the City Room. It is a fact that Salman Abedi was in the City Room for a lengthy period

1 before he detonated his bomb. The families were
2 therefore right yesterday to emphasise the importance of
3 this issue. I must immediately give a jargon warning.
4 The experts have said that something they describe as a
5 "counter-terrorism sweep" should have been conducted
6 in the City Room. ShowSec did in fact conduct several
7 routine searches that encompassed the City Room during
8 the night. Those searches are known as pre-egress
9 checks.
10 Is a pre-egress check a counter-terrorism sweep?
11 The labels of course are not important and the inquiry
12 must look at the substance of the matter. The experts
13 have explained that what they mean by
14 a counter-terrorism sweep is simply a check that an area
15 is free from threats to the crowd, and that such a check
16 should look out for, among other things, suspicious
17 items, individuals and activity.
18 It is certainly SMG's understanding that that was
19 one of the core functions of the pre-egress checks. As
20 you will hear in evidence, another of the functions of
21 those checks, indeed the main function, was to check
22 that egress routes were clear, but it was certainly
23 SMG's understanding that the ShowSec staff conducting
24 these checks were always subject to the standing
25 instruction that they received in training to look out

1 for and to report anything suspicious or concerning.
2 You will therefore need to consider whether as
3 a matter of practice there really was any difference
4 between the counter-terrorism sweeps that the experts
5 describe and the pre-egress checks that were actually
6 being performed. Viewed as a matter of substance, we
7 suggest not.
8 A few other short points on this before I move on.
9 You will need to consider the physical scope of the
10 searches on the night. The experts have pointed to
11 documentation stipulating that the pre-egress checks
12 should cover the whole of the City Room and, in
13 particular, the area of the mezzanine floor where
14 Salman Abedi was hiding, but it appears from the
15 evidence that the ShowSec member of staff who conducted
16 the checks that night did not go at least to that part
17 of the mezzanine floor. It's worth remembering that all
18 the ShowSec staff were expected to do was to look out
19 for and, if appropriate, report suspicious behaviour.
20 That was a task for which they had been trained and
21 which they routinely performed.
22 The use of the term "counter-terrorism sweep" might
23 indicate that they were expected to confront or even
24 disarm a suspect, but that is plainly not the case. All
25 they were expected to do was to report their concern

1 just as ShowSec staff did day in, day out.
2 Again, sir, we invite you to set aside the jargon
3 and look at this as a matter of substance.
4 Finally on this, sir, we say that it is important,
5 whilst considering the various issues relating to
6 pre-egress checks, not to lose sight of the fact that
7 those checks were only one element of the ShowSec
8 presence in and surveillance of the City Room on the
9 night of the attack. As you will hear, there were other
10 ShowSec staff in and around the City Room throughout the
11 evening. All of them had been trained to look out for
12 suspicious behaviour and were, no doubt, doing so, and
13 as of course you know, two of them did see and observe
14 Salman Abedi.
15 Those two members of ShowSec staff were
16 Mohammed Agha and Kyle Lawler, which brings me to my
17 fourth point. Mr Cooper referred yesterday to
18 Mr Lawler's recent witness statement in which he
19 describes repeated unsuccessful attempts to make a radio
20 report of his concerns about Salman Abedi. He says he
21 couldn't use his radio because the network was very
22 busy. In fact, he says that he made repeated attempted
23 reports over several minutes and that the network was
24 jammed for that entire period. Sir, that is a factual
25 matter that you will of course investigate. You're

1 well-placed to do so because many of the witnesses you
2 are calling were using the radio network that night. We
3 note that none of them have given evidence similar to
4 that of Mr Lawler.
5 Whatever the position with the radios, in
6 considering Mr Lawler's actions you will need to
7 consider the other means available to him of reporting
8 his concerns. We have referred to those other means of
9 contacting the control room at paragraph 105 of our
10 written opening statement, including, you may think
11 particularly striking, Miriam Stone's evidence that
12 it would only have taken about 1 minute to walk from the
13 City Room to the Sierra Control Room and that it was
14 quite common for members of staff simply to come and
15 knock on the door during a show.
16 The fifth point that I wish to emphasise as to SMG's
17 confidence that there was a system in place for looking
18 out for suspicious behaviour in the City Room takes me
19 back to the submission that I made at the very outset
20 regarding responsibility for security in the City Room.
21 As I said then, although SMG accepts that it had
22 a responsibility for security in the City Room, it does
23 not accept that it had sole responsibility. The
24 City Room was a public space that, to SMG's knowledge,
25 was routinely patrolled by BTP officers on event nights.

1 Given all the guidance and training that SMG had
2 received from NaCTSO and others as to the importance of
3 looking out for suspicious behaviour, SMG assumed that
4 the BTP officers on patrol would be performing
5 a counter-terrorism function. Indeed, it was reasonable
6 to assume that the BTP officers would have had more
7 specialised training, would have received a more
8 detailed briefing, and would have had access to better
9 intelligence than the SMG and ShowSec staff on duty that
10 night.
11 The inquiry will have to consider the evidence that
12 in fact the BTP officers on duty that night did not have
13 any form of counter-terrorism briefing and did not
14 follow instructions about the timing and manner of their
15 patrols.
16 In summary, sir, on the question of what, if
17 anything, went wrong on the night of the attack in terms
18 of identifying and reporting Salman Abedi as a threat,
19 it is clearly one of the central questions that this
20 inquiry must address. You will hear detailed oral
21 evidence from those who were there. These are very
22 early days. The first question you must answer is
23 whether in fact Salman Abedi was someone who was
24 suspicious so that a report should have been made. If
25 you conclude that he was, then you will need to consider

1 what went wrong, why a report was not made, and what
2 realistically could have been done if a report had been
3 made.
4 What we say, admittedly at this very early stage, is
5 there was good reason for SMG's belief that there was an
6 effective system in place for looking out for and
7 reporting suspicious behaviour.
8 Sir, I said at the outset that I would address
9 two main topics, the first being all the issues relating
10 to SMG's conduct in advance of the attack, risk
11 assessment, training, the measures in place on the night
12 and so on, and the second being SMG's response to the
13 attack.
14 I now turn to the second of those issues and you'll
15 be glad to hear that I'll be very much shorter on it.
16 The reason for that is that there is little, if any,
17 criticism of the way SMG staff responded to the
18 detonation of the bomb in the City Room.
19 SMG staff rushed to the City Room and assisted the
20 victims without thought for their own safety. SMG's
21 employees, Paul Worsley and John Clarkson, stayed with
22 one victim who survived her injuries for 2 hours,
23 providing first aid and comfort even after they were
24 told to leave the City Room by armed police, and the
25 security experts pay tribute in their report to the fact

1 that Miriam Stone, Tom Rigby and the SMG and ShowSec
2 staff on duty successfully evacuated some 14,000
3 concertgoers from the arena following the explosion,
4 many of them children and young persons, in a short time
5 and without causing a major crushing incident.
6 Although it can be described briefly, sir, the
7 significance of that achievement should not be
8 underestimated. Some of us in this room were involved
9 in the Hillsborough inquests and the terrible events
10 that took place there are testament to the dangers that
11 can ensue when large crowds are mishandled in an
12 emergency. SMG is understandably proud of how its staff
13 coped under unimaginable pressure that night.
14 Sir, this inquiry will, of course, be astute to
15 identify things that went wrong that night. We are
16 confident that you will be equally astute to identify
17 things that went right and we respectfully submit that
18 the emergency evacuation of the arena was one of them.
19 The very last topic that I want to touch on before
20 I sit down is that of post-attack changes and hindsight.
21 Earlier this year, we provided, at your request,
22 a statement setting out the changes that SMG has made to
23 the security arrangements at the arena since the attack.
24 Those changes are the product of the internal review
25 that I mentioned at the very start of my submissions

1 this morning. The changes that have been made are
2 significant.
3 SMG now employs an internal security specialist to
4 oversee, amongst other things, a new system of risk
5 assessment and security audit at all its European venues
6 and the physical security arrangements in the areas
7 around the arena have also changed. Walk-through metal
8 detectors are now used at every event and the City Room
9 is also closed before, during and after events to create
10 a sterile area, in effect extending the perimeter.
11 Sir, it is, of course, a truism that an inquiry of
12 this nature should be aware of the risks of hindsight.
13 That is particularly important in the arena security
14 context, we submit, precisely because the attack was
15 such a devastating and significant event which has had
16 a profound impact not only on the arena itself but also
17 on security best practice and the understanding of
18 terrorism risk across the entertainment industry. We
19 know, for example, the observation of DAC Lucy D'Orsi
20 that the terrorist attacks in London and Manchester in
21 2017 marked a watershed moment for UK society, the
22 emergency and intelligence services, and in particular
23 counter-terrorism policing.
24 You will hear evidence about the greater
25 understanding following the attack of risks associated

1 with so-called grey spaces such as the City Room and
2 also about the developing understanding since 2017 of
3 risks associated with egress from entertainment venues
4 and, in the particular context of the arena, you will
5 hear evidence from SMG witnesses that the closure of the
6 City Room on a permanent basis only became a practical
7 possibility as a result of the impact of the attack
8 itself.
9 For all those reasons, sir, we urge you to avoid the
10 temptation to analyse the events of 2017 through the
11 prism of hindsight. The task of this inquiry is to
12 consider the complicated evidence regarding the status
13 of and the security arrangements within the City Room
14 at the time of the attack and to reach conclusions about
15 the appropriateness of those arrangements, based not on
16 hindsight, not on the basis of what has happened since,
17 but on the basis of the contemporary standards and
18 prevailing circumstances as at May 2017.
19 Sir, may I end these submissions simply by repeating
20 SMG's expression of sympathy to the families of
21 Salman Abedi's 22 innocent victims and to all those who
22 survived the attack.
23 SIR JOHN SAUNDERS: Thank you.
24 Mr O'Connor and Mr Greaney, you can actually help
25 me, and we need to resolve this issue to start with.

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1 There have been different ways of doing these opening
2 statements. Some have been simply reading out what
3 we've already had in advance, word for word, and others
4 have been to deviate considerably to highlight points so
5 it's entirely different from the written opening, and
6 I have no problem with either of those methods.
7 But I am not sure that at the moment we are
8 routinely uploading the written statement which was
9 given in advance because normally the inquiry would
10 ensure that what was made public on the website was
11 what was actually said. So we'll check up on all this,
12 but if you are relying on an opening note rather than
13 the written statement, if it could be supplied to the
14 press contemporaneously with you doing it, which I think
15 they would like, if that was possible, or they will have
16 to wait until they can see the transcript. If it is
17 possible to resolve this with core participants'
18 agreement then that would seem to me to help the press
19 in reporting but also make us all understand what's
20 actually going to go on the website.
21 MR O'CONNOR: It was certainly my understanding that the
22 written opening statements we had provided were to be
23 published by the inquiry at the time we made our oral
24 openings and that was why I have referred to the
25 document in the way that I have.

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1 MR GREANEY: The position is that the written openings that
2 we've been supplied with are being uploaded as a tranche
3 at the end of each day.
4 SIR JOHN SAUNDERS: Right. Okay, so that will happen, but
5 if you want your actual opening remarks, they will
6 obviously go on the transcript, which can be read later,
7 but I know the press would find it helpful to have it
8 earlier if it's possible.
9 MR GREANEY: I'm sure they would, and I ought to say
10 Mr O'Connor has offered to supply the inquiry with a
11 copy of his speaking note and Mr Laidlaw, who is about
12 to address you, sir, has provided a copy of his speaking
13 note, but if others could bear that in mind, if they are
14 going to deviate from their written openings, if we
15 could have speaking notes and we'll consider with the
16 press whether we're able to supply those at the time
17 which they are delivered.
18 SIR JOHN SAUNDERS: I think a member of the press has come
19 in. Do you want to go near a microphone?
20 MEMBER OF THE PRESS: Just to make clear that the press
21 don't get access to the transcript until we've already
22 filed our copy, so anyone assuming that we can rely on
23 that, unfortunately the way it works doesn't work for us
24 and so a copy of people's speaking note would be
25 enormously helpful.

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1 I know some of the parties are aware of that, but
2 again, because the written submissions are quite often
3 different from what has been said orally, it would be
4 very helpful, particularly today and tomorrow, when
5 there's a lot of people.
6 SIR JOHN SAUNDERS: We'll try and do what we can to assist.
7 From the transcriber's point of view, listening
8 yesterday to Mr Weatherby's, there were so many names,
9 which would be quite difficult to spell, I can
10 understand why it would take some time to get a proper
11 copy out and obviously they do need to check things.
12 MEMBER OF THE PRESS: Absolutely, and that's the same
13 problem that we're facing, because we're struggling with
14 spellings and names as well.
15 SIR JOHN SAUNDERS: Everybody now knows that and if they can
16 provide you with a speaking note of what they're going
17 to say, I am sure with the help of the inquiry we can do
18 that.
19 MR GREANEY: We're learning all the time, but that would
20 seem a sensible solution to the problem.
21 Next, as I indicated, we are going to hear the
22 opening statement on behalf of ShowSec delivered by
23 Mr Laidlaw.
24 SIR JOHN SAUNDERS: Thank you.
25

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Opening statement by MR LAIDLAW

MR LAIDLAW: Sir, I have one of ShowSec's directors with me, Mark Logan, who sits to my right, and the other two directors, Mark Harding and Simon Battersby, are watching remotely as is the rest of ShowSec's legal team.

Our remarks, which are really the first of the substantive submissions to be made publicly on ShowSec's behalf, are also preceded by an expression of sympathy to those who suffered so grievously as a result of this attack. And nobody who had listened, as we have, to the 2 weeks of the commemorative pieces could be left in any doubt as to the scale of that loss and the irreparable damage which has been done to the lives of so many.

In this opening, we will seek first to respond to those parts of Mr Greaney's introduction which bear upon the company and its performance and the performance of those who were working for ShowSec at the arena on the night of the attack, along also with aspects of the openings provided by the other CPs, and in that way I hope we will assist you, sir, to focus upon what is in issue in terms of your decisions about the nature and the extent of ShowSec's responsibility for the safety of those attending the event of 22 May and those who had gathered in the City Room to collect the concertgoers.

Second, and by way of the making of concession in respect of what might have been done better by ShowSec, I hope that will allow you to arrive more quickly at your conclusions as to how well or otherwise the company discharged its obligations at the arena. Inevitably, our remarks will touch again upon ShowSec's position as we previously set it out to be, but I hope not unnecessarily to repeat what can be read perfectly well by you and by others at the end of the day.

I start, as indeed the families have, with an expression of hope -- or perhaps expectation is a rather better word -- for the company we represent. We have no doubt that you, sir, will deliver the thorough and fearless investigation that the family groups have called for and which, of course, is the essence of the task that the Home Secretary has set for you. But in doing that, we have, as I have said, four or five hopes or expectations.

First, that despite the reservations expressed by the families' lawyers, those fears can be allayed and that you will find that ShowSec has acted with the candour and has approached this inquiry with the sensitivity to the families and with the openness that you are entitled to expect of this company in your investigation of this appalling attack. Time will, of

course, tell and you will be the judge of that. But we sincerely hope that when you see the witnesses, you will be satisfied that ShowSec, through its senior management team, has been prepared to think carefully about what the bombers did and the extent to which the company might have done more to prevent the attack or, as is perhaps more realistic having regard to ShowSec's position, to mitigate the impact of it.

And where honest reflection has revealed shortcomings, as will inevitably be the case for every state and corporate entity in this inquiry, including the company we represent, that ShowSec has been prepared to acknowledge those failings and to address them.

Second, as for the ShowSec witnesses who were in the City Room at the time of the explosion, some of whom are to be the subject of searching examinations to come, we hope that all will have regard to their position and to that which they also experienced. ShowSec was very lucky indeed that none of its staff lost their lives, but a number of their people were injured and they too witnessed those terrible scenes after the attack. It was also those individuals who did all they could to assist the dying and the injured; they too acted without regard to their own safety.

Third, we hope that you will not find that ShowSec

has taken an overly defensive position on the issue of the extent to which it had counter-terrorism responsibilities and the proper limits to be placed on the part it had to play in that regard. In the public areas of the Victoria Complex, and particularly the City Room, it was certainly not possible in May of 2017 for ShowSec to prevent anyone other than concertgoers having access to those areas. That said, Salman Abedi's unchallenged position in that area, out of sight and hidden away for an hour or so before he detonated the device, does raise of course the important questions Mr Greaney and the families have identified.

Fourth, in seeking to emphasise the limited counter-terrorism role it was reasonable to expect ShowSec staff to discharge, we hope, although again this will be for you to say in due course, that we have not mischaracterised the company's relationship with SMG or overplayed the extent to which ShowSec was entitled to rely upon the BTP to play their part and to take responsibility for the discharging of that function in the public areas of the complex.

What we anticipate will emerge during the course of the hearing is that there is a good deal of common ground between ShowSec and SMG that is reflective of the very close relationship that exists, that existed and

1 continues to exist between those two companies, and it's
2 very much in the public interest that whatever your
3 finding, the operator of venues such as the arena and
4 those engaged in crowd management continue to work
5 collaboratively.
6 But there are, as Mr O'Connor has identified, some
7 important differences in the respective positions
8 between the companies and, in particular, whether
9 ShowSec was providing specialist counter-terrorism
10 advice to SMG.
11 This is not, and I really want to emphasise this,
12 this is not a question of buck passing, as was asserted
13 yesterday. What I'm attempting to do on the company's
14 behalf is to set out its understanding of the role it
15 had at the arena and to avoid the advantage that
16 hindsight brings.
17 And whilst of course ShowSec understands the
18 importance of putting the families first and at the
19 centre of this inquiry, they, in common with all the
20 other CPs, are nonetheless -- as I'm sure you will
21 afford to them -- entitled to fairness and balance and
22 accuracy in your assessment of their role.
23 There is not enough time at this point, nor before
24 the evidence is called is this the appropriate place for
25 the detailed analysis of all that touches upon ShowSec

1 and the part its workforce played in the events of
2 May 2017, so we have selected five areas to focus upon,
3 anticipating that these will be amongst the central
4 issues you will seek assistance upon in respect of our
5 client.
6 These are: the services ShowSec were providing
7 at the arena and the extent to which the company was or
8 could be expected to carry out a CT role; second, the
9 particular challenges presented by the nature of the
10 City Room; third, the criticisms the security experts
11 make about training, risk assessment, searching and
12 pre-egress checks; fourth, what it was reasonable for
13 ShowSec to expect of BTP; and fifth, the approach to be
14 taken to the question whether working for ShowSec in the
15 City Room, so this is Mohammed Agha and Kyle Lawler,
16 there were opportunities or an opportunity missed to
17 escalate concern about Salman Abedi's presence.
18 Area 1 is the nature of the services ShowSec
19 provided at the arena. In his opening words, Mr Greaney
20 described ShowSec as contracted security provider. He
21 also said that SMG had contracted with ShowSec to carry
22 out security operations. Those phrases were no doubt
23 intended to be a convenient shorthand and security is,
24 as will become clear when the ShowSec witnesses give
25 evidence, a broad concept, so we are not in any sense

1 complaining.
2 In fact, ShowSec's work at the arena, and indeed
3 elsewhere, is more accurately described as being
4 concerned with event crowd management and the provision
5 of stewarding services. SMG had not asked ShowSec to
6 provide security of the sort we might all associate with
7 the guarding of individuals or of securing buildings,
8 and it was not, by way of example, ShowSec who SMG
9 employed to deliver the security of the complex or its
10 maintenance under the facilities management agreement
11 when the arena itself was closed.
12 Security, as the areas of responsibility within
13 ShowSec's operational plan show, was just one element of
14 crowd management at live events. The point is this, and
15 if at first blush this is a point which has the
16 appearance of one of those rather unattractive legal or
17 technical points, or it appears to be an example of me
18 taking an overly defensive position, then I am sorry,
19 but what we are not going to be apologetic about is
20 repeating that ShowSec's role, its work and its area of
21 responsibility in the City Room falls primarily to the
22 determined by its contractual relationship with SMG,
23 and, in particular, the stewarding services agreement.
24 We've dealt with the contract at paragraph 4 of our
25 written opening and I will not repeat all that we say

1 there, but it is this document which defines and imposes
2 the various obligations on these two separate companies,
3 SMG and ShowSec. This is not contentious, as
4 I understand it. It was and is SMG as the occupier and
5 the operator of the arena who obviously occupy the
6 dominant position in this relationship and they gave the
7 relationship its direction. It is SMG who determine how
8 many staff ShowSec were to provide for any event and who
9 remained -- as SMG accepts and as you've heard
10 Mr O'Connor say, it was SMG who were and remained
11 responsible for the safety of those attending and
12 present at the arena. It was SMG and not ShowSec who
13 had the relationship with the CTSA and with the British
14 Transport Police.
15 The essential point is that ShowSec were appointed
16 to provide, and I quote:
17 "Stewarding and event services."
18 That's defined in the second schedule to the
19 agreement and there, as one would expect, the services
20 to be provided are set out in a little more detail and
21 are in these terms, and again I quote:
22 "Event stewarding. Event security. Evacuation and
23 emergency planning. Customer services. Crowd
24 management advice and staff training. Contract
25 management. Personnel training. Development and

1 external work."
2 So security is but a part of its services and of
3 note, we would suggest, counter-terrorism is not
4 a specified service, although elsewhere in the agreement
5 ShowSec had agreed it would make its staff available to
6 SMG to take part in venue-specific desktop exercises for
7 emergency situations, which might include but were not
8 limited to crowd disorder, terrorist attack and show
9 cancellations. But that is the only reference to
10 terrorism to be found in the agreement between the
11 parties.
12 The point goes further than that: not only was
13 counter-terrorism advice not a service sought, nor did
14 ShowSec specialise in or purport to offer advice of that
15 sort, neither did ShowSec employ, by way of example,
16 recently discharged military personnel with extensive
17 experiences in such matters.
18 Indeed, sir, as you will understand, typical amongst
19 the groups it offered part-time work to would be
20 students and to others who were seeking to supplement
21 their income. Those who worked for ShowSec were people
22 who would not have policing experience and even those
23 who have become SIA licensed would have had no form of
24 specialist security or counter-terrorism training or
25 access to protective equipment.

1 Indeed, as will become clear in the evidence
2 you will hear, it is only recently that the SIA has
3 begun to consult on counter-terrorism training as the
4 security experts have noted.
5 So against this picture, and the evidence we
6 anticipate you will hear from the security experts,
7 you will no doubt want to give careful consideration to
8 Mr O'Connor's submission on SMG's behalf, which is to
9 the effect that you should simply ignore the contract.
10 As he has observed correctly, this is not an action in
11 the Chancery Division, but is it right to impose on
12 ShowSec responsibility or a level of responsibility for
13 counter-terrorism which was not the subject of
14 discussion before the agreement was reached, the scope
15 and nature of which has never been set out and was a
16 service for which ShowSec were not to be paid?
17 If not counter-terrorism security experts, what was
18 ShowSec's role or its area of responsibility in this
19 particular field at the arena? The answer, as we have
20 set out in our written opening, is that ShowSec had
21 accepted and accepts, as you would no doubt expect, that
22 as part of the stewarding and crowd management services
23 it provided to SMG, it did have a responsibility to
24 identify threats to attendees at events, and those
25 threats, along with fire, public disorder and the like,

1 include the threat of a terrorist attack, and that
2 meant, of course, that ShowSec had to have effective
3 counter-terrorism plans and policies in place as well as
4 measures to mitigate that threat.
5 Our submission for your consideration is, however,
6 that there are limits to what could and can reasonably
7 be expected of ShowSec's staff, or indeed any other
8 company offering crowd management services when at work,
9 particularly in areas such as the City Room with its
10 special challenges, to which I will turn in a moment.
11 Put shortly, and again for your consideration, what
12 we would suggest was reasonable to expect of the company
13 was that its staff had been sufficiently well-trained to
14 enable them to identify any individual behaving
15 suspiciously in the City Room and to remain vigilant
16 when managing the crowds attending events at the arena,
17 such vigilance to include keeping an eye out for
18 possible instances of hostile reconnaissance, suspicious
19 behaviour and anything else which might present as
20 a risk to the concertgoers and, where there were
21 concerns, that those concerns would be escalated
22 promptly to the event control room for the SMG
23 management figures there to assess and, where
24 appropriate, to inform the police.
25 But, and I am now repeating myself, that role did

1 not extend any further than that or to those functions
2 that are the preserve of the police or other
3 counter-terrorism specialists such as conducting
4 counter-terrorism sweeps, confronting possible suicide
5 bombers or anything of that sort. That is not what
6 ShowSec had been asked to provide by SMG, it does not
7 fall reasonably to flow from the services it was
8 contracted to provide and, more to the point, its staff
9 inevitably, as we hope all will accept, would lack any
10 of the skills or experience required to execute tasks of
11 that sort.
12 As to how well ShowSec staff discharged the role we
13 accept they had, the views of the security experts,
14 again drawing from their most recent report, can be
15 summarised in this way. The experts say at paragraph 10
16 that, in relation to assessing suspicious activity,
17 there is evidence of several examples of SMG/ShowSec
18 staff managing situations well, the correct procedures
19 were in place, it was clear what should be done, SMG and
20 ShowSec were good at dealing with suspicious behaviour
21 once it had been highlighted to event control room.
22 In their conclusions at paragraph 871 they say:
23 "ShowSec security staff in and around the City Room
24 were sufficiently trained for them to know that they
25 should report suspicious activity and to know how to do

1 so."
2 The second area we focus upon, in the hope that this
3 will be of assistance to you, is the City Room. In your
4 introductory remarks, sir, you spoke of the
5 investigation which will take place into the question of
6 whether there were opportunities to stop Salman Abedi on
7 the night of the attack, and, if there were, why they
8 were not taken. In addressing that question, you will
9 no doubt pay careful regard to the geography and the
10 nature of the City Room and the extent to which ShowSec,
11 a company primarily concerned with the management of the
12 crowd, could exercise any sort of level on anyone else
13 entering, moving through, or indeed remaining in that
14 area.
15 As Mr Greaney explained on more than one occasion
16 during the course of his opening, and Mr O'Connor has
17 made the same point this morning, the City Room was and
18 continues to be a public thoroughfare connecting
19 Victoria Station to Trinity Way, providing access to the
20 various other facilities on that side of the complex
21 including the NCP car park and it was the route through
22 to the Cheetham Hill and Green Quarter areas of this
23 city.
24 Furthermore, and whilst the McDonald's restaurant
25 had recently closed, it was also home to what will be

1 referred to as the JD Williams call centre, premises
2 where staff work late into the night.
3 As such, and as you obviously understand, in
4 May 2017, the City Room was open to the public and not
5 just those attending events at the arena or who'd
6 arrived there to collect concertgoers. To borrow
7 a phrase, it is an example of a problematic grey area.
8 And bearing in mind the places served by the
9 station, which is a hub both for the TransPennine rail
10 routes from Liverpool to (inaudible: distorted), with
11 access also to Manchester Airport and the tram terminus,
12 it would not be in any sense unusual to see a young man
13 wearing a rucksack, heavy or otherwise, entering the
14 City Room.
15 Related to that issue is the legal position occupied
16 by ShowSec staff which has, as the security experts
17 correctly identify, been set out, namely they had no
18 general power to stop and search those members of the
19 public. That is not to say, again I emphasise, and
20 again as we accept, that ShowSec staff were powerless to
21 respond to suspicious individuals or indeed objects in
22 this area. There was a clear procedure of escalation
23 available to and understood by every member of ShowSec
24 staff: behaviour which gave rise to concern was to be
25 reported directly or, if the steward concerned was not

1 a radio holder, via a radio holder to the event control
2 room. If the matter appeared urgent, it would always be
3 open to ShowSec staff to report the matter to the
4 nearest police officer or indeed, as the point was made
5 by Mr O'Connor, to go to the event control room directly
6 themselves.
7 At the event control room level there might be an
8 attempt to investigate the matter by using CCTV or by
9 requesting a member of staff to attend. Alternatively,
10 the matter could be escalated to the Whiskey Control
11 Room where a decision might be taken by SMG whether to
12 investigate further or to call the police. That process
13 inevitably took time, it might involve the exercise of
14 fine judgements as to whether it was necessary,
15 proportionate or indeed safe, for example, to deny
16 ingress or egress to and from particular entrances,
17 whether to set up diverts and/or to call the police, who
18 themselves would take time to respond.
19 The reality, I'm afraid, and as unpalatable as this
20 will sound to those who suffered so grievously, is that
21 once a suicide bomber entered the City Room, even if, as
22 has been suggested by the security experts, there had
23 been time to close the exits and move people out of that
24 area, that would not have prevented Salman Abedi, had he
25 been confronted or if he'd seen the efforts to clear the

1 room, from detonating his device at that point.
2 Speculation, particularly in this area, is never
3 helpful, but we would suggest it is highly unlikely that
4 any form of intervention or the taking of any action at
5 that point would have prevented the loss of life.
6 Whether it might have limited or reduced the terrible
7 extent and impact of his murderous behaviour is possible
8 and no doubt, if you feel it appropriate, you will
9 express a view about that.
10 Area 3 is criticisms and concessions. It is
11 probably convenient next to deal with the criticism made
12 of ShowSec by the security experts and to indicate the
13 extent to which those are accepted and whether, with an
14 eye to the terms of reference, those failings were
15 causative, that being, for the reasons Mr O'Connor set
16 out, certainly a focus of the inquiry's work. But
17 I have no doubt that you will have regard to the passage
18 that Mr O'Connor has already read to you, which is drawn
19 from paragraph 200 of his report and which I will not
20 repeat here.
21 There are four aspects, please, of the criticism we
22 seek to address here -- shall I just pause for a moment?
23 MR GREANEY: Mr Laidlaw is obviously aware of the activity
24 in front of him. I'm very sorry that that might have
25 been distracting. The position is that I have received

1 a message that the feed to Spinningfields has frozen.
2 I don't know whether that's a very temporary problem or
3 something that is likely to take longer to resolve, but
4 I suspect it's sensible, with apologies to Mr Laidlaw,
5 if we have a short break at this stage, please.
6 SIR JOHN SAUNDERS: Do you mind a break at this point, Mr
7 Laidlaw?
8 MR LAIDLAW: Not at all, of course not.
9 SIR JOHN SAUNDERS: Would you like me to rise while we sort
10 it out?
11 MR GREANEY: Yes, please, sir.
12 (11.10 am)
13 (A short break)
14 (11.38 am)
15 MR GREANEY: The live feed to the annex has been reinstated.
16 If there is any further problem during the course of the
17 morning, it will switch instantaneously, or nearly, to
18 the YouTube feed so those who are watching in the annex
19 will miss nothing, and moreover, so as to ensure that
20 they did not miss anything before the feed was broken,
21 Mr Laidlaw will go back over the relevant section of his
22 opening.
23 SIR JOHN SAUNDERS: Thank you. I'm sorry, Mr Laidlaw, for
24 the breakdown, and I'm also sorry for those at
25 Spinningfields. We will try and make sure it's sorted.

1 I don't take personal responsibility as there is no way
2 that I can do anything to the system at all, but --
3 MR LAIDLAW: There's no need to apologise to me, of course,
4 but thank you.
5 In the speaking note, which will be available later,
6 I was at paragraph 26, so I will pick up it from there
7 if I may.
8 The point I was making was this: that the reality
9 I am afraid, and this is unpalatable to those who
10 suffered so grievously, is that once the suicide bomber
11 had entered the City Room, even if, as has been
12 suggested by the security experts, there had been time
13 to close the exit and to begin to move people out of
14 that area, that would not have prevented Salman Abedi,
15 had he been confronted or if he'd seen the efforts to
16 clear the room, from detonating the device at that
17 point.
18 Speculation, particularly in this very sensitive
19 area, is never helpful, but our suggestion is that it's
20 highly unlikely that any form of intervention or the
21 taking of any action at that point could have prevented
22 the loss of life, whether it might have limited or
23 reduced the terrible extent and impact of his murderous
24 behaviour is possible and, no doubt, if you feel it
25 appropriate, you will express a view about that.

1 Area 3 is criticisms and concessions. It is
2 probably convenient next to deal with the criticisms
3 made of ShowSec by the security experts and to indicate
4 the extent to which those are accepted and whether, with
5 an eye to the terms of reference, those failings were
6 causative. I have no doubt that in this context
7 you will have regard to the passage that Mr O'Connor has
8 already read to you and drawn upon, which is at
9 paragraph 200 of the final expert report; I won't repeat
10 it again.
11 There are four aspects of that criticism we seek to
12 address and the first is training. The security experts
13 are in particular critical of ShowSec's online
14 counter-terrorism events training module for its staff,
15 which all of ShowSec's personnel were required to
16 undertake. They suggest that in selecting parts of the
17 NaCTSO document "Counter-terrorism protective security
18 advice for bars, clubs and nightclubs", the training
19 missed some key areas, and the experts also suggest
20 there is no evidence of a refresher programme, and that,
21 and I quote from their report:
22 "Once completed It would appear this would be all
23 a staff member would receive internally."
24 Whilst accepting that at the time there was, and
25 again I quote, no mandated history standard for CT

1 security training, the conclusion of the experts is that
2 the module fell below the quality of guidance that could
3 have been provided.
4 Well, ShowSec accept inevitably, particularly with
5 the benefit of hindsight, that things could have been
6 done better. But that does not mean that ShowSec's
7 training was deficient or that it fell below the
8 standards of the time, or indeed even those of the
9 present day. It did not.
10 Mark Harding, ShowSec's managing director, in
11 a further statement, which is with your team but not as
12 yet on Magnum, has done what the inquiry may regard as
13 useful work, comparing ShowSec's training both against
14 the counter-terrorism training which was available
15 elsewhere in 2017, such as NVQ level 2 and the SIA
16 accredited training, along with the current ACT
17 awareness course. The picture, although it appears to
18 have been one overlooked by the security experts, is
19 a revealing one.
20 Both the training available elsewhere in 2017 and
21 indeed the ACT course today are very similar to that
22 which ShowSec was teaching to its staff in 2017.
23 Mr Harding, when he gives evidence, will speak both to
24 this exercise, and he'll also set out for you the
25 additional counter-terrorism training which has been

1 introduced since the attack and will be available to its
2 staff at all levels within the company.
3 Turning then to whether those criticisms may amount
4 to a causative failing, regard will no doubt be had to
5 other of the views expressed and offered by the security
6 experts. As to suicide attacks, they say:
7 "The guidance in ShowSec's model appears to be fully
8 aligned to that which would be distributed by CTSAs or
9 NaCTSO."
10 And ShowSec's trainees were told, "Your vigilance is
11 essential".
12 The central point, as Mr O'Connor has identified
13 this morning, is this: there can be no doubt that
14 ShowSec's staff had been trained sufficiently well to
15 know how to react to suspicious activity. The point, we
16 suggest, is this: the asserted deficiencies in training
17 can have played no part in any failing by Mohammed Agha
18 or Kyle Lawler to escalate any concern brought to their
19 attention. Both, as indeed they effectively accept in
20 their most recent witness statements, knew what they
21 were to do.
22 As for the counter-terrorism briefing, the experts
23 observe they see no evidence that a CT briefing was
24 provided to staff on the night of the attack. ShowSec's
25 position is that with a well-trained workforce it is not

1 necessary and indeed it is impracticable to brief on
2 each aspect of the duties of their staff on every
3 occasion they come on duty. In fact, counter-terrorism
4 awareness had been briefed to staff at work at the arena
5 as recently as the 3rd, 4th, 5th, 6th, 7th and 8 May.
6 Mohammed Agha was at work on 3 May and Kyle Lawler on
7 the 3rd, 4th and 8 May.
8 Moreover, the Ariana Grande briefing sheet contains
9 the following instructions in capital letters to access
10 control manning the entrances:
11 "LOOK OUT FOR SUSPICIOUS CHARACTERS."
12 Taken together, we would suggest for your
13 consideration that ShowSec was plainly doing what was
14 expected of it.
15 Next, the risk assessment. For present purposes
16 I'll deal with this very shortly. ShowSec accepts, as
17 has been made clear in the written opening, the
18 deficiency of its Manchester Arena risk assessment.
19 That is not to say that threat levels and the like had
20 been overlooked, they had not. Each of those omitted
21 matters, as we have set out, had been correctly
22 identified in the company's counter-terrorism awareness
23 document and the company's managing director in his
24 further statement will also provide you with help as to
25 the changes and improvements made to the risk assessment

1 process and to the risk assessment itself.
2 Again, on the question whether the inadequacy of the
3 2017 document contributed in a causative way to the
4 attack, you will no doubt once again have regard to the
5 training ShowSec staff had undoubtedly received.
6 Searching and screening. The security experts --
7 this is a complaint which figured large in
8 Lord Kerslake's review -- are critical in a number of
9 respects about searching and screening of those who
10 attended the event on 22 May 2017. Those criticisms
11 include the nature and the extent to which concertgoers
12 were searched, that the searching of bags was undertaken
13 by unlicensed staff, and that insufficient numbers of
14 SIA licensed staff were on duty.
15 Whilst it was SMG who imposed staffing levels and
16 directed the nature of the searching to be carried out,
17 ShowSec accepts and takes full responsibility for the
18 fact that unlicensed staff carried out bag searches. In
19 their latest statements, Mark Harding and Tom Bailey
20 will explain what had gone wrong at the arena.
21 Since the incident there has been a substantial
22 increase in both the number of stewards and SIA-trained
23 staff requested from ShowSec by SMG and there is also,
24 as you know, a wholly new searching regime based around
25 an expanded perimeter.

1 Mr Greaney, having dealt, albeit briefly, with the
2 opinions of the security experts on this issue in his
3 opening, then made this point and I quote:
4 "Given that Salman Abedi did not actually seek to
5 gain access to the Ariana Grande concert itself, this
6 issue may be of less causative significance than
7 others."
8 With that, we agree.
9 Whatever the failings of the search policy or the
10 way it was implemented, the fact remains security of the
11 site itself was not penetrated for the reasons
12 Mr O'Connor has set out and again which I will not
13 repeat now.
14 That takes me next, please, to pre-egress checks,
15 the pre-egress checks carried out by ShowSec staff, and
16 the question that Mr Greaney raised in his opening as to
17 whether those checks should have covered the whole of
18 the City Room and, in particular, the mezzanine level.
19 In terms of the primary purpose of such checks
20 we have dealt with that point in our written opening and
21 the inquiry will hear from Jordan Beak, ShowSec's
22 SIA-licensed operative, who made those checks on the
23 night of the concert.
24 Despite the terms of the pre-egress check sheet,
25 which was in fact a SMG document, the purpose of these

1 checks from ShowSec's perspective, as is clear from its
2 internal check sheets and its counter-terrorism
3 awareness document, was different. It was to ensure the
4 safe egress of attendees at events from the point at
5 which they left their seats to the time they left the
6 arena. This involved checking for obstructions and
7 objects that could present a hazard.
8 So, as the CCTV footage reveals, the staff would
9 clear those gathering at or on the staircases leading up
10 to the mezzanine level. That would obviously include
11 looking out for suspicious behaviour, but ShowSec's
12 staff were not in the habit of climbing those steps to
13 carry out any sort of visual check at the mezzanine
14 level, and neither would they conduct any sort of search
15 of that area as the mezzanine floor did not represent
16 a route out of the City Room which would be available to
17 concertgoers or indeed anyone else.
18 The question of whether ShowSec's pre-egress duties
19 should have extended up to that level or they should
20 have been discharging a patrol-type function on the
21 mezzanine floor might also be tested by a consideration
22 of the use to which that area had been put. Whilst the
23 McDonald's restaurant had recently closed, could it be
24 sensibly suggested that when open it was for ShowSec
25 staff to police that area? The JD Williams call centre

1 was a functioning building, it had its own security
2 staff; see for example the statement of Martin McGuffie.
3 Did this area, as Mr Atkinson suggested yesterday,
4 amount to, using his words, the arena's doorstep? Or
5 again, is that area more accurately to be regarded as
6 the responsibility of the security staff employed there?
7 It's another of the issues which appears to have been
8 overlooked by the security experts.
9 Area 4 takes me next to the British Transport
10 Police. Earlier in these opening submissions I had
11 asked you to reflect upon the nature of ShowSec's
12 responsibility for counter-terrorism measures arising
13 from the work it had been contracted to provide at the
14 arena. Now can I address what must be one of the
15 central questions for you, sir, to address in due
16 course, namely who is it who has primary responsibility
17 for these grey spaces such as the City Room?
18 The short answer, as I expect all will accept,
19 is that the responsibility for CT measures in this
20 country rests with Central Government and in public
21 places, which is what the City Room was and is. The
22 protection of the public is the responsibility of the
23 security services and the police, but nobody is
24 suggesting, least of all ShowSec, in this day and age --
25 and the Martyn's Law proposal is a perfectly sensible

1 reminder of this -- nobody is suggesting that the police
2 should be expected or could act alone in seeking to
3 address the threat of a terrorist attack.
4 So, as will be clear, ShowSec had accepted, long
5 before the attack at the arena, it had its part to play.
6 But that part could be, for the reasons I have set out,
7 no more than a supporting role to that of the security
8 services and the police. In other words, a role which
9 complemented, but could not replace the efforts of the
10 police.
11 The body or organisation having primacy in this
12 area, the areas through which Salman Abedi travelled
13 in the station complex and the City Room where he was to
14 conceal himself, and whose responsibility it was, is not
15 something the policing experts have overlooked. As the
16 policing experts have clearly identified, the City Room
17 was demonstrably a public place at the time of the
18 attack. As they say, borrowing from their words:
19 "In our view, BTP had adopted responsibility and
20 primacy for arena events."
21 Whilst this is the clearly expressed view of the
22 policing experts, we on ShowSec's behalf find ourselves
23 confronted with criticism from the security experts, who
24 appear at best to have had no more than a passing regard
25 to the role of the relevant police force in their

1 consideration of SMG and ShowSec's responsibility for
2 security in this area.
3 The security experts, as you know, have pored over
4 literally every line of ShowSec's training modules, its
5 risk assessments and the like, in a report which now
6 runs to over 500 pages. Hardly a word is said about the
7 arrangements the relevant police force had or did not
8 have with regard to the securing of the safety of the
9 public in the City Room. And we find, as you know from
10 our opening, this disparity in approach surprising and
11 troubling.
12 Mr Weatherby is right: the physical security
13 arrangements at the arena cannot be considered in
14 isolation. One needs to have regard to the part the
15 police had to play. I hope it's not inappropriate for
16 me to ask the question or to pose the question: how can
17 an expert properly comment on the extent to which
18 ShowSec had or had not discharged its supporting role
19 without setting out in a more detailed analysis the
20 extent to which, if at all, the relevant police force
21 had discharged the primary function in this regard?
22 The question which appears to be overlooked and
23 which we would suggest ought to be addressed at some
24 point, whether by the security experts or the policing
25 experts, is the extent to which it is appropriate to be

1 critical of a private company in ShowSec's position for
2 its asserted failure to discharge counter- terrorist
3 functions in public areas which it fell to BTP to
4 police, a role, as I have said, ShowSec staff were first
5 not contracted to provide and, second, in any event, for
6 the reasons I have set out, were incapable and entirely
7 ill -equipped to carry out.
8 Equally, when the focus of what has been referred to
9 as missed opportunities falls in particular upon
10 two individuals working for ShowSec, is it unreasonable
11 or unfair, if only on their behalf, to raise the
12 question what might have happened if BTP had had
13 a presence in the City Room when Witness A became
14 concerned about Salman Abedi?
15 Would a police presence have been of assistance to
16 help Mohammed Agha and Kyle Lawler at 22.14? Police
17 Sergeant Wilson had, after all, directed these officers
18 should be on patrol in the City Room at egress. ShowSec
19 staff would have known that and they presumably worked
20 on this basis. Again, we would suggest any
21 consideration of ShowSec staff must obviously also have
22 regard to what they were reasonably entitled to expect
23 of the police.
24 In his opening remarks, Mr Greaney drew attention to
25 what little the security experts had said about BTP. He

1 put it in this way:
2 "The experts have identified some issues with the
3 planning and activity carried out by BTP in relation to
4 security at the arena. Policing arrangements at the
5 arena were undertaken by BTP officers on a semi-formal
6 basis with no fully dedicated detail, operational order
7 or event commander or supervisor. Although a specific
8 briefing was given to officers who covered events, no
9 reference was made to CT in this briefing."
10 As one would expect, this was a faithful summary of
11 what little the security experts have said on the issue
12 of BTP's part in policing this area at the time of
13 a concert, although the words "some issues" may be
14 something of an understatement.
15 Mr Greaney then turned and dealt with PC Corke's
16 evidence. He was described, as he no doubt was and is,
17 as a highly experienced officer with a good
18 understanding of the police role at such events.
19 Mr Greaney spoke of his practice to stand on the
20 mezzanine level in the City Room at both ingress and
21 egress as it provided a good view.
22 Importantly, as Mr Greaney made clear, this was
23 around the very spot where Salman Abedi waited before
24 carrying out the attack. It was described as
25 unfortunate that PC Corke was not able to attend the

1 concert on 22 May because he was dealing with another
2 matter, and again I quote from Mr Greaney's words:
3 "He does not appear to have been tasked with
4 returning to the arena as soon as he dealt with that
5 matter."
6 That is, of course, but part of the picture because
7 your findings will no doubt also involve a consideration
8 of the roles of the individual officers who were on duty
9 on that night.
10 It was we, I think, who first set out in our written
11 opening what occurred and what, by a very brief summary,
12 emerges is this: that at egress there was not a single
13 BTP officer in or indeed close to the City Room.
14 As to the practice PC Corke had adopted of
15 positioning himself on the mezzanine floor at egress,
16 that does not appear to have been a reflection of any
17 written BTP policy or standing order and neither is it
18 a direction to be found in Police Sergeant Wilson's
19 briefing email.
20 More generally, in the evidence disclosed thus far
21 there is little indication that BTP had recognised or
22 acknowledged their counter- terrorism responsibilities
23 at the arena.
24 The other shortcomings of BTP, as Mr Atkinson
25 identified yesterday, included no documented risk

1 assessments, no CT briefing, very little by way of
2 counter- terrorism training, no structured approach to
3 the deployment of officers at the arena, a lack of
4 proper instruction to the officers on the ground. All
5 that goes largely unchallenged in the report of the
6 security experts. Their rather bland general conclusion
7 is this, and I quote from the final report:
8 "BTP evidence indicates several failures in their
9 procedures and supervision of personnel on the night of
10 22 May."
11 In respect of egress they say this:
12 "Had there been a BTP or security staff presence on
13 the mezzanine before egress, the course of events may
14 have been different."
15 It's no part of our role in the inquiry to launch an
16 attack upon the police and, as Mr Greaney has
17 acknowledged, those who have responsibility for
18 maintaining security at venues like the arena and other
19 crowded places do not have an easy task. Equally,
20 in the same way we hope that those working for ShowSec
21 will not become scapegoats. We have no wish to become
22 critical of the individual officers, a number of whom
23 displayed great courage after the bombing, but -- and
24 this is our point -- a proper and a fair consideration
25 of ShowSec's part and its limited part in discharging

1 a counter- terrorism function by the security experts --
2 and they have had three goes at this -- would not, we
3 suggest, be complete without the same exacting analysis
4 being brought to bear on the performance of the relevant
5 police force.
6 The final area of my submission is titled "Missed
7 opportunities", along with the approach to be taken to
8 the evidence of Mohammed Agha and Kyle Lawler. Both
9 young men now have CP status and although they will be
10 represented during the chapter 7 hearings, their
11 representatives do not propose to make any opening
12 statements. In those circumstances, because they both
13 worked for ShowSec and the company will continue to
14 offer its support to these young men, I hope you will
15 not think it inappropriate of me to make some brief
16 opening remarks about the issue of missed opportunities
17 and about the approach to evidence of the sort they will
18 give.
19 In opening, Mr Greaney, having said there was much
20 about the security set-up at the arena which was good,
21 added, and I borrow again from his words:
22 "A key task of this inquiry is to identify whether
23 there were problems or gaps in the measures in place or
24 if there were missed opportunities to stop Salman Abedi
25 on 22 May."

1 Perhaps the starkest example of what might be
2 a missed opportunity will be the report Witness A made
3 to Mohammed Agha at 22.14, just 17 minutes before
4 detonation, which led to the subsequent interaction
5 between he and Kyle Lawler at 22.22.23, just 8 minutes
6 before detonation.
7 Before we turn to this area, may I trespass briefly,
8 but with care, into your preserve, namely the approach
9 to be taken to this body of evidence? In doing this,
10 I am, of course, acutely conscious of the fact that for
11 you this might sound like a statement of the obvious,
12 although others who do not have your forensic experience
13 may find our submissions rather more difficult to
14 accept.
15 The witnesses who are to provide the evidence on the
16 issue of missed opportunities, and I have in mind not
17 just Witness A but the other civilian witnesses, along
18 with the members of ShowSec staff including
19 Mohammed Agha and Kyle Lawler, who were in or near to
20 the City Room at the time of the explosion, were all
21 exposed to one of the most, if not the most, traumatic
22 events it is possible to imagine. Experience has taught
23 those of us who deal with evidence coming from this
24 category of witness that great care is required when
25 considering accounts which follow an event of this

1 enormity. Trauma at this truly shocking level and the
2 exposure to the horrifying and deeply distressing scenes
3 that followed can do great damage to the ability to
4 recollect accurately, as can hindsight bias when the
5 reality and the horror of what Salman Abedi was
6 intending to do becomes clear.
7 The recollection of some witnesses may also be made
8 less reliable because they experience a wholly
9 unjustified sense of guilt as to what they might have
10 done which unconsciously affects their memory of the
11 earlier events. Memory can also be affected by the
12 perfectly natural process of trying to rationalise and
13 to make some sort of sense of events as terrible as
14 this.
15 In the cases of both Mohammed Agha and Kyle Lawler,
16 as they now accept, the first accounts they have
17 provided cannot in important respects be accurate.
18 Indeed, Kyle Lawler's latest statement contains detailed
19 reflections on what he got wrong and the reasons why.
20 These various factors touching upon the reliability of
21 the accounts of witnesses of this sort means -- and
22 I suspect that Mr Greaney shares this view as to
23 approach -- that their evidence must be approached with
24 care and circumspection. The starting point, we would
25 suggest, in the assessment of the weight to be given to

1 the witnesses who will provide evidence to the issue of
2 missed opportunities should not necessarily therefore be
3 their accounts of what they think they saw and what they
4 say they were thinking. Instead, reference should also
5 be had, and it may be that in some cases this ought to
6 be the starting point, to the incontrovertible and
7 indisputable material which establishes actually what
8 happened. In other words, the CCTV material from the
9 City Room and what it reveals in the half an hour or so
10 before Abedi carried out his attack.
11 It is also this material which will no doubt assist
12 you to draw the safe inference as to what was or may
13 have been going through these individuals' minds.
14 With that in mind, I turn to missed opportunities
15 and to the question whether, first, there was more than
16 a single opportunity. You will remember that the
17 security experts point to 20.51 and identify this as the
18 first opportunity. For our part we would urge you to
19 tread carefully before accepting their opinion on this
20 issue. Before Salman Abedi took the lift up from the
21 station concourse on the first occasion, he had walked
22 past two BTP officers. They do not find themselves
23 being criticised for obvious reasons. A young man
24 travelling through a station with a rucksack, heavy or
25 otherwise, would not have aroused suspicion.

1 When Salman Abedi arrived in the City Room on that
2 first occasion at 20.51, you will remember that, in his
3 opening, Mr Greaney drew our attention to
4 Mohammed Agha's position and he does indeed appear to
5 have been looking at Salman Abedi. Mohammed Agha is
6 clear he did see him, which is what he said in his first
7 witness statement and he's repeated that in the more
8 recent witness statement, where he says this, and
9 I quote from his most recent witness statement:
10 "The male [so this is the bomber] did not raise any
11 suspicions for further observation. He was not acting
12 differently to anyone else in the area or differently to
13 any other member of the public who may come and go on
14 any other day. The City Room was open to the public and
15 with direct access to the train station and
16 Manchester City centre, so it was not unusual to see
17 people with rucksacks, backpacks or suitcases."
18 Later in his statement he says this in relation to
19 Salman Abedi's return:
20 "It was not unusual for people to come and go due to
21 the facilities in the area, including the car park and
22 JD Williams."
23 What may be of note, although again, of course, this
24 is all for you, is that Mr Greaney in his introductory
25 remarks did not suggest the failure on that first

1 occasion at 20.51 to identify or report Salman Abedi as
2 a suspicious character was a missed opportunity. His
3 focus, as you'll remember, sir, was on the bomber's
4 return and to his remaining on the mezzanine floor for
5 the best part of an hour before the attack.
6 During that hour or so which Salman Abedi spent on
7 the mezzanine floor, the inquiry will also hear from
8 a number of witnesses who will provide their reactions
9 to seeing or finding him in that area. It is of note,
10 we would suggest, that of those witnesses only one,
11 Witness A, reported that concern to the ShowSec staff
12 positioned on the floor below and nobody sought to
13 report their suspicions or concerns to the police.
14 I turn then to Witness A and I have well in mind, as
15 I make these preliminary observations about his
16 evidence, that he did not escape injury. His partner
17 was amongst the many who were seriously injured.
18 Nobody, of course, would be in any sense critical of him
19 but Witness A stands out as the only person to have
20 brought concerns about Salman Abedi's presence to
21 a member of ShowSec staff.
22 What does Witness A's subsequent behaviour reveal as
23 to the level of concern he was then expressing? There
24 is no doubt that Witness A spoke to Mohammed Agha at
25 22.14; that is what the CCTV shows. Mohammed Agha in

1 his witness statements accepts that. Witness A has said
2 he did this because he became concerned at
3 Salman Abedi's appearance and the size of the rucksack.
4 What the CCTV material then reveals, although
5 Witness A at the time of his interview could not
6 remember having done this, is that having spoken to
7 Mohammed Agha, Witness A then left the City Room for
8 6 minutes or so while he visited the toilets in the
9 station below. That left, of course, his partner,
10 Witness B, in the same area occupied by Salman Abedi.
11 Does this perhaps more accurately reflect the level of
12 concern Witness A had at that time?
13 There are then those witnesses who also saw Abedi on
14 the mezzanine level but were not suspicious of him or
15 thought he might be involved in selling illegal
16 merchandise. That was a thought that crossed the mind
17 of Witness B. William Drysdale and Julie Merchant who
18 work for Copyright Trademark Protection, reached the
19 same view. Mr Drysdale's initial thought was he was
20 a bootlegger and then, when he saw Abedi praying,
21 changed his mind. Seeing a young man in prayer did not
22 strike him as unusual and in his second witness
23 statement he has said he didn't find it suspicious that
24 somebody would have chosen a relatively private and
25 quiet place in which to pray.

1 Ms Merchant says it was not unusual to see an
2 individual with a large rucksack in the City Room. In
3 her more recent statement, as Mr Greaney opened, she
4 speaks of her conversation with PC Bullough at 21.59.
5 She too did not regard it as unusual to find someone
6 seeking out a more private place in which to pray.
7 Neither of them regarded Salman Abedi as a threat.
8 This evidence, which will obviously be for you and
9 nobody else to analyse in the final event, this
10 evidence, you may think, highlights the dangers of
11 assuming that it must have been obvious at 22.14 that
12 Salman Abedi, whilst on the mezzanine floor, and even
13 when apparently seeking to hide away, represented an
14 obvious threat as it began to grow on the City Room
15 floor.
16 You will also no doubt want to have particular
17 regard to the most recent account provided by
18 Mohammed Agha and whether and to what extent you can
19 rely upon it.
20 Similarly, you will want to look with care at
21 Kyle Lawler's latest account and, in particular, what he
22 has had to say about his conversation with Mohammed Agha
23 at 22.23. Kyle Lawler says that Mohammed Agha did not
24 seem unduly concerned. He did not regard Salman Abedi's
25 presence as suspicious and thought he could have been

1 waiting for a train. This is not the time for
2 a detailed analysis of what Kyle Lawler saw and thought,
3 but it is worth stressing at this point that he
4 acknowledged the difficulty he now has disentangling
5 what he knew then from what he knows now with the
6 benefit of hindsight.
7 What is also revealing about Kyle Lawler's account
8 is the dilemma he says he found himself facing. Was
9 this an innocent Asian male, perhaps waiting for his
10 sister, or was he overreacting or coming to a judgment
11 based in large part on ethnicity? Again, to illustrate
12 the difficulty in coming to a snap judgment, Kyle Lawler
13 noted that Salman Abedi appeared to relax when he felt
14 he was no longer being looked at, which put Kyle Lawler
15 more at ease because he could understand it was not
16 pleasant to feel watched or under observation.
17 Then there were these words from Kyle Lawler towards
18 the end of his latest statement and I quote:
19 "I did not think Salman Abedi was really
20 a terrorist. I did not think I would be so unlucky as
21 to be in such a situation. It seemed unreal. If you
22 could have given me any scenario of what could have
23 happened, what actually did happen next would have been
24 at the bottom of my list. Nevertheless, I wanted to
25 hand it over to Control for them to decide what to do."

1 Finally, sir, can I return briefly to the question
2 of training. As to what the inquiry may feel to be the
3 essential aspect of the training ShowSec provide to its
4 staff, and I have made this point repeatedly already.
5 Each member of its staff understood that any concern
6 about an individual who might have presented as a risk
7 to the safety of those in the area was to be reported
8 immediately to the event control room.
9 That is not to say that ShowSec has been complacent
10 about its performance. As I've said, this process has
11 revealed areas where ShowSec could and should have done
12 better. The inquiry will hear in due course how some of
13 those errors/mistakes arose and the steps the company
14 has taken to put those failings right and to strengthen
15 its procedures.
16 Thank you.
17 SIR JOHN SAUNDERS: Thank you, Mr Laidlaw.
18 MR GREANEY: Sir, we're going to hear next from Mr Gibbs on
19 behalf of British Transport Police. But before that,
20 would you rise, please, just for 5 minutes or so to
21 enable those who need to be in the room to be in the
22 room, please?
23 SIR JOHN SAUNDERS: Certainly. Thank you.
24 (12.18 pm)
25 (A short break)

1 (12.25 pm)
2 MR GREANEY: Sir, we're now ready to hear from Mr Gibbs. He
3 expects to be no more than an hour and once he has
4 finished, we'll take lunch.
5 Opening statement by MR GIBBS
6 MR GIBBS: Rather less than that, I think.
7 As you know, sir, I represent British Transport
8 Police. British Transport Police is the national police
9 force for the railways of Great Britain. We also police
10 the London Underground and the mass transit networks of
11 Glasgow, Tyneside, the West Midlands and many
12 metropolitan areas.
13 Our police officers have policing powers on all
14 those networks and on all land owned by the rail
15 industry. The Manchester Arena sits on Network Rail
16 land and that's the reason that our officers take the
17 lead in policing the arena, both day to day and for
18 events like concerts and boxing matches, and that's why
19 they were the first on scene when the bomb went off.
20 Some months ago, you asked us to give you a concise
21 written response to your terms of reference and we did
22 that. It will be available in full on the website, the
23 inquiry website, later today, I know --
24 SIR JOHN SAUNDERS: Thank you.
25 MR GIBBS: -- and it would be idle of me simply to repeat it

1 now. Instead I'm going to use this brief opportunity to
2 focus on two things on behalf of BTP: first, what we
3 hope to be able to help you with, and secondly, what we
4 hope that you may be able to help us with, and by "us",
5 I mean the bereaved, the surviving victims of the
6 attempted murders, the emergency services, the arena
7 staff, and the people of Manchester. I'm going to do
8 that, if you'll permit me, quite shortly and under
9 15 headings. That sounds like a daunting number, but
10 each is relatively short.
11 My first heading is the murderers. I'm going to say
12 very little about two of the murderers. Just as the
13 Prime Minister of New Zealand has asked us not to speak
14 the name of the gunman who murdered 51 innocent people
15 in her country, I do not need to say out loud the name
16 of the bomber who murdered 22 people here in Manchester;
17 it's their names, not his, that should be heard.
18 But what of the other potential murderers? We don't
19 yet know their names, but listening to Mr Greaney's
20 opening statement and his description of the intricate
21 and lengthy and carefully planned preparations for this
22 attack, it will have been obvious, I suggest to all of
23 us, that those brothers did not act alone. They must
24 have received technical help and financial help and
25 training and support from other people. Other people

1 must have known, or at least suspected, what they were
2 up to and those other people are at large.
3 To that, although a mountain of public time and
4 money has rightly been spent on this inquiry and will be
5 spent in the months that come, at a time when public
6 money is in short supply, if one or more of those
7 accessories to mass murder can by your process be run to
8 ground and brought to justice, then there will be no
9 question but that it has been money well spent.
10 Put another way, your inquiry, I suggest, is
11 probably our last opportunity to track down those
12 without whose help and inspiration these murders could
13 not have been committed.
14 Number 2, information. Back in May 2017, we at
15 British Transport Police knew nothing of the bomber or
16 of his radicalisation or of his associates. The same is
17 true of the brother. Neither of them had previously
18 come to BTP's attention, none of their bomb preparation,
19 their purchase and storage and assembly of bomb
20 components, their attack planning, their private
21 calculations and machinations, none of those things had
22 brought them into contact with BTP.
23 We had no intelligence about either of them and,
24 like most other core participants in this process, we
25 won't be in the room when you hear secret evidence in

1 closed session.
2 3, familiarity. Growing up in Manchester, the
3 brothers must have been very familiar with the railway
4 stations and the tram stations and the arena. What's
5 clear now from the detective work of Greater Manchester
6 Police is that in the 5 days after his return from Libya
7 and before the murders, the bomber made three visits to
8 the arena, which brought him on to Network Rail
9 property, which was policed by BTP. Those visits are
10 now classified as hostile reconnaissance because we all
11 now know why he was there and what he had in mind, but
12 at the time, as we saw from the CCTV which Mr Greaney
13 played for us, there was nothing hostile-looking about
14 any of it. Nothing in the way he walked or where he
15 walked or when he walked was remarkable then.
16 Unsurprisingly, nothing that he did on those visits,
17 those earlier visits, drew him to the attention of BTP
18 officers or indeed anyone else. When he returned to
19 Victoria with his rucksack at 8.30 on the night, we have
20 now pieced together with the help of Mr Greaney his
21 movements on the tram, on the platforms, on the
22 concourse, in the lavatories, the lift, the foyer, and
23 again now that we know what was in the rucksack and what
24 he intended to do with it. We can't take our eyes off
25 him on the footage: he sticks out a mile, his every

1 gesture is macabre, and that's the agony of hindsight.
2 Number 4, 2 hours before. Dealing with those
3 2 hours before the explosion from a BTP perspective.
4 BTP had 18 officers on duty in central Manchester at the
5 time of detonation. They were based at
6 Piccadilly Station, at Victoria Station and at
7 Peninsula House.
8 There were four officers on duty in uniform at
9 Manchester Victoria and, as part of their role that
10 evening, as others have said, they patrolled the railway
11 station and the arena surrounds and the CCTV has
12 recorded some of their movements which we'll see in more
13 detail soon.
14 During those patrols, they were at various different
15 times and in different combinations: one, two or four
16 officers in the foyer. But at the moment of detonation
17 all four officers were on the station concourse opposite
18 the overbridge stairs where they had a clear view of
19 audience dispersal on to public transport and, as you
20 know, their instantaneous reaction was to run towards
21 the explosion. And that's why they were the first
22 policewoman and men at the scene.
23 They tended to the dead and to the dying and to
24 those who were saved. They carried the wounded to the
25 concourse, where they were treated by medics and they

1 kept evacuating the foyer until all of those survivors
2 had been rescued, after which they comforted the injured
3 as they waited for ambulances.
4 Two of those officers had been in the foyer near the
5 overbridge doors at 6.34 when the bomber, on his last
6 recce, approached and then immediately left the area.
7 When he returned by tram with his rucksack he spent
8 10 minutes in a cubicle in the lavatories on the
9 concourse and he left at 8.48. Tantalisingly, we can
10 see now that he avoided, by a matter of seconds, being
11 in there when another two of the officers inspected the
12 premises at 8.49. As he left, he crossed with them, he
13 passed them on the concourse, and nothing about him
14 caught their attention.
15 Forward to 9.47. Between 9.47 and 9.59, when two of
16 the officers were in the foyer with the arena security
17 staff, the bomber was in that same area, out of sight,
18 out of CCTV view, probably behind the raised area where
19 the member of the public spoke to him. That
20 pre-explosion period, we acknowledge, is obviously
21 an important part of the evidence and on the very first
22 day of this inquiry Mr Greaney dwelt in great detail on
23 the individual named officers and members of security
24 staff and revenue protection personnel who have been
25 asked over the years at different times to try to

1 resemble from the smithereens of what followed their
2 fragile recall of what they said and did on a night
3 which, at that stage, was peaceful and unremarkable, we
4 suggest.
5 Surprisingly, some of those tentative fragments of
6 prompted memory were still being teased out of one of
7 the witnesses while Mr Greaney was speaking and I know,
8 rather in the same way that Mr Laidlaw has just
9 submitted to you, that you will recognise that body,
10 that type of evidence for what it is, with all the usual
11 cautions that need to be applied to it and that you will
12 tread warily when it is examined.
13 In any event, back on the first day of the inquiry,
14 those very junior officers and staff and personnel found
15 themselves identified in the media spotlight before
16 their evidence had even been called, but I know that
17 they will have been reassured to hear Mr Greaney also
18 say that it was not his intention to look for scapegoats
19 and I know, of course, it's the last thing you would
20 want.
21 Number 5, what if? One very obvious "what if" will
22 have crossed all our minds: what would have happened if
23 the timeline had played out slightly differently, if BTP
24 officers had coincided with the murderer in the
25 lavatories at 8.40 or if they'd come across him in the

1 foyer just before 10.00? Or if he'd been pointed out to
2 them as suspicious, would they have spoken to him, how
3 would he have reacted?
4 His plan was to kill as many people as possible, it
5 seems. It's easy to imagine what he would have done
6 next, but impossible to know quite what that would have
7 looked like. As the timeline did play out, no BTP
8 officer was killed in the blast, but one of the issues
9 which we invite you to consider, as others have, is
10 whether an officer should have been in the foyer at the
11 moment of detonation.
12 It's right that the sergeant who briefed the
13 Piccadilly and Victoria deployment for that night had
14 envisaged a police presence near each of the three main
15 arena exits at the end of the concert and, when that
16 moment came, all four officers were near the war
17 memorial, probably the single most effective vantage
18 point for overseeing the main line station and the crowd
19 exiting towards trains and trams and taxis and buses.
20 It was from there that they ran, all four of them,
21 immediately towards the smoke of the blast.
22 6, the aftermath. Dealing briefly with the
23 aftermath of the explosion from a BTP perspective, as
24 the president of the Queen's Bench Division recently
25 reminded us in upholding your earlier ruling, it would

1 be a fundamental error to treat a public inquiry
2 established to investigate the deaths of the 22 as
3 a public inquiry into all the circumstances of the
4 Manchester bombing. And by that same logic, we expect
5 that your counsel, when dissecting the police part of
6 the emergency response, may choose to prioritise the
7 first hour or so after the explosion, to be specific,
8 the period between 10.31 and either 11.29 or 11.42.
9 I say those times because at 11.29 the last of those
10 who were to die was brought from the foyer to the care
11 of the medics on the concourse, and it was at 11.42 that
12 the last of the casualties who survived was brought
13 down. I think I've got those times right.
14 If so, what that means is that by 11.43 the
15 evacuation of the injured from the foyer was complete
16 but BTP's work was plainly still far from over. There
17 was agony everywhere and our officers were hard at it
18 for hours to come thereafter. We know that there will
19 be many lessons to be learned about organisation and
20 communication and co-location and Gold, Silver and
21 Bronze after 11.42, but at that point the fight for life
22 and the prospects of survival passed, you may think,
23 principally into the hands of the expert medical teams
24 who now had charge of the injured.
25 If that is right, it may be that most of what we did

1 and didn't do thereafter won't bear directly at least on
2 your analysis of the outcomes of those who died. So
3 that's the period up to 11.42, which I am going to
4 concentrate on briefly today, and as my heading
5 number 7, may I give you the facts and figures?
6 In addition to the four BTP officers on site who ran
7 up towards the foyer and the 11 officers who immediately
8 deployed the short distance from Piccadilly and the
9 three who ran down the hill from Peninsula House, BTP's
10 offices, at least 62 further officers and staff of BTP's
11 Pennine Division attended that scene in the next
12 3 hours. On duty, off duty, they came from Warrington,
13 Wigan, Liverpool, Preston, Leeds, Southport, Lancaster,
14 Birkenhead, Chester, Crewe, Stoke, Doncaster, Sheffield,
15 Middlesbrough, York, Bangor and Rhyl.
16 Each of them has a personal story to tell in which
17 respect they are no different from the scores of
18 survivors and security staff and arena staff and
19 ambulance workers and GMP officers and members of the
20 public who, in exactly the same way as the BTP officers,
21 threw themselves into the communal rescue effort to the
22 best of their abilities.
23 I state the obvious. It would take months of this
24 inquiry's time to acknowledge fully and publicly all the
25 many acts of kindness and selfless courage which were

1 performed that night and so many will probably, even at
2 the end of this process, remain unremarked. But they
3 know what they did.
4 Looking at the figures from another point of view,
5 beginning with the timing, within 5 minutes of the
6 detonation, 18 BTP officers were at Victoria Station and
7 dealing with the chaos. By 11 o'clock a further 23 BTP
8 officers were on site. By 11.30 that number had risen
9 to 50. In total, more than 80 BTP officers and scenes
10 of crime staff went to Victoria that night.
11 Those are the facts and figures.
12 My heading number 8 is the control room. In the
13 foyer it was immediately obvious that a bomb had been
14 detonated. BTP officers had policing powers there and
15 it was an area where BTP took the lead for day-to-day
16 policing. In the BTP force control room in London, the
17 force incident manager, overseen by the senior duty
18 officer, took command of BTP's initial response and he
19 initiated calls to BTP's chief officers, to GMP, to the
20 Ambulance Service, to the Fire Brigade and to
21 Network Rail.
22 He promptly declared a major incident, he considered
23 declaring Plato and decided against it, and it may be
24 when you've heard the evidence you'll agree that that
25 was a sound judgment on the evidence available to him

1 because this was a suicide bomb and not a marauding
2 terrorist with a firearm.
3 He was unable to establish contact with his opposite
4 number in the GMP control room. That's why the formal
5 recognition by the two Gold Commanders that GMP was
6 taking the lead in the police response wasn't officially
7 approved until much later. But he knew from information
8 in our control room that GMP and North West Ambulance
9 had deployed a large number of officers and medics to
10 the scene and it's notable that as early as 10.43 GMP's
11 armed officers were on the site and, as a vital part of
12 their role, they protected the unarmed officers and the
13 medics and the civilians who were fighting to rescue the
14 injured.
15 In the foyer, the senior BTP officer was a sergeant.
16 He was able to radio a formal METHANE report at 11.04,
17 which largely confirmed what was already known in BTP's
18 control room. There was no facility to pipe a live CCTV
19 feed from Victoria Station to the force control room,
20 but that sergeant in the foyer provided METHANE updates
21 at 11.17 and 11.25.
22 Then at 11.29 he provided a situation report to the
23 GMP chief inspector on the scene and, soon after
24 midnight, he did the same for the BTP chief inspector
25 who had self-deployed to Victoria from her home.

1 My number 9 is evacuation. The principal concern of
2 all at the scene was to rescue whomever could be saved
3 by evacuating the injured from the foyer into the care
4 of medically trained personnel. That's what they did
5 and that's what they achieved. In just over an hour
6 after the explosion, the last living casualty had been
7 carried to the concourse with the possible exception,
8 which you will explore, of Mr John Atkinson. Subject to
9 the evidence that you'll hear about his circumstances,
10 your blast experts have so far advised that none of
11 those who died could have been saved from the murderous
12 effects of the bomb. What that means, subject to
13 hearing important and perhaps quite complex evidence
14 about Mr Atkinson's situation, is that all or all but
15 one of the lives which were saveable were saved.
16 That is our tentative submission to you.
17 If right, that was no mean feat. It may be perhaps
18 some comfort to the emergency responders and the arena
19 staff and the members of the public who laboured so
20 selflessly in the horror to know that there was probably
21 nothing more or different that they could have done
22 which would have changed the death toll.
23 As number 10, I pass to things that went badly.
24 It would be irresponsible to suggest that everything
25 that BTP and its officers did that night could not be

1 bettered. The urgent imperative to save life in
2 appalling circumstances created a big gap between JESIP
3 guidance and practical reality. Communication between
4 the different emergency services was tested beyond
5 breaking point. Joint situational awareness between the
6 different control rooms was not achieved in the way that
7 JESIP expects.
8 As with the other emergency services, BTP's actions
9 in relation to searches and cordons and rendezvous
10 points and manuals and plans and decision logs will all,
11 we know, be vigorously deconstructed in January. And
12 BTP certainly, speaking for ourselves, expects to
13 extract valuable learning from that process over and
14 above the lessons which it has already registered from
15 its own retrospective dissection of the events.
16 But the consequential changes which we have made at
17 BTP have been described for you by a senior officer in
18 a witness statement, parts of which Mr Greaney has
19 already summarised, but over and above that, BTP is
20 confident that additional improvements will be
21 identified during the inquiry process.
22 My 11 is provisional conclusions, and in particular
23 how to describe the response of BTP to the attack. The
24 first and most obvious thing to say is that it would be
25 stupid and impertinent for us to jump to conclusions

1 now, stupid because the evidence hasn't been started and
2 any worthwhile conclusions will be founded on evidence,
3 and impertinent because the conclusions which will
4 matter are yours, not ours, and we should, none of us,
5 presume to know what you'll make of the evidence.
6 Once the evidence has been heard some time next
7 year, we'll have the chance to make a closing statement
8 at which point we certainly will be better informed, not
9 just about the detail but about which parts of all that
10 detail will really matter.
11 So at this provisional stage, on behalf of BTP,
12 I can at least say this: that the operational response
13 of British Transport Police to this bomb attack was the
14 sum of the responses of its individual officers, senior,
15 junior, at whatever level of experience. BTP believes
16 that the overall response to the attack by its officers
17 and staff was extremely good. We believe that each of
18 our officers did his or her best on the night and that
19 they demonstrated a body of courage of which they should
20 be proud.
21 And BTP believes the same is true of the officers of
22 GMP and the staff and medics of the arena and the
23 Ambulance Service and the Travel Safe officers and the
24 Northern Rail staff and all those brave members of the
25 public who joined in. In fact, some of the most

1 striking images from the night, which will come up on
2 the screen next year, if we didn't see them during
3 Mr Greaney's opening, are of different combinations of
4 men and women from each of those organisations and from
5 no organisation at all rescuing the injured in gangs
6 from the foyer to the concourse and then going back into
7 the smoke again and again.
8 We at BTP have nothing negative to say about any of
9 those organisations in this inquiry. We've blamed none
10 of them in our responses to date and I'm certainly not
11 about to do so now. Mr Atkinson spoke yesterday of
12 a carousel of blame and, on one view, Mr Laidlaw has
13 this morning found himself a carousel and set it
14 spinning, but I'm not going to get on to that carousel.
15 We doubt you'll find that game attractive and it's
16 certainly not a game that I'm going to play.
17 I understand, of course, that commercial
18 organisations have shareholders and insurers and so on
19 and that what has been said today doesn't come from the
20 ShowSec staff alongside whom we at BTP work. For the
21 record, for the employees and the representatives of SMG
22 and ShowSec with whom our officers worked on a daily
23 basis and with whom they're still working today, we have
24 nothing but good things to say about their commitment to
25 the arena and its safety in our experience of working

1 alongside them. We've got great confidence in our
2 partner agencies and that confidence was reinforced by
3 their performance on the night, wherever they were
4 working, alongside BTP officers and our civilian staff.
5 To those particular BTP officers whom I have already
6 described in the foyer and in the control room, I should
7 add, please, the search teams and the dog handlers who
8 established the safety of the site, the identification
9 and scenes of crime officers who performed the
10 exceptionally difficult task of recovering the bodies of
11 the deceased from the foyer to the temporary mortuary;
12 the control room operators, civilians in Birmingham and
13 in London, all of whom played their parts in the
14 communal effort.
15 My 12 is a constructive approach. It is always the
16 case, isn't it, in this kind of inquiry that the things
17 that particular officers did and the order in which they
18 did them and the other different things which they might
19 have done and what they knew and thought and said and
20 why are all susceptible to being picked apart by lawyers
21 in hindsight, lawyers who weren't there. And no doubt
22 to some extent that will happen again in this inquiry,
23 which is a shame, but that's the way the world is.
24 By contrast, sympathetic, constructive and, above
25 all, practical criticism is not something to be feared.

1 It's not something to be avoided, it's something to be
2 welcomed. Dedicated professional people are usually
3 their own harshest critics, we all know that. Many of
4 our officers will have quite properly have asked
5 themselves: could I, should I have done more or better?
6 And BTP as a force has asked itself that same question.
7 It was in that vein that we identified in writing,
8 which you will have later today, if you don't have it
9 already, a number of specific questions which we ask you
10 to include in your deliberations, including at a micro,
11 personal level the real-time choices faced by police
12 officers in their rescue efforts, how to decide whether
13 to tend to the injured person in front of you or instead
14 to push on towards the epicentre in case there's someone
15 there who needs you even more. How to know whether to
16 persevere with CPR for an unresponsive casualty in the
17 hope that you may bring them back to life or instead
18 stop and move on to the next one. How to decide whether
19 to save life here and now in front of you or to step
20 back and to provide a report to your control room
21 because someone's got to do that.
22 And then at a macro, organisational level, the
23 real-time choices faced by police officers in command
24 and control roles. Where best to locate Silver? Whom
25 best to appoint as Bronze? Whether to prioritise rank

1 or proximity in those appointments. How to establish
2 and to maintain inter-agency communication when every
3 emergency service is at full stretch.
4 We at BTP have digested our own internal review and
5 Lord Kerslake's analysis and the policing report which
6 you commissioned, and we at BTP agree with many of the
7 key criticisms made in that policing report. We have
8 said so plainly and simply in writing. But moving
9 beyond that, in our search for improvement we have
10 invited you to consider a number of the judgement calls
11 made by BTP on the night to see how they measure up
12 against the various hindsight critiques.
13 BTP believes that its officers' judgements were
14 understandable in real time, but it goes without saying
15 that it welcomes your insights across the board and on
16 a number of issues, which, although they don't bear
17 directly on the deaths of the 22 people who were
18 murdered, may yet be relevant for optimising our
19 response to the next terrorist attack.
20 As my number 13, I hope I will be forgiven for
21 emphasising out loud just one of those issues because
22 it's such a perennial problem, and it's communications.
23 That's my 13. The unanimous experience of every police
24 force in the United Kingdom in every UK mass terror,
25 mass murder terror attack that has taken place to this

1 day has been that inter-agency liaison in the urgency of
2 immediate response throws up communication problems. So
3 systems and processes and human reactions which may be
4 workable on paper or in multi-agency training exercises
5 simply don't perform in the same way in reaction to the
6 real-life devastation of a bomb site with mass
7 casualties.
8 I suggest, and you will decide, that the evidence in
9 this case is likely to provide yet another illustration
10 of the gap between theory and exercise and reality. The
11 easy point to register is that information sharing
12 between the emergency services on 22 May was obviously
13 far from perfect. The more important, I suggest, and
14 more complicated questions may be, (i), what practical
15 difference that made and, (ii), how it could be improved
16 in future.
17 You may in due course find that the story on the
18 night is a story of both successes and of failures, so
19 that on the ground at the scene, BTP officers, GMP
20 officers, ambulance staff were liaising and
21 communicating and making those complementary decisions
22 face to face, side by side, which helped save the lives
23 of those who survived. But many departures from the
24 JESIP paradigm are clear and they are acknowledged by
25 BTP.

1 For instance, the absence of a forward control point
2 at the scene. The failure to communicate formal
3 declarations made by individual control rooms. Gaps and
4 delays in information sharing between control rooms.
5 A failure to share the METHANE information in concise
6 METHANE form, imperfect joint situational awareness.
7 Yet, in practical terms, even without stretchers and
8 without inter-agency talk groups, it is clear certainly
9 to the ambulance expert analyst that co-location of
10 police and medics at the scene, in practical effect,
11 ensured that the movement of patients from the foyer to
12 the concourse was swift and effective -- I think that's
13 their phraseology -- and that the medics and the arena
14 staff and the civilians were reassured by the presence
15 of a large number of both armed and unarmed officers.
16 So we will ask you to explore that expert
17 conclusion, which might be summarised as: although
18 formal JESIP structures and methodology were lacking,
19 completely lacking in places, yet in immediate practical
20 terms communication and coordination at the scene was
21 effective.
22 But away from the scene in the force control room,
23 as I have said, BTP's FIM correctly identified from the
24 reports coming in to him that there was a major incident
25 in progress at the arena, he declared a major incident

1 and he contacted -- I have listed them already -- GMP,
2 ambulance, fire, Network Rail, Northern Rail, Metrolink
3 and the army EOD. He sought and received a METHANE
4 report from the sergeant at the scene and he ensured
5 that his senior officers were alerted and briefed,
6 during which process the two -- as you know, BTP has two
7 control rooms in London and in Birmingham -- combined
8 electronically as an effective single virtual room and
9 business-as-usual radio traffic was separated off in
10 order to prevent it from cluttering the air waves.
11 Yet, although initial contact between the several
12 services' control rooms was quickly established, it is
13 plain that it soon became overwhelmed by a volume of
14 traffic and information and tasks, so that, as I have
15 said once already, significantly from our point of view
16 at BTP, the FIM would have liked to speak directly to
17 GMP's FDO, but every attempt to make this connection was
18 unsuccessful on the night, and similar problems were
19 experienced later when BTP Silver tried to speak
20 directly to GMP Silver, and that's not to blame anyone,
21 that's just what happened.
22 14, the exercise gap. As you know, BTP delivers and
23 participates in regular exercises by which preparedness
24 is tested for responding to major incidents, including
25 terrorism and mass casualties, which is a significant

1 expense for a widely spread national force, but BTP is
2 committed to the value of those exercises. Standing
3 back from the detailed timeline of radio and telephone
4 calls which you will have laid out for you, it's clear
5 to BTP that some of the challenges which were identified
6 in multi-agency training exercises and other mass terror
7 events emerged again on the night. In particular, the
8 failure to maximise shared situational awareness among
9 co-located agencies. So our hope is that you will
10 consider again, and perhaps find the answer, to how that
11 perennial difficulty can be remedied.
12 15, and I have come to it last, but even at this
13 stage in the proceedings I should say something about
14 it, I feel, primacy. The experts whom you have
15 commissioned have been at different times split about
16 this and their reports have pulled in different
17 directions, even if they are co-aligning more now,
18 perhaps because it's a complicated subject.
19 As I have tried to analyse it, in a nutshell there
20 are four main policing roles in the arena and two police
21 forces who could perform them and several permutations
22 in which the four roles might be divided between the two
23 forces.
24 The four roles are: counter-terror advice,
25 contingency planning, day-to-day policing and event

1 policing; I will leave responding to a terrorist attack
2 on one side, which is quite a different thing in which
3 GMP will always take the lead.
4 So returning to the four and the two. One force
5 could take the lead for all those four roles, or the
6 other force could take the lead for all those four
7 roles, or both forces could share them jointly, or
8 a blend of responsibilities could be agreed upon with
9 the two forces supporting each other, keeping each other
10 informed about what each was doing.
11 Whether the blend which was preferred in 2017 and
12 which is still preferred today, although improved, is
13 the best solution is a question that we hope you will be
14 able to find time to consider without dragging attention
15 away from the inquiry's core concerns. Once we've heard
16 the evidence on that subject, called and examined, and
17 once you've published your findings and any
18 recommendations you may have about it, we hope to be
19 able to review that subject comprehensively with the
20 other stakeholders who are, I suppose, SMG and
21 Network Rail and GMP.
22 Before I sit down, I hope I'll be allowed to say
23 this lastly. It's about contact between those who
24 shared that night. Although some of our officers have
25 been able to stay in touch with those whom they helped

1 on the night and with their families, I know that there
2 are other BTP officers who have never been able to do so
3 and many of them are uncertain about how to go about it.
4 Everyone feels differently about his or her
5 experiences on the night and some find that it helps to
6 talk about it, others need to keep it buried deep inside
7 them, and our officers are exactly the same. Some are
8 able to talk about it, others not so much, frankly.
9 They don't want to impose themselves on anyone or to
10 re-enliven traumatic memories unnecessarily, but meeting
11 and sharing has proved a comfort to some people at
12 least; for others of course it's the last thing they
13 want. But perhaps the most sensible thing for me to say
14 at this time is that -- and I hope I can use this
15 opportunity to say it, you'll stop me if I can't -- that
16 if any of those who were injured or lost loved ones that
17 night recognise by face or by the description of what
18 they did any of the dozens of BTP officers who will
19 provide evidence to you in the next months, I hope that
20 they would feel able, if they wanted to, to make contact
21 at whatever stage was right for them, by whatever means
22 was right for them, to BTP, to your inquiry team, to the
23 force solicitor, Ms Mariel Irvine, however it felt right
24 to them and whenever it felt right to them so that that
25 might help with the healing.

1 SIR JOHN SAUNDERS: Thank you. I'm sure we will do our best
2 to facilitate and give any help for that to those who
3 want it.
4 MR GIBBS: Thank you very much.
5 SIR JOHN SAUNDERS: Thank you, Mr Gibbs.
6 MR GREANEY: Sir, would you now rise, please, and we'll
7 return at 2.15.
8 (1.15 pm)
9 (Lunch adjournment)
10 (2.15 pm)
11 MR GREANEY: Sir, you will now hear from Mr Horwell on
12 behalf of Greater Manchester Police.
13 Opening statement by MR HORWELL
14 MR HORWELL: May it please you, sir, I appear on behalf of
15 Greater Manchester Police together with
16 Mr Guy Ladenburg, Mr Daniel Mansell and Ms Ruby
17 Shrimpton. On my left, as you will know, is Assistant
18 Chief Constable Russ Jackson, and on my right is
19 Ms Naz Saleh, the head of the legal department.
20 SIR JOHN SAUNDERS: Mr Jackson has been here for a good deal
21 of the hearing already.
22 MR HORWELL: I know he has.
23 Nearly 3.5 years ago Salman and Hashem Abedi
24 murdered 22 people and seriously injured many more.
25 They targeted families and young children as they were

1 leaving a concert at the Manchester Arena. Their crimes
2 were of extraordinary wickedness and cowardice and were
3 described by Mr Justice Baker as "atrocious, large in
4 scale, deadly in intent, appalling in their
5 consequences."
6 The loss and pain suffered by those affected by this
7 outrage will be with them for the rest of their lives
8 and they rightly demand answers to a number of central
9 questions. It is the purpose of this inquiry to
10 investigate what happened and to provide those answers.
11 Whenever terrorists strike, the principal question
12 will always be whether the attack could have been
13 prevented by the authorities. That involves a number of
14 issues connected especially to Salman and Hashem Abedi:
15 their background, their radicalisation, what was known
16 about them, and the actions of the security service and
17 GMP.
18 It is right that the inquiry will consider this
19 issue very carefully. Most of this consideration will
20 of necessity have to take place in a closed hearing.
21 There is nothing that GMP can usefully say with regard
22 to preventability today other than to provide our
23 commitment to assisting the inquiry as fully as possible
24 as it looks at that aspect of its work.
25 The inquiry will also examine the attack planning,

1 the attack itself and the response of the emergency
2 services to it. The inquiry will also look back at the
3 security arrangements inside and outside the arena and
4 ask if they were adequate and whether any inadequacies
5 had an impact on the attack and its consequences.
6 This opening statement provides GMP with the
7 opportunity of commenting upon the expert reports which
8 the inquiry has commissioned and, in particular, of
9 making it clear which principal criticisms it accepts
10 and which it does not. This will help narrow the issues
11 which the inquiry must consider, and GMP will take that
12 opportunity.
13 In doing so, however, a number of associated
14 submissions will have to be made to place certain events
15 in context and that is because the events of that night
16 were complex. Straightforward or simplistic answers are
17 not possible and it is a mistake to assume that they
18 are.
19 All core participants have been invited to keep
20 their opening statements brief, some more successfully
21 than others. We will do our best to do so.
22 Of the principal criticisms which have been made,
23 GMP's reply is as follows. GMP has a good record of
24 holding exercises to train and prepare its officers for
25 emergencies and, where it has fallen below the expected

1 standard, in implementing change as a result of the
2 lessons learned from those exercises.
3 Winchester Accord is a good example. Within the
4 parameters set by that exercise, the force duty officer,
5 the FDO, was overstretched and at times it was
6 impossible to contact him. Those weaknesses were
7 identified through debriefs after Winchester Accord and
8 although that exercise was not directly comparable to
9 the conditions which would prevail in real life,
10 insufficient was done before the attack to provide extra
11 support for and better access to the FDO.
12 We would also accept that it would be wrong to
13 concentrate too much on Winchester Accord because there
14 is a broader issue here. That an FDO might be
15 overwhelmed was more widely known. Retired
16 Inspector June Roby speaks of this and a prior
17 inspection by HMIC FRS had noted that GMP plans had
18 placed an over-reliance on the FDO.
19 Second, in 2017, and before, Plato training was
20 principally directed at armed officers. That was
21 because Plato is primarily an armed police response to
22 a marauding terrorist firearms attack. But unarmed
23 police officers and other responders will also be
24 involved. Inspector Michael Smith, for example, such
25 a key figure in the events of that night was aware of

1 Plato but had received no formal classroom training and
2 had not taken part in a Plato exercise.
3 His training followed the national curriculum and
4 this issue was nationwide and not confined to
5 Greater Manchester, but there should have been greater
6 Plato awareness and better training for unarmed officers
7 anywhere, but especially for those in cities and
8 particularly for those in a city as large as Manchester.
9 Third, the five core JESIP principles, particularly
10 co-location and information sharing, were plainly not
11 followed in the way they should have been, though there
12 were reasons for that, to which I shall come. GMP's
13 emergency service partners were not informed that
14 Operation Plato had been declared and they should have
15 been, but they were not.
16 That was because the FDO made a deliberate decision
17 not to do so for the reasons he has given. This was
18 not, therefore, due to inadequate training or a systems
19 failure. GMP is very clear on this: there must be
20 complete transparency with its partners whatever the
21 consequences, and I will return to that later.
22 Point number 5. The Fire Service was not at the
23 scene. Had it been, and at an early stage, and had it
24 been prepared to enter the City Room, GMP accepts that
25 the treatment and evacuation of casualties would have

1 progressed more quickly.
2 It is also clear that GMP and those of its emergency
3 service partners who were at Victoria Station could have
4 done more in an attempt to bring the Fire Service to the
5 scene. There appears to have been a widespread lack of
6 appreciation of the treatment and evacuation skills of
7 the Fire Service.
8 This will plainly be a difficult and awkward part of
9 the hearing because GMFRS had received notice of the
10 explosion at a very early stage. It had been given
11 an RVP to attend. The reason why GMFRS did not arrive
12 when it should have done will be for that organisation
13 to explain. All that we wish to point out is the amount
14 of information which was in fact available to the Fire
15 Service and it is important that we stress that none of
16 this is a reflection on the many firefighters who were
17 desperate to go to the scene and help.
18 Point number 6. GMP accepts its share of the
19 criticism made by both the police experts and Kerslake
20 that the ability of those in the emergency services
21 control rooms to communicate with each other in the
22 immediate response to the attack was poor. The
23 tri-service communication system was available to be
24 shared and used amongst the three principal emergency
25 services, and it could and should have been used on the

1 night.
2 The fact that it was not used is likely to have been
3 a consequence of lack of familiarity, training and
4 staffing resources. A tri-service talk group to
5 increase the flexibility and application of the system
6 was in the process of being ratified at the time of the
7 attack.
8 As to airwave capacity, GMP does not accept that
9 there was any significant issue affecting its airwave
10 capacity or capability. But clearly, opportunities were
11 missed to establish effective communications with GMFRS
12 and NWAS in particular.
13 Point number 7. A survivor reception centre was not
14 set up as it should have been at the first opportunity.
15 A number of those who could walk away from the scene
16 gravitated towards two nearby hotels. To any who were
17 inconvenienced or upset by the lack of such a facility,
18 GMP apologises and it is hoped that they will understand
19 that the maximum effort was directed at the scene and to
20 the seriously injured casualties who were there.
21 In addition, considerable resources were sent to the
22 various hospitals to which casualties were taken. But
23 more could have been done for others and GMP takes its
24 share of that responsibility.
25 Point number 8. The arena contingency plan. That

1 had not been reviewed by the time of its review date,
2 which was June 2016. That was primarily because of
3 budgetary restraints. But on any view, the plan was
4 usable and it is submitted that if the arena plan had
5 been reviewed by its due date it would have made no
6 material difference to the events of that night.
7 Point number 9. A small number of the PSIA scores
8 were incorrect -- the CTSA, Kenneth Upham, accepts
9 that -- but the following must also be taken into
10 account. First, that the scores are not important in
11 and of themselves other than as an indication out of
12 a total score that a site can work towards.
13 Second, PSIA scoring relates to the footprint of the
14 venue and not to the surrounding areas such as the
15 City Room.
16 Third, the advice was given to SMG and not ShowSec.
17 Fourth, and perhaps most importantly, it is not the
18 role of a CTSA to provide an audit or an assessment of
19 the security arrangements in action.
20 Fifth, a number of emails and bulletins were sent to
21 SMG which stressed the importance of looking out for and
22 reporting suspicious behaviour.
23 That particular security imperative was plainly
24 a matter for SMG and especially ShowSec to put into
25 operation. CTSAs by definition advise, they do not

1 monitor or observe, let alone mark those who actually
2 provide security at the site. The competence of the
3 actual security operation was a matter for SMG and
4 ShowSec. That is where their considerable financial
5 resources and experience were directed, and it was upon
6 their performance that visitors primarily relied.
7 There is a dispute about the proper construction of
8 the now out-of-date Plato guidance and its drafting in
9 parts was plainly not of the finest. What may be a more
10 constructive use of this inquiry's time is to
11 investigate whether or not there was a command vacuum at
12 the scene and, if there was, what should be done about
13 it.
14 For the avoidance of any doubt, it is not accepted
15 that there was a command vacuum at the scene. From an
16 early stage, those in command were experienced and
17 highly professional. The operational firearms
18 commander, the OFC, PC Edward Richardson, was at the
19 scene by 22.43 and in the City Room by 22.46. He had
20 served in the British Army, he had been an AFO for
21 10 years and an OFC for eight.
22 The City Room Bronze Commander, Bronze 1, Inspector
23 Michael Smith. He was at the scene by 22.44, in the
24 City Room by 22.47. He had been a police officer for
25 25 years and a Bronze Commander for five.

1 The outer area or cordon Bronze Commander, Bronze 2,
2 inspector Lee Cooklynn. He was at the scene by 23.11.
3 He had been a police officer for 22 years and
4 a Bronze Commander for five.
5 Taking into account that operational commanders are
6 role and not rank- specific , those three scene commanders
7 brought with them a significant amount of experience and
8 ability . They performed well. There is a dispute as to
9 the level of command at the scene, but there is none as
10 to the skills of Inspector Smith, who was described by
11 the police experts as follows:
12 "It was indeed fortunate that he was, in our
13 opinion, an officer with considerable experience,
14 command ability and fortitude , precisely the type of
15 police officer the public would want to be in
16 operational command of a scene such as this ."
17 The GATFC, then Chief Inspector Mark Dexter, a very
18 experienced firearms commander, who was given and took
19 command of the Victoria Station area. Unarmed police
20 officers knew what was expected of them and they did
21 their best to do their duty. Much has been said of the
22 role of the GATFC, but as to the part he played during
23 these vital stages, sight must not be lost of the fact
24 that Dexter did not arrive at the scene until 23.24, by
25 which time 29 of the 46 casualties had been evacuated

1 from the City Room.
2 The critical decisions as to the treatment and
3 evacuation of casualties had already been made. Within
4 only 16 minutes of his arrival , the last casualty had
5 been evacuated out of the City Room.
6 Sir , as to the response times of police officers in
7 general, as you heard this morning, the first BTP
8 officer , Police Constable Jessica Bullough, was in the
9 City Room within 2 minutes of the explosion.
10 One of the reasons why the events of that night are
11 so complex and not representative of either training or
12 established procedure is that the FDO, as he has
13 explained, made a deliberate decision not to follow his
14 training and not to implement the procedures he had been
15 taught to use.
16 He decided that he would not inform the other
17 agencies that Plato had been declared and, when he had
18 the opportunity to bring the Fire Service to the scene,
19 he declined to do so. No training exercise or manual
20 could ever have contemplated that such decisions would
21 be made, and this abandonment of protocol had
22 a significant impact on what followed.
23 The FDO accepts that he was well-trained in both
24 Plato and JESIP, and he was well-prepared to meet this
25 attack. He had written a Plato aide-memoire which had

1 been approved and shared with other FDOs. Had he
2 followed it , NWAS and GMFRS would have been told that
3 Plato had been declared and joint and shared situational
4 awareness would have begun as best it could until the
5 three agencies met at the scene at an FCP or otherwise.
6 This much is very clear . What would then have
7 happened is a matter of considerable speculation. The
8 FDO, Chief Inspector Dale Sexton, has explained that he
9 did not follow policy because he believed that to have
10 done so would have caused loss of life . He believed
11 that to have informed NWAS and GMFRS that Plato had been
12 declared and that the City Room, as he thought it to be,
13 was a hot zone would have caused those at the scene to
14 abandon the casualties and thereby delay their treatment
15 and evacuation. In his words, he took a calculated risk
16 to leave vulnerable responders in the City Room in order
17 that they would remain and continue their treatment and
18 evacuation of the casualties .
19 As I have said already and as I now repeat, GMP
20 cannot support any withholding of relevant information
21 from its emergency service partners. GMP's relationship
22 with them must be based on complete trust and openness
23 whatever the consequences. They must be able to make
24 their own informed risk assessments, which may or may
25 not be in accord with those of GMP. That is why GMP

1 cannot support that aspect of the FDO's decision.
2 The entire operation was complicated and would have
3 tested the capabilities of any police force , but the
4 reason why any analysis of what happened is so difficult
5 is that not only was policy deliberately not followed
6 but in addition there are many permutations as to what
7 could have happened that night.
8 In particular , whether or not Plato should have been
9 declared and, if declared, the zonal categorisations of
10 the City Room and the Victoria Station concourse, hot,
11 warm or cold. Opinions could quite properly have
12 differed as to what the zones should have been and what
13 consequences should then have followed. It must be
14 understood that following an attack of this gravity the
15 decisions which have to be made cannot always be
16 described as being right or wrong.
17 In extremis, attitudes and opinions will vary, and
18 the designation of the zone for either of those two
19 areas may have had a considerable impact on the
20 treatment and evacuation of casualties . That is clear
21 from both practice and the 2016 JOP, which is the joint
22 operation principles , in force at the time.
23 That is why these events are far from
24 straightforward and why it is such a mistake to ignore
25 the evidence, especially the efforts made in the first

1 hour or so and to believe that they are straightforward .
2 Although GMP cannot support the withholding of
3 information from the other emergency services , it does
4 understand why the FDO did what he did and one of the
5 many possibilities is that his decision may have saved
6 lives . The Kerslake Report supported the FDO and
7 described him as, and these are the words of the report :
8 "Having been required to make a life or death
9 decision . It was the force duty officer 's decision to
10 let the responders stay in place. It is the panel's
11 belief , in terms of protecting saveable lives , that this
12 was one of the most crucial decisions taken on the
13 night , and the force duty officer should be
14 congratulated for this dynamic decision-making."
15 The authors of the ambulance report tend to agree
16 with the Kerslake approach and believe that if NWAS had
17 been told that Plato had been declared, casualties would
18 have suffered . And again I read from that second
19 report :
20 "Had there been gunfire or had the declaration of
21 Operation Plato been known to the ambulance commanders,
22 actions are likely to have been taken by control and at
23 all levels of command. At the scene ambulance personnel
24 would not have moved forward or, had they already been
25 deployed, would have withdrawn to a place of safety .

1 This would have created a therapeutic vacuum and would
2 have prejudiced the continuation of triage , treatment
3 and evacuation. This would, in all likelihood , have led
4 to a significant detrimental effect on the clinical
5 outcomes and survivability of some patients ."
6 All of this goes to underline the following : that in
7 an emergency of this nature, decisions will be difficult
8 and will often be finely balanced. Sometimes only
9 hindsight will determine whether they were correct or
10 not.
11 Inspector Smith, the City Room Bronze Commander,
12 used the national decision model, always referred to as
13 the NDM, and he used that to make an informed risk
14 assessment, and he concluded, as best he could, that it
15 was safe to remain in the City Room and for the
16 responders to treat and evacuate the casualties .
17 The NDM is key to all decision-making in policing
18 and it has as its centre the code of ethics which
19 contains this question among others, which a police
20 officer must ask: what would the victim or community
21 affected expect of me in this situation ?
22 Inspector Smith had no doubt that the casualties and the
23 community at large would have expected him and the
24 others to remain. That is one of the reasons why he
25 says that even if he had known that Plato had been

1 declared , he is not sure that the nature of his response
2 would have been any different .
3 Manuals and policies offer guidance. The NDM
4 assesses what is actually happening and if the NDM and
5 guidance are not aligned , the NDM should prevail.
6 I move now to lessons learned . The lessons which
7 have been learned from this attack by GMP and every
8 other organisation have been taken into account, and the
9 lessons which GMP has learned have been set out in the
10 second and third witness statements of Deputy
11 Chief Constable Pilling . This is not the occasion to
12 refer to them in any detail .
13 As well as identifying the weaknesses and mistakes,
14 we suggest it is equally important that this inquiry
15 should recognise what went well, both before and after
16 the attack . The most significant part GMP had in the
17 response was in the hour or so immediately following the
18 attack . That was its opportunity to make a difference ,
19 to save lives by ensuring that the casualties were
20 evacuated from the City Room as quickly as possible , and
21 then to be transferred to the care of the ambulance
22 crews and doctors below in the station concourse.
23 That involved two separate though combined factors,
24 and both related to resources . The first was to ensure
25 that armed officers were available in sufficient numbers

1 so that they could be at the scene in the shortest time
2 possible . Their presence was critical to the events
3 that followed . It was their duty to locate and
4 neutralise any current threat and to protect
5 first - aiders from any secondary attack . Without armed
6 protection , the evacuation was very likely to have been
7 delayed and would certainly have been compromised.
8 The second was to ensure that unarmed police
9 officers were then available in sufficient numbers to
10 give first aid, as best they could, and then to evacuate
11 the casualties .
12 Whatever part budgetary restraints may have played
13 in other sections , extra funding had been available
14 nationally to increase the number of firearms officers .
15 The National Armed Uplift Programme began in 2016 and
16 was intended to make more armed response vehicles, ARVs,
17 available in preparation for a marauding terrorist
18 attack . As a consequence, in 2017, GMP had an excellent
19 armed capability , and as a result of the armed uplift
20 programme had more ARVs available on the night of the
21 attack than it would otherwise have done.
22 The first ARV arrived 11 minutes and 1 second after
23 the explosion . Within 12 minutes of the attack , the
24 first GMP officer entered the City Room. He was off
25 duty and had self-deployed.

1 Thirty minutes after the explosion, there were at
2 least 27 unarmed police officers in the City Room. By
3 1 am, at least 150 GMP officers, 25 armed and
4 125 unarmed, had attended the scene and surrounding
5 area. Those numbers do not take into account the police
6 officers from BTP and the police officers, armed and
7 unarmed, from other constabularies. No response will
8 ever be quick enough for those affected, but those are
9 impressive response times and numbers.
10 The nature of the scene itself must not be
11 underestimated. Not even the photographs, the CCTV or
12 the body-worn video images can convey the devastation in
13 the City Room, the shock of being there, and the
14 atmosphere of danger, the fear that any one of those
15 discarded bags might be a secondary device, the risk of
16 a secondary attack, and the threat from the damaged
17 glass roof, which could have collapsed at any stage.
18 GMP officers ran towards that danger, some without
19 a second thought for their safety, some concerned about
20 the risks but nonetheless pressed on. They regarded
21 their own personal safety as secondary to the immediate
22 need to save life. Police officers are not medical
23 experts, they never can be, but they did their best to
24 treat casualties and then to extricate them, sometimes
25 through the use of improvised stretchers. A crowd

1 barrier to carry and transport the injured is not ideal,
2 but it is better than nothing.
3 The evacuation was conducted in very difficult
4 circumstances, but it was, to use the words of the
5 authors of the ambulance report, "swift and efficient".
6 The last casualty was evacuated out of the City Room
7 just before 23.40, 1 hour and 9 minutes after the
8 attack.
9 The Chief Constable of Greater Manchester Police is
10 very proud of the contribution his officers made in the
11 immediate aftermath of the explosion. None of them went
12 to work that night having any idea of what they would
13 have to confront and they responded to this attack with
14 conspicuous courage. They did their best.
15 The Chief Constable would also wish to make clear
16 that he is very proud of everyone who responded to the
17 attack because it was not only GMP officers who were
18 involved. Officers or staff from BTP, other
19 constabularies, NWAS, ETUK, SMG, ShowSec and Travel Safe
20 all played their important parts in the treatment and
21 evacuation of casualties from the City Room, as did
22 members of the public, including off-duty doctors and
23 off-duty nurses. It was interoperability of a high
24 order together with a united defiance against the aim of
25 terrorists to divide communities.

1 We have not always been in agreement with the
2 authors of the police report, but they have reported as
3 follows, and again I read directly from the report:
4 "In addition, it is important to record that the
5 overall conduct of the GMP, BTP and other police
6 response to the arena attack was extremely good.
7 A considerable amount of care was given, the crime scene
8 managed effectively, responders were extremely
9 well-protected by armed officers, and individual
10 officers performed at a level of professionalism of
11 which the communities of Greater Manchester have good
12 reason to be extremely proud."
13 And with that, we would unhesitatingly agree.
14 To the next stages, the painstaking investigation,
15 the extradition from Libya and the prosecution of
16 Hashem Abedi, each conducted in a thorough and highly
17 competent fashion. On the evidence available to them,
18 the forensic examination of the scene and the CT
19 investigation were described by the police experts as
20 exemplary, and those efforts of course have recently
21 concluded in Hashem Abedi's conviction and sentence,
22 a trial described by the Crown Prosecution Service as
23 the largest murder case in English legal history.
24 Plans and especially planning are essential, but
25 nothing can fully prepare anyone for a sudden attack of

1 this nature, and it is often said that no plan will
2 survive first contact with the enemy. It is the role of
3 the police to bring order out of chaos, and to do so
4 will often require a degree of pragmatism in addition to
5 all of the necessary guidance, training and experience.
6 The de facto RVP became Victoria Station Approach
7 rather than the other nominated sites, and the initial
8 de facto FCP, such as it was, became the City Room for
9 Inspector Smith and Advanced Paramedic Patrick Ennis,
10 and the station concourse for others. If Smith and
11 Ennis did not invoke precise JESIP principles, if their
12 actions were not a considered application of a JESIP
13 principle, they certainly complied with the spirit of
14 JESIP.
15 The description by experts that they engaged in
16 solid and effective joined-up operational work within
17 such a short time of a terrorist attack when there were
18 lives to be saved is again exactly what the public would
19 have expected. These arrangements evolved naturally out
20 of the demands of the emergency and they were not
21 necessarily the worse for that.
22 It is recognised that the de facto RVP, for example,
23 was better than the nominated and more distant sites
24 because it ensured the quick arrival to the scene of the
25 Ambulance Service, and therefore to the casualties, and

1 that must have been of great comfort to the shocked and
2 injured survivors.
3 The fact that a plan may not always be followed to
4 the letter is not necessarily a failing; it is the
5 performance and the result that matters. It is also of
6 note that GMP had supplied two of its commanders with
7 recording devices and encouraged their use. Both the
8 FDO and the GATFC activated their Dictaphones from an
9 early stage of their involvement, and the provision and
10 the use of this equipment has provided an extensive and
11 invaluable record of what happened.
12 There will nearly always be lessons to be learnt
13 from an extreme event of this nature, and this attack
14 was no exception. Numerous recommendations and changes
15 have been made. Of particular importance was the
16 subsequent move of the FDO, the increase in support for
17 the FDO, and the improvement in access to the FDO.
18 A new role has been created, that of Force Critical
19 Incident Manager, to take command of emergencies such as
20 this at an early stage and then to transfer command to
21 Silver once Silver Control has been established.
22 Many may well have thought that moving the FDO to
23 force headquarters would have been a relatively
24 straightforward exercise. Well, it was not. It was
25 a logistical and technical challenge of a very high

1 order. It was a time-consuming and expensive
2 proposition. From contemplation to execution took
3 7 years and it is estimated that the overall cost of
4 this extensive programme -- it involved more than the
5 move of the FDO -- will be in excess of č8.2 million.
6 In addition, there is now a dedicated telephone line
7 between the FDO and the ambulance and fire NILOs,
8 that is the national inter-agency liaison officers, and
9 there is a dedicated radio channel for the sole use of
10 GMP, NWAS and GMFRS, which is now tested three times
11 a day and has performed well. And training across the
12 ranks has improved.
13 There can be no doubt that GMP is better prepared
14 for a terrorist attack today than it was 3.5 years ago.
15 It has been steadfast in its resolve to learn lessons
16 and to progress, and this work will continue.
17 GMP has placed the bereaved families and the
18 survivors at the centre of everything and has tried its
19 very best to support those who have been injured or
20 affected by this atrocity and, from the outset, was
21 wholly committed to the many commemorative events which
22 attempted to bring communities together and help heal
23 the psychological and emotional wounds.
24 The last 2 weeks have been a deeply moving and
25 emotional experience, the families and loved ones of

1 those who died reminding each of us why we are here.
2 They are entitled to expect the best from all of us.
3 They are entitled to expect a thorough investigation.
4 But a thorough investigation is not one measured by
5 either the number of days or the number of pages;
6 a thorough public inquiry is a focused public inquiry,
7 and in the work all the core participants have done in
8 recent weeks, responding to the experts' reports, we
9 cannot be the only ones to be concerned about a lack of
10 focus in some aspects of those reports together with the
11 part that hindsight has undoubtedly played in some of
12 their conclusions. Sir, we look with confidence to the
13 inquiry team to ensure that efforts are concentrated on
14 what matters.
15 GMP has sought to assist this inquiry at every stage
16 and looks forward to this investigation and to
17 discovering whether there are any further lessons to be
18 learned. It has never suggested that its immediate
19 response was perfect or anything like it, but its
20 response was effective and is likely to have saved
21 lives.
22 All that GMP, or any CP, can ask is that there is
23 a fair evaluation of the facts, and what that means in
24 these circumstances, more than 3 years after the event,
25 is that every effort is made to exclude hindsight from

1 the analysis of the evidence. Everything is so
2 straightforward with hindsight: the attack was always
3 going to be in the City Room and nowhere else; there
4 were no other terrorists waiting to attack responders;
5 there was no secondary device; the ceiling was never
6 going to collapse; Plato should never have been declared
7 and, if declared, should have been withdrawn in minutes,
8 and so on.
9 The police officers and staff of GMP go to work to
10 protect the people of Manchester, to keep them safe, and
11 it is a matter of the deepest regret that they were not
12 able to do so that night. GMP expresses its most
13 sincere condolences to all of those affected by this
14 attack. GMP assures them of its unwavering commitment
15 to keep people in Manchester free from acts of terror
16 and to pursue and bring to justice those who seek to
17 perpetrate such offences with the same determination and
18 dedication as was brought to bear against Hashem Abedi.
19 Those are our opening remarks, sir. Thank you.
20 SIR JOHN SAUNDERS: Thank you, Mr Horwell.
21 MR GREANEY: Sir, would you now rise, please, until 3.25?
22 (3.15 pm)
23 (A short break)
24 (3.25 pm)
25 SIR JOHN SAUNDERS: Mr Greaney.

1 MR GREANEY: Sir, you're now going to be addressed by
2 Mr Butt on behalf of the National Counter-terrorism
3 Policing Headquarters.
4 SIR JOHN SAUNDERS: Thank you.
5 Opening statement by MR BUTT
6 MR BUTT: As you know, sir, I represent the
7 Counter-terrorism Policing Headquarters, CTPHQ, known
8 until recently and mostly referred to in the papers for
9 this inquiry as NCTPHQ. I'm instructed by
10 Andrew Fairbrother from the Directorate of Legal
11 Services at the Metropolitan Police Service.
12 Before I say anything on the terms of reference on
13 behalf of CTPHQ I would like to offer the sincere
14 condolences of all who work within counter-terrorism
15 policing to the victims, their families and all of those
16 whose lives have been damaged and destroyed by this
17 terrible and evil attack.
18 In particular, Assistant Commissioner Neil Basu,
19 Assistant Chief Constable Tim Jacques, and Deputy
20 Assistant Commissioner Lucy D'Orsi have asked me to
21 again express their condolences to the families.
22 The CTPHQ senior leadership wanted to be physically
23 present at court for the openings out of respect to
24 those families, but at present recognise it is better
25 they do not come to the Magistrates' Court in order to

1 enable better social distancing.
2 Jeremy Wilson, a former counter-terrorism senior
3 police officer, who was recruited to assist CTPHQ in
4 these proceedings is present and sits beside me.
5 The men and women who work within counter-terrorism
6 policing are relentless in their determination to
7 protect the public from terrorists. It is important for
8 the public not to lose sight of the fact that the vast
9 majority of attacks are prevented. In 2017 alone,
10 13 attacks were disrupted and stopped by law enforcement
11 activity. That is of little comfort to the victims and
12 nobody in this inquiry needs reminding of the tragic
13 reality that that year alone a number were not stopped,
14 including the Manchester bombing.
15 My client understands that the families of the 22
16 do not want to become a statistic or a reference point
17 for lessons learned; they want truth and accountability
18 as to what happened that terrible day. CTPHQ seeks to
19 work with you, sir, to assist you in your inquiry with
20 that objective in mind.
21 In making this brief opening statement, I want to
22 explain a little about the body I represent, to outline
23 what relevant evidence those who work for my client will
24 be able to give, and to put that evidence in context.
25 First of all, CTPHQ. Its name may not be

1 immediately familiar to the public as it does not itself
2 have any significant public-facing role, it also has no
3 independent legal status. CTPHQ exists only by way of
4 a collaboration agreement between all police forces in
5 England and Wales entered into under the Police Act
6 1996. That agreement is in the public domain, it can be
7 found online on the National Police Chiefs' Council
8 website and a copy has been disclosed in this inquiry on
9 the document management software. It's referenced by
10 a number of the senior policing witnesses and your
11 policing experts.
12 That agreement recognises there is some CT work
13 that is better done at a national level and an HQ is
14 needed to set (inaudible: distorted) objectives for
15 countering the terrorist threat.
16 Summarised at a high level, CTPHQ seeks to provide
17 national support and guidance to the CT network and
18 police forces in countering terrorism. The public face
19 of that work is substantially undertaken by the National
20 Counter-terrorism Security Office, NaCTSO, which reports
21 to CTPHQ and which I therefore also represent.
22 Unsurprisingly, given its legal status, CTPHQ does
23 not sit above police forces in a hierarchy. It's
24 important to note that each Chief Constable and each
25 counter-terrorism policing region remains responsible

1 for counter-terrorism policing within his or her own
2 geographical area, for instance Greater Manchester
3 Police, or area of responsibility, for instance British
4 Transport Police, which includes the provision of
5 general counter-terrorism advice where appropriate.
6 CTPHQ's work is designed to assist in the delivery
7 of the government's counter-terrorism strategy known as
8 CONTEST. As you know, sir, CONTEST is divided into four
9 pillars: Protect, to strengthen the country's protection
10 against terrorists; Prepare, to reduce the impact of
11 attacks that cannot be stopped by preparing for them;
12 Prevent, to stop people from becoming terrorists; and
13 Pursue, to detect, prosecute and disrupt terrorists.
14 The key leadership roles within CTPHQ are described
15 within the collaboration agreement and are delivered by
16 senior officers who remain constables with their own
17 forces, but also discharge national roles under the
18 agreement. You will be hearing from a number of those
19 officers, including the senior national coordinator for
20 Protect and Prepare, Lucy D'Orsi, who oversees the work
21 of NaCTSO. That role at the time was known as DACSO,
22 Deputy Assistant Commissioner Security Operations. You
23 will also hear from Neil Basu, who at the time of the
24 attack was the senior national coordinator for Prevent
25 and Pursue, a role referred to as the SNC. Witnesses

1 connected to NaCTSO, such as Lucy D'Orsi, will be able
2 to assist you in relation to the question of protective
3 security at the arena within chapter 7 and will focus on
4 the Protect strand of CONTEST.
5 Other witnesses will give evidence more relevant to
6 Prepare and will be able to assist the inquiry
7 in relation to the emergency response to the attack
8 within chapter 10.
9 You will also hear evidence from witnesses including
10 Richard Thomas, who is the head of specialist and armed
11 policing capabilities for CTPHQ. In that role he has,
12 since 2013, led police engagement for the marauding
13 terrorist attack joint operating principles known as
14 JOPs and the Operation Plato police guidance.
15 Can I briefly turn to chapter 7, Protect. As
16 I mentioned, NaCTSO is counter-terrorism policing's
17 public face and as such is may be more familiar to some,
18 in particular in the industry, than CTPHQ. NaCTSO's
19 work includes the Protect strand of CONTEST and in that
20 regard seeks to provide practical, protective security
21 guidance by drawing upon the combined knowledge of
22 counter-terrorism policing and its partners.
23 NaCTSO works under the same collaboration agreement
24 between all police forces I mentioned previously. It
25 reports the National Police Chiefs' Council and CTPHQ.

1 One of NaCTSO's responsibilities is the training and
2 accreditation of CTSAs about whom much has been said
3 already today. The CTSA network is an important part of
4 the way counter-terrorism policing engages with, in
5 particular, crowded places under the crowded places
6 model introduced in its current form in 2014.
7 CTSAs are trained and accredited by NaCTSO but they
8 work for and are the responsibility of the lead force
9 within their police region, in this case in particular
10 Greater Manchester Police, with the strategic objectives
11 for their work set by NaCTSO.
12 NaCTSO also devises and publishes material and
13 content which can be delivered by CTSAs, including, for
14 example, training courses. You have heard already of
15 two, known as Project Griffin and Project Argus,
16 designed to be delivered to front line staff, Griffin,
17 and senior managers working at crowded places, Argus.
18 NaCTSO also has communication channels through which
19 regular updates are sent to the CTSA network and crowded
20 places themselves. Under the crowded places model,
21 CTSAs provide bespoke advice to sites. This process
22 will commence with a vulnerability survey followed by
23 the protective security improvement activity, PSIA,
24 scoring process, which is completed by a CTSA. It would
25 be wrong to view the vulnerability survey, the PSIA

1 process or the resultant action plan as being the
2 totality of advice provided to a crowded place or the
3 final word as to their security posture.
4 In fact, the survey is merely the beginning of the
5 process.
6 Local police regions will submit quarterly returns
7 to NaCTSO containing performance management information,
8 but NaCTSO does not play a supervisory or audit function
9 in relation to the work of CTSAs. Given the number of
10 sites across the country which receive bespoke advice,
11 it would be impossible to do so and wrong for a national
12 body to interfere in assessments made by trained
13 security professionals who have in-depth local
14 knowledge.
15 Turning to this case, the evidence shows that
16 Manchester Arena was appropriately classed as a tier 2B
17 crowded place and received priority attention at least
18 in line with NaCTSO policy as a result. The evidence
19 also shows that the level of engagement was what would
20 have been expected at a tier 2A site. This reflects the
21 reality that once a CTSA had engaged with the tier 2
22 site, the A or B rating quickly falls away.
23 NaCTSO continually evaluates the threat from
24 terrorist groups to ensure the most useful and
25 up-to-date guidance and advice is provided. At the time

1 of the 2017 attacks, and unsurprisingly, the prevalent
2 terrorist methodology suggested the most likely form of
3 a person-borne improvised explosive device attack to
4 a crowded place would be by way of an attempt to
5 detonate a device within the crowded place itself. This
6 did not mean that security outside the site was ignored,
7 either by NaCTSO or CTSAs. In opening we point to three
8 features of the evidence that are no more than examples
9 to support that proposition.
10 First of all, the PSIA score for the arena took into
11 consideration CCTV coverage and security patrols
12 including outside the arena space itself and in the
13 City Room.
14 Secondly, and as your experts have noted, guidance
15 was also available from NaCTSO and elsewhere, which
16 would have been relevant to countering the threat from
17 a device outside the arena. Examples are provided in
18 the fourth statement of Lucy D'Orsi, but these include,
19 first of all, the crowded places, stadia and arena
20 guidance, which highlights exits and external
21 vulnerabilities as points for consideration; secondly,
22 NaCTSO tasking number 2 of 2015, published in response
23 to the November 2015 Paris attacks, which advises that
24 consideration be given to extending the security
25 perimeter by, for example, provisional searches and

1 screening before entry to the venue; and thirdly, NaCTSO
2 guidance note 3 on hostile reconnaissance, which gives
3 paying attention to specific access and egress areas as
4 an example of suspicious behaviour.
5 Finally, and more generally, there was a wealth of
6 material directing sites to be on the lookout for
7 suspicious behaviour inside and outside their venues.
8 This was contained in specific training programmes such
9 as Argus and Griffin and elsewhere as detailed in the
10 statement of Mr Upham, the CTSA. Sites were also
11 encouraged to work with other nearby venues to improve
12 security using, for example, SIA staff and CCTV to
13 detect both internal and external threats, including at
14 ingress and egress points.
15 In particular, this sharing of information between
16 venues can be of great assistance in dealing with
17 so-called grey spaces between venues. The arena PSIA
18 survey, for example, makes reference to intelligence
19 sharing, community safety zones, and engagement with
20 stakeholders, which, as your experts observe, can be
21 considered an extension of security beyond the site.
22 It is only right to acknowledge that the security
23 risks at the arena and the added complication of the
24 City Room were difficult and the challenges posed can be
25 fairly described as unique. GMP provided priority

1 support to the site on a bespoke basis in recognition of
2 this.
3 Where a CTSA provides protective security advice to
4 a venue, it is at present entirely discretionary whether
5 that is followed or not. CTSAs are able to make
6 recommendations to sites which can be implemented in
7 order to improve security, but this does not amount to
8 an audit of security or a risk assessment for the site
9 by the CTSA. It remains the responsibility of the site
10 to ensure that, amongst other matters, employees and
11 non-employees are safe so far as is practicable from
12 terrorist attack.
13 CTSAs are tenacious in following up on their work,
14 but they do not have legal powers to compel compliance.
15 It is well-established that since the appalling events
16 of 2017, there has been a recognition within
17 counter-terrorism policing and government that the
18 crowded places model is insufficiently flexible and it
19 does not reflect the consequence-focused rather than
20 target-focused approach espoused in, for instance, Daesh
21 propaganda, the so-called "anyone, anywhere" threat.
22 As a result, there has been a review of the crowded
23 places model and this led to a national assessment of
24 crowded places by NaCTSO in 2019, which itself has
25 brought about a far wider review, which is currently

1 underway, led by the Home Office and fully supported by
2 CTPHQ.
3 I should just add this, however, in the context of
4 this case. Unlike London and Westminster Bridge, and
5 Parliament Square, which were not crowded places as
6 defined under the model, Manchester Arena was, as I have
7 said, recognised as priority crowded place and received
8 priority support from an appropriately trained CTSA in
9 line with NaCTSO's expectations as a result.
10 Chapter 9, Prevent. As we have detailed in our
11 addendum opening statement, CTPHQ was not aware of Abedi
12 or any of the intelligence that relates to him before
13 the attack. Under the collaboration agreement, the SNC
14 at the time, Assistant Commissioner Basu, would be
15 informed of intelligence about an individual suspect
16 where there is, for example, a high threat operation
17 with the possibility of imminent public threat which
18 required the SNC to take national strategic command.
19 As this was never the case with Abedi, intelligence
20 was not provided to CTPHQ and nor should it have been.
21 To put this in context, it's in the public domain that
22 at any one time there are around 800 live CT police
23 investigations and around 3,000 subjects of interest who
24 are the subject of active investigation. Closed SOIs,
25 like Abedi, total 40,000. There are well-established

1 procedures for counter-terrorism policing and the
2 security services to work closely together in these
3 investigations. This is not therefore an area we are
4 able to assist with in this inquiry.
5 I appreciate that now is not the time to discuss
6 questions relating to restriction orders, but can I say
7 a very few brief words on this topic to reassure core
8 participants. CTPHQ have submitted two applications
9 which relate to the statements of Neil Basu and
10 Terry Nicholson. The areas we have asked to be
11 restricted relate to information that is, to use an ugly
12 phrase, not the property of CTPHQ. It was included in
13 order to be entirely transparent.
14 The closed statements have been viewed by your team
15 and it's our understanding that the redacted parts of
16 the statement of Neil Basu are covered by the extant PII
17 order. The same redacted material is replicated in the
18 statement of Terry Nicholson. We will continue to work
19 with your team and our partners to ensure that as much
20 material can be heard in open or seen by the families as
21 is consistent with national security.
22 Chapter 10, Prepare. As is apparent from what
23 you have heard in opening so far, it is hardly
24 controversial to say that in the aftermath of an attack
25 tremendous strain is placed upon emergency responders

1 and their resources. These responders and commanders
2 are only human and the impact of events such as these
3 should not be underestimated. CTPHQ has read the
4 policing experts' report with care and made a number of
5 observations in line with the protocol.
6 The relevant witnesses from CTPHQ have also
7 considered the addendum report and your experts'
8 responses to our observations. As you will have seen
9 from our written opening, CTPHQ stand by the
10 observations made in our response and hope to assist you
11 in considering the relevant policies and guidance during
12 chapter 10.
13 The majority of our observations have in fact been
14 accepted or constructively engaged with by your experts.
15 The primary area of professional disagreement relates to
16 the role of the police on scene commander under JOP 3
17 and police Plato guidance. It is of course of great
18 importance to counter-terrorism policing that the
19 decisions which were made that night are evaluated
20 objectively and fairly and that the relevant policy and
21 guidance are interpreted consistently, albeit that JOP 3
22 and the Plato guidance have been substantially revised
23 and reissued since 2017 as part of the learning from the
24 terrible attacks that occurred that year.
25 In dealing with these matters, CTPHQ will provide as

1 much assistance as you require, of course accepting that
2 these are all matters for you and that none of our
3 witnesses are or could purport to be experts in a legal
4 sense in relation to the events of this attack.
5 Assistant Commissioner Basu will give evidence as to
6 what steps he took as SNC to step up and coordinate the
7 national counter-terrorism response mobilisation and
8 support following the attack, but this is only
9 incidentally relevant to the terms of reference. In
10 keeping with the collaboration agreement and the
11 national strategic role played by the SNC under that
12 agreement, CTPHQ was not directly involved in the
13 immediate response on the ground at the arena.
14 Sir, in conclusion, CTPHQ repeats its sincere
15 condolences to all of the victims of this terrible
16 attack. Our witnesses are here to assist you in your
17 inquiry and to ensure that we can move forward together
18 in the future, better able to protect from terrorists
19 in the future.
20 That is our opening statement, thank you for your
21 time.
22 SIR JOHN SAUNDERS: Thank you, Mr Butt.
23 MR GREANEY: Sir, we will need to have another short break,
24 but no more than 5 minutes, and we'll then hear the
25 final opening statement for today.

1 SIR JOHN SAUNDERS: There's no such thing as 5 minutes, so
2 however long it takes.
3 (3.55 pm)
4 (A short break)
5 (4.00 pm)
6 MR GREANEY: Sir, we are now going to hear from Ms Roberts
7 on behalf of the North West Ambulance Service.
8 Opening statement by MS ROBERTS
9 MS ROBERTS: Sir, I make this opening statement on behalf of
10 the North West Ambulance Service NHS Trust, for whom
11 throughout this statement I shall refer to as "NWAS".
12 Sir, I make this statement alongside and
13 considerably assisted by Mr Adam Fullwood and sitting
14 behind me and in attendance today are Mr Ged Blezard,
15 director of operations from NWAS, and Ms Emma Shiner,
16 head of NWAS Legal.
17 Sir, on behalf of all those at NWAS and all who work
18 for NWAS, we wish to begin by expressing our heartfelt
19 condolences to the families and to the friends of the
20 22 people who lost their lives as a result of the
21 callous attack at the Manchester Arena on 22 May 2017.
22 Sir, the commencement of this phase of the inquiry
23 is a significant milestone in the response to this
24 incident. NWAS remains fully committed to supporting
25 the inquiry in its difficult and important work as it

1 has done from the start.
2 Sir, that commitment will continue. Indeed, members
3 of the NWAS team have attended this inquiry every day,
4 listening with care to the opening submissions of CTI,
5 but, more importantly, to the commemorative hearings of
6 the 22.
7 All of those who responded to this incident have
8 been deeply affected by the events of that night and
9 have reflected on what happened, their experiences, and
10 their actions. NWAS, as an organisation, has done the
11 same and sees this inquiry as an opportunity for
12 learning and for improvement.
13 This opening statement will identify certain aspects
14 of the NWAS response which were less than adequate or
15 which could have been improved. There may well be other
16 inadequacies and areas for improvement that emerge
17 during the evidential hearings. Indeed, that is almost
18 inevitable when analysing with the benefit of hindsight
19 what has been described by the independent ambulance
20 experts as "an exceptionally complex operational
21 response".
22 The independent ambulance experts have concluded
23 that the NWAS response was "mostly good and mostly
24 compliant with expectations", but that a limited number
25 of opportunities were missed that could have enhanced

1 its response to this incident and that mistakes were
2 made.
3 NWAS accepts this conclusion and sincerely
4 apologises that there were elements of the response
5 which could have been better and could have been
6 improved.
7 Whilst doing so, NWAS also wishes to make clear that
8 it is fully committed to addressing all of the issues
9 not already remedied and to continue to work to improve
10 the way in which it provides emergency care and other
11 services to those living in and visiting the city of
12 Manchester and the wider regions served by NWAS.
13 The inquiry will also hear evidence about many
14 things that NWAS and its staff did well and with skill,
15 care and incredible bravery. The Kerslake Report
16 commissioned by the Mayor of Manchester, Andy Burnham,
17 commended the sound judgment exercised by emergency
18 personnel, including those from NWAS, at critical points
19 during their response. The independent ambulance
20 experts concluded that NWAS worked to provide the best
21 standard of care that they were able to provide in very
22 difficult, distressing and stressful circumstances.
23 On 30 January 2020, you ruled that each core
24 participant, CP, provide an opening statement to include
25 "a narrative for the CP's performance with respect to

1 the relevant terms of reference in this inquiry". The
2 relevant terms for NWAS are those contained in
3 sections 3.3, 5.1 to 5 and 7.3.
4 The stated aim is to encourage CPs to identify where
5 mistakes have been made by their organisations or their
6 employees so as to make clear to the inquiry what
7 remedial action can be taken. This opening statement
8 will therefore include a narrative of the performance of
9 NWAS in addition to other matters considered relevant
10 whilst at the same time seeking to adhere to the call
11 for brevity.
12 Now is not the time to draw conclusions.
13 Conclusions will be based on the evidence, not on
14 anything we or any other core participant says at this
15 stage.
16 The relevant sections of the terms of reference will
17 now be addressed in turn.
18 Term of reference 3.3, the immediate response to the
19 detonation of the explosive device. This part of the
20 terms of reference is focused on the moments immediately
21 after the explosion, whilst no specific time frame is
22 identified, you stated that you would be most assisted
23 by focusing on the first 10 minutes or so following the
24 explosion for this part of the inquiry.
25 Events after this period will form part of the

1 operational response under sections 5.3 to 5.5 of the
2 terms of reference.
3 It should be noted that immediately before NWAS
4 received the first call in relation to this incident,
5 there were 75 emergency ambulances signed on duty across
6 the Greater Manchester region. Of those ambulances,
7 there were only eight available to be deployed
8 immediately. Of the eight, none were located in the
9 immediate central Manchester area. This is not unusual
10 for ambulance services. At any given time the majority
11 of ambulances are actively engaged in responding to
12 a wide range of incidents 24 hours a day. Despite this,
13 NWAS were able to rapidly deployed multiple resources
14 from across the north-west in response to this incident.
15 The NWAS Cumbria and Lancashire emergency operations
16 centre, the EOC, received its first call in relation to
17 this incident at 22.32.03 seconds on 22 May 2017. By
18 22.33 hours, less than a minute later, NWAS had alerted
19 nine managers, advanced paramedics and a senior
20 paramedic to that first call.
21 Within 5 minutes, communication was established
22 between control rooms of NWAS, GMP and North West Fire
23 Control.
24 Within 6 minutes, resources were allocated to the
25 arena and within 8 minutes of the initial call the EOC

1 had also transmitted the first of a series of group
2 calls asking crews to clear from other incidents.
3 An NWAS advanced paramedic took the decision to
4 deploy to the scene and notified the EOC of his decision
5 at 22.36.33 hours.
6 Two ambulances were allocated at 22.37 hours.
7 Multiple resources continued to be allocated thereafter,
8 and by 22.38 hours a rendezvous point, or RVP, was
9 identified, and by 22.42 hours an advanced paramedic had
10 arrived at Hunts Bank, within 10 minutes of the first
11 call.
12 So dealing specifically with term of reference 3.3,
13 the first 10 minutes or so after the explosion, NWAS
14 maintains that by any standard the immediate response
15 and deployment of resources by NWAS was quick and
16 effective. In so doing, NHS was able to begin the
17 process of obtaining situational awareness to assist
18 in the management of the immediate response and initiate
19 the further steps required.
20 As the independent ambulance experts commissioned by
21 the inquiry have commented:
22 "NWAS reacted swiftly in both control and
23 operations."
24 The reference is taken from the second independent
25 report of June 2020 at page 209.

1 Term of reference 5.1: planning and preparation for
2 responding to terrorist and mass casualty incidents,
3 including inter-agency planning, preparation and
4 exercises prior to the attack.
5 NWAS carries out significant training, planning and
6 preparation, including multi-agency exercises for a wide
7 range of emergencies, hazards and threats that could
8 have a significant impact on individuals and communities
9 pursuant to its responsibilities under the Civil
10 Contingencies Act of 2004, the CCA, and other
11 requirements. This includes planning and preparation
12 for terrorist and mass casualty incidents with other
13 agencies.
14 In the period leading up to this incident, NWAS was
15 compliant with the relevant NHS emergency preparedness
16 resilience and response, the EPRR, contractual
17 requirements in relation to planning and preparedness.
18 NWAS maintains a Major Incident Response Plan, MIRP.
19 The relevant MIRP at the time of this incident was
20 approved on 18 June 2016 and issued on 18 October 2016.
21 It was specifically devised to guide and inform the NWAS
22 response to incidents such as this. The 2016 MIRP was
23 fully compliant with EPRR requirements and was otherwise
24 fit for purpose.
25 The NWAS resilience business plan in place at the

1 time of the incident provided a comprehensive
2 understanding of the requirements for the organisation
3 in respect of emergency preparedness and resilience.
4 The action cards produced by NWAS were consistent with
5 national standards and requirements at the time. In
6 terms of preparation, NWAS had sufficient stocks
7 available for emergency mobilisation to support a large
8 mass casualty emergency and were able to maintain and
9 meet business as usual requirements.
10 However, in relation to planning and preparedness
11 for responding to terrorist and mass casualty incidents,
12 the following issues have been identified.
13 Site-specific arrangements. At the time of the
14 incident, NWAS had a site-specific information sheet for
15 the arena, which provided some, albeit limited,
16 information. This has since been replaced by an
17 operational order which is currently the subject of
18 a review with the benefit of multi-agency input.
19 A number of expectations have been highlighted as
20 part of the review, including that the on-site medical
21 provider will call 999 as soon as necessary, request
22 NWAS to attend if appropriate, and provide information
23 using the METHANE approach.
24 It is likely that the operational order will be
25 replaced with a new information sheet that will also

1 include recommendations for rendezvous points, a
2 casualty clearing station and other relevant
3 information. This will then be loaded and available on
4 the computer-aided despatch, the CAD systems, to support
5 personnel attending future incidents at the arena.
6 Learning from exercises. In the period prior to
7 this incident, NWAS was involved in a large number of
8 exercises, each with specific aims and objectives. Some
9 were tabletop exercises but many were live, multi-agency
10 exercises carried out in accordance with the joint
11 emergency services interoperability principles, the
12 JESIP principles.
13 NWAS was involved in a number of large scale,
14 multi-agency exercises in the years prior to this
15 incident. Invaluable lessons were learned from these
16 exercises. For example, in Exercise Socrates a new mass
17 casualty distribution plan was tested and was then
18 utilised during this incident. However, NWAS
19 acknowledges that some learning was not identified and
20 implemented from these exercises to the extent that it
21 should have been. This included the use of forward
22 command points, FCPs, and the need to improve joint
23 understanding of risk and shared situational awareness
24 between co-located police, fire and ambulance commanders
25 during a major incident response. It is accepted that

1 further work is needed by all emergency services to
2 ensure that lessons learned during exercises are
3 identified, actioned and reviewed, and NWAS is committed
4 to ensuring that this work is undertaken.
5 Handover of responsibility. NWAS was not
6 responsible for the provision of on-site event medical
7 services or equipment at the arena at the time of the
8 incident. The relevant guidance for event planning, the
9 Purple Guide, states that it is considered to be best
10 practice for there to be a handover of responsibility
11 document drawn up between the statutory
12 ambulance service and the event medical provider to use
13 in the event of a major incident occurring. Such
14 a document was not in existence at the time of the
15 incident. NWAS questions the extent to which it would
16 have enhanced its response to a sudden and violent
17 incident of this type. It is acknowledged that such
18 a document may be helpful when responding to a different
19 type of incident where the demands increase in a slower
20 manner, sometimes described as a rising tide incident.
21 NWAS will keep under review the potential utility of
22 such a document.
23 NWAS also takes the view that there should be
24 consideration of more effective regulation of event
25 medical providers, possibly involving the Care Quality

1 Commission, the CQC, together with clearer and more
2 effective guidance.
3 Term of reference 5.2, policies, systems and
4 practices relevant to the above. NWAS policies, systems
5 and practices for responding to terrorist and mass
6 casualty incidents have been described in some detail
7 in the command and control statements already provided,
8 in particular that of Mr Gerard Blezard, director of
9 operations and dated 11 December 2019.
10 Mr Blezard confirms that at the time of the
11 incident, NWAS had developed its own Major Incident
12 Response Plan with the aim of ensuring that its response
13 to a major incident is patient-focussed, clinically led
14 and is effectively managed. The MIRP operates together
15 with action cards designed to support decision-making
16 for a wide range of operational staff. As already
17 mentioned, both the MIRP and its action cards were
18 compliant with the relevant statutory framework and
19 guidance at the time of the incident.
20 NWAS also produced deployment guidance for its
21 emergency operation centres in accordance with the
22 National Ambulance Resilience Unit and the NHS England
23 Ambulance Command and Control Service Specification.
24 The mass casualty distribution plan had been
25 developed just prior to this incident and was informed

1 by lessons learned from exercises and close working with
2 the NHS and other partners in the Greater Manchester
3 area.
4 Training was undertaken as required, including
5 national interoperable specialist services, JESIP
6 principles were accepted and followed in all policies,
7 systems and practices, including the JESIP joint
8 decision model, followed by other blue-light agencies.
9 Arrangements were also in place for expert medical
10 support for NWAS when responding to major incidents,
11 including NWAS medical directors and associates, Medical
12 Emergency Response Incident Team members, and
13 pre-hospital doctors. These arrangements ensured that
14 direct clinical care, clinical supervision and policy
15 support were available to NWAS as required.
16 Specialist resources were also available in response
17 to major incidents and to be called upon, where
18 appropriate, when responding to major incidents. These
19 resources included the Hazardous Area Response Team,
20 HART, Specialist Operations Response Team, and the
21 Ambulance Intervention Team, each with their specific
22 capabilities and advantages.
23 NWAS participates fully in the Greater Manchester
24 Resilience Forum in its capacity as a category 1
25 responder and attends numerous meetings in compliance

1 with its requirements under the CCA 2004. It also
2 participates in task and finish groups set up by GMRF
3 and other projects such as the generic multi-agency
4 response plan.
5 NWAS is responsible for the well-being of all
6 healthcare personnel at the scene of a major incident
7 and follows the JESIP approach to gaining joint
8 understanding of the risk between all relevant agencies.
9 A dynamic risk assessment process is identified
10 in the Major Incident Response Plan and the National
11 Ambulance Resilience Unit Command and Control Guidance.
12 This risk assessment model is designed to be repeated
13 and to be constantly monitored to react to relevant
14 changes during an incident as they occur.
15 All policies, systems and practices relating to the
16 planning and preparation for terrorist and major
17 incidents are subject to significant statutory
18 requirements and national and local guidance. NWAS is
19 also subject to oversight by both NHS England and the
20 CQC.
21 Sir, NWAS was compliant with all of its requirements
22 in relation to policies, systems and practices arising
23 from the relevant statutory and regulatory framework.
24 Term of reference 5.3, the operational responses of
25 relevant emergency services, those contracted to provide

1 first aid to concertgoers, the operator of the arena
2 venue and relevant security providers, including their
3 adequacy and compliance with relevant planning,
4 preparation, policies, systems and practices.
5 This section of the opening statement will focus on
6 the operational response by NWAS after the initial
7 10-minute period following the detonation of the
8 explosive device in the City Room of the arena.
9 Approximately 21 minutes following detonation, an
10 advanced paramedic entered the City Room and passed
11 vital information back to his colleagues at the
12 emergency operations centre. It has been acknowledged
13 by the independent ambulance experts that his actions
14 enhanced both the speed of NWAS response and its
15 situational awareness. The advanced paramedic did not
16 adopt the role of acting operational commander, but
17 focused on obtaining situational awareness and assisting
18 with the process of initial triage and moving patients
19 to the station concourse.
20 He consulted with the senior GMP inspector present
21 in that area, who had taken control of the City Room
22 area, and who had made the decision to start moving
23 patients before the NWAS operational commander had
24 arrived.
25 NWAS quickly identified that this was a major

1 incident and a major incident was declared at
2 22.46 hours. This meant that the MIRP was quickly and
3 fully invoked. The Emergency Operations Centre liaised
4 with other emergency services and mobilised resources to
5 the scene. The EOC continued facilitating communication
6 and the flow of information between the scene,
7 hospitals, commanders and other services.
8 One of the on-call tactical commanders was notified
9 of the incident and contacted a number of key personnel.
10 The operational commander arrived at Hunts Bank at
11 approximately 22.55 hours. Following their arrival at
12 the scene, NWAS paramedics and other emergency
13 responders were confronted with an incredibly
14 distressing and chaotic scene from which they were
15 required to establish order, set priorities and tend to
16 large numbers of injured people.
17 During the initial phase of a response to an
18 incident of this kind, it is almost inevitable that the
19 number of patients substantially exceeds the number of
20 paramedics and other ambulance responders present.
21 Nonetheless, as the independent ambulance experts have
22 noted, NWAS reacted quickly to the first reports of the
23 attack, allocated a sufficient number of resources to
24 the incident, consistent with the number of
25 significantly injured people, and did its best to

1 provide care and treatment in very distressing
2 conditions.
3 Sir, it is entirely understandable that the injured
4 and others assisting them may have expected paramedics
5 to begin immediately providing care upon their arrival.
6 However, it is important to highlight that the priority
7 for the first paramedics on scene is not to provide
8 immediate clinical care but develop situational
9 awareness and establish a command and control structure
10 as quickly as possible.
11 Such an approach is mandated by national guidance
12 and provides the best means of managing a major incident
13 in a sustainable way that makes the best use of
14 available resources. It recognises the inevitable
15 uncertainties that are present as incidents unfold and
16 also allows responders to make provision for the
17 potential needs caused by other incidents and risks.
18 GMP and BTP officers, along with event personnel,
19 arrived at the seat of the explosion in the City Room
20 before any paramedics. The decision to initiate the
21 plan for moving patients out of the City Room to the
22 station concourse had already been made by GMP and
23 instigated prior to the arrival of the operational
24 commander on scene.
25 Despite not knowing whether the attack was or was

1 likely to be part of a more extensive series of
2 incidents, the advanced paramedic carried out his own
3 dynamic risk assessment and decided to operate in that
4 area.
5 The GMP inspector on scene had already begun to take
6 charge of the City Room and was taking steps to secure
7 that area. A decision was made not to allow anyone
8 through the double doors towards the arena, due to the
9 potential risks present in that area. Police in the
10 City Room took the view that patients should continue to
11 be moved as quickly as possible out of the City Room
12 down to the station concourse. Based on the information
13 known to him at the time, the advanced paramedic was in
14 full agreement with this approach.
15 When the NWAS operational commander arrived at
16 Hunts Bank at approximately 22.55 hours, the process of
17 moving patients to the station concourse was underway.
18 He quickly surveyed the scene, assessed the information
19 available to him, and concluded it was appropriate for
20 that process to continue. There was a limited number of
21 NWAS responders at the scene at that time.
22 Between 23.05 and 23.10 hours, three HART, Hazardous
23 Area Response Team, operatives arrived on scene. It was
24 considered appropriate for some HART operatives to move
25 forward and assess patients in the City Room.

1 At approximately 23.15 hours, two HART operatives
2 entered the City Room to join the advanced paramedic.
3 The remaining members of the same HART team arrived on
4 scene at approximately 23.22 hours and were deployed to
5 assist setting up the casualty clearing station on the
6 concourse.
7 By approximately 23.30 hours, NWAS had completed its
8 triage of the City Room. The advanced paramedic had
9 built up significant knowledge of the situation in the
10 City Room and his continued involvement there was of
11 considerable benefit to the process of moving patients
12 as quickly as possible according to their priority to
13 a more suitable environment.
14 By approximately 23.40 hours, all patients had been
15 moved to the casualty clearing station on the station
16 concourse.
17 It was considered more appropriate to utilise the
18 remaining members of the HART team to help to set up
19 a CCS away from the seat of the explosion after
20 balancing all the relevant risks and other factors that
21 were known at the time.
22 NWAS believes that this was a reasonable decision
23 based on the information available at the time.
24 NWAS does not dispute that there was more than one
25 approach that could have been adopted by the first

1 paramedics to arrive on scene when confronted by the
2 chaos and devastation caused by the explosion. The
3 dangers of judging decisions with the benefit of
4 hindsight are obvious. An extremely difficult decision
5 had to be made in a very short period of time based on
6 the limited information that was available. The
7 decision that was made was to prioritise the quickest
8 possible extrication of patients from the City Room to
9 enable assessment and care on the station concourse in
10 a more suitable environment and where it was easier to
11 start the process of transporting patients to hospitals.
12 Such a decision calls for rapid assessment based on
13 a number of factors. There was a clear need to
14 establish a system for patient prioritisation,
15 assessment and appropriate care and intervention in the
16 quickest, most effective and sustainable manner in
17 circumstances where residual risks to both patients and
18 ambulance personnel could not be discounted.
19 Those risks included potential damage to the
20 structure of the building caused by the detonation of
21 the bomb. Concerns remained in relation to a secondary
22 device or an active shooter. The well-being and safety
23 of front line responders is also a factor that always
24 has to be considered. This is not only for their
25 benefit but also to ensure that they can continue to

1 operate for the benefit of the injured. All of these
2 matters had to be considered in the context of a process
3 whereby patients were already being moved out of the
4 City Room to the station concourse.
5 Through the heroic efforts of many of those present,
6 including members of the public, that process appeared
7 to be working quickly and efficiently.
8 After balancing all of the relevant factors, the
9 decision not to deploy more HART operatives to the
10 City Room but to prioritise the continued extrication of
11 patients from that area to a casualty clearing station
12 on the station concourse as quickly as possible was, in
13 NWAS's view, a reasonable decision amongst one of
14 a number of reasonable decisions available at the time.
15 With the benefit of hindsight, NWAS acknowledges
16 that further HART operatives could have been deployed to
17 the City Room upon their arrival together with a sector
18 commander located at the entrance to that area, with the
19 advanced paramedic redeployed to the station concourse
20 thereafter.
21 However, NWAS currently remains of the view that the
22 decision for the advanced paramedic to return to the
23 City Room with the support of the HART operatives and
24 for other members of that team to assist with
25 establishing the CCS on the station concourse was

1 reasonable when judged in the incredibly challenging
2 circumstances that existed at that time.
3 This is an issue that NWAS will continue to consider
4 carefully as the evidence emerges during the hearings.
5 Whilst its overall operational response to the
6 attack was quick, effective and adequate, NWAS
7 acknowledges that this is subject to a number of
8 important exceptions. We now address those in turn.
9 Allocation of roles. The following operational
10 roles were not allocated in accordance with the MIRP,
11 the relevant action cards and other expectations: safety
12 officer, equipment officer, a tactical adviser for the
13 operational commander, and loggists for all commanders.
14 The allocation of a safety officer could have
15 enhanced the process of risk assessment and other
16 operational decisions at the scene. It should be noted,
17 however, that a safety officer, whose responsibilities
18 included specific consideration for the welfare of
19 ambulance personnel, might have insisted on removing all
20 paramedics from the City Room, especially if they had
21 been notified of the Plato declaration. That said,
22 a safety officer could have supported the operational
23 commander and others in a number of important respects.
24 The allocation of equipment officer would have
25 contributed to the knowledge of the operational

1 commander as to the amount and type of equipment and
2 supplies available on ambulance vehicles, both present
3 and elsewhere in the fleet. The extent to which it is
4 possible to conclude that this would have materially
5 changed the operational decisions made at the time
6 remains unclear, but it is accepted that this role ought
7 to have been established.
8 The allocation of a tactical adviser for the
9 operational commander would have provided him with more
10 support when making decisions and could have improved
11 communication with other agencies.
12 It is also accepted that loggists should have been
13 available to all commanders as part of the response to
14 this incident to assist with decision-making at the time
15 and to contribute to post-incident recovery and
16 learning.
17 Radio and telephone communications. Whilst
18 inter-agency communication is dealt with under term of
19 reference 5.4 below, it is appropriate to address issues
20 around radio and telephone communications in this part
21 of the opening statement. The use of specific talk
22 groups, including open and point-to-point features, was
23 not properly considered or established so as to assist
24 communications with NWAS and with other agencies.
25 Dedicated telephone lines for outgoing calls only,

1 which could have further assisted communication to and
2 from the EOC and between the emergency services were
3 also not considered or established and ought to have
4 been.
5 Equipment and supplies. NWAS maintained a large
6 fleet of vehicles containing a range of equipment, drugs
7 and other medical supplies. Those vehicles are located
8 at various sites across the region and many require
9 deployment using trained staff from specialist teams.
10 The extent to which deployment of such resources would
11 have made any material difference to the operational
12 decisions will be a matter for careful consideration.
13 The early deployment of national capability mass
14 casualty vehicles, NCMCVs, is unlikely to have made any
15 material difference to the NWAS response to this
16 incident.
17 However, it is acknowledged that public support
18 units, PSUs, are each equipped with 10 canvass
19 stretchers, which could have been utilised to assist
20 with the extrication of patients from the City Room. If
21 those vehicles had been deployed, so as to arrive during
22 the early stages of the response.
23 The operational commander considered that the flow
24 of patients to the CCS from the City Room to the station
25 concourse was working effectively, but it is accepted

1 that purpose-designed stretchers would have been
2 preferable to advertising boards and crowd barriers.
3 It is also acknowledged that proper consideration was
4 not given to the existence of such resources as it
5 should have been and some NWAS personnel were not fully
6 aware of the equipment that was carried on all of the
7 vehicles.
8 It should be noted that PSUs are a HART resource.
9 The first HART operatives arrived at the scene directly
10 from another incident between 23.05 and 23.10 hours,
11 with the remaining part of the team arriving at
12 23.22 hours.
13 Plato. When Plato is declared, everyone apart from
14 armed police must immediately leave areas designated as
15 hot zones. GMP declared Plato at 22.47 hours and the
16 NWAS tactical commander was notified of the same at
17 00.18 hours. At the time of this incident, the
18 expectation would have been and remains that the
19 tactical commander would notify the operational
20 commander as soon as a Plato declaration is notified to
21 NWAS.
22 During this incident, the tactical commander took
23 the view that the available evidence did not warrant
24 Plato status. She carried out her own assessment, which
25 included the absence of an active shooter or any other

1 similar ongoing risks, and did not notify the NWAS
2 operational commander at scene until 00.54 hours. It is
3 acknowledged that the decision to delay notifying other
4 NWAS personnel, notably the operational commander, was
5 not strictly in accordance with what was expected of
6 a tactical commander who should have also considered
7 discussing the issue with a strategic commander.
8 However, it is likely that the NWAS tactical commander's
9 decision actually enhanced rather than hindered the care
10 that was provided to patients at scene.
11 NWAS suggests that this reflects the ability of one
12 of its senior commanders to challenge decisions and
13 assessments made by others where appropriate.
14 Rendezvous point. Ambulance crews were given
15 different versions of information on voice calls and to
16 their mobile data terminals as to the location of the
17 RVP. At 22.35 hours, the RVP was identified as
18 Thompson Street Fire Station by the NWAS tactical
19 commander. During the course of events the RVP was then
20 notified to some resources as being Hunts Bank. On the
21 evidence available, NWAS takes the view that there was
22 some ambiguity as to the location of the RVP, but it
23 does not appear to have made any material difference to
24 its response.
25 It is noted that when the emergency operations

1 centre received a telephone call from GMP Control at
2 23.05 hours requesting as many ambulances as possible to
3 the front of the arena, vehicles were dispatched in
4 groups from the RVP to the arena as required by the
5 ambulance commanders at scene.
6 Walking wounded. Whilst not a formal requirement of
7 NHS EPRR core standards for NWAS, it is acknowledged
8 that both operational and tactical commanders could have
9 given more consideration to the welfare and management
10 of those described as walking wounded. There ought to
11 have been coordination with the other emergency
12 services, which may have led to the use of voluntary aid
13 support, such as the British Red Cross. However, the
14 focus in the early response stages was quite properly on
15 those who were more seriously injured and the need to
16 save life.
17 Term of reference 5.4. The inter-agency liaison,
18 communication and decision-making between the relevant
19 emergency services and with others, including their
20 adequacy and compliance with relevant planning,
21 preparation, policies, systems and practices.
22 NWAS has adopted the joint decision model in common
23 with other responding agencies. Successful
24 interoperability relies on close working relationships
25 with other agencies and NWAS has long enjoyed good

1 relationships with all the other emergency services
2 in the area it serves, including the Greater Manchester
3 area. It is imperative that these relationships are
4 maintained and improved as far as possible so as to
5 continue to improve their abilities to respond to major
6 incidents in the future.
7 In addition to the other emergency services, NWAS
8 also works closely with other ambulance services,
9 hospitals and the National Health Service. NWAS
10 contributed to the production of the Greater Manchester
11 Multi-agency Generic Response Plan by the GMRF and is
12 also part of the Local Health Resilience Partnerships
13 which was established to consider a range of local
14 health issues at a strategic level. One important
15 development to come out of the LHRP was the mass
16 casualty distribution plan used so effectively in
17 response to this incident.
18 NWAS works closely with colleagues from other
19 emergency services. However, it is acknowledged that
20 inter-agency liaison, communication and decision-making
21 was one of the main inadequacies of the NWAS response.
22 Declaration of major incident. As already noted,
23 NWAS declared a major incident at 22.46 hours. However,
24 whilst NWAS ensured this information was shared with its
25 own personnel, steps were not taken to ensure that it

1 was shared with other agencies as expected.
2 METHANE reports. Paramedics at the scene provided
3 METHANE reports to their own control room and also
4 communicated with the other agencies and provided
5 information including number of casualties and
6 ambulances attending. However, NWAS did not share any
7 formal METHANE reports with other agencies as expected.
8 FCP. There was no FCP established by the main
9 emergency services as expected. The operational
10 commander was positioned at the entrance to the station
11 concourse and took the view that the operational plan
12 was being implemented effectively without reference to
13 the other agencies. It is noted that the experts
14 believe that there was a reasonable expectation that the
15 FCP would be created around the area in which the NWAS
16 operational commander was operating. However, NWAS
17 accepts that a formal FCP could have enhanced the
18 response to the incident in a number of ways, including
19 by improving joint situational awareness, consideration
20 of zoning and risk assessment.
21 Multi-agency JESIP working. During a response to
22 a major incident, all emergency services and other
23 relevant agencies share a responsibility to establish
24 regular meetings to facilitate greater situational
25 awareness and joint risk assessment in accordance with

1 the JESIP principles. No multi-agency JESIP huddle
2 meetings took place at the scene of the incident until
3 00.59 hours. Ambulance commanders ought to have taken
4 steps to ensure that such meetings took place earlier
5 than they did.
6 Airwave communications. As noted above, the ability
7 to establish both open and point-to-point radio
8 communications with other agencies existed at the time
9 of this incident but was not properly considered as
10 expected. A multi-agency airwave was established by GMP
11 but it was not utilised by NWAS in its response to this
12 incident as it should have been.
13 GMFRS. The extent to which GMFRS could have
14 enhanced the overall emergency response to this incident
15 remains difficult to assess. However, it is
16 acknowledged that NWAS did not properly consider
17 requesting support from GMFRS during its response to the
18 incident as expected. When the Chief Fire Officer
19 directly contacted the NWAS operational commander to
20 request what support was required, the NWAS commander
21 answered as best as he could in the circumstances.
22 It is accepted that the request did not follow the
23 established command structures and that this ought to
24 have been made clear at the time.
25 Co-location of strategic and tactical commanders.

1 The NWAS strategic commander co-located with the
2 tactical commander, which was not what was expected.
3 Multi-agency liaison and information sharing at tactical
4 and strategic level through the TCG and SCG could also
5 have been improved.
6 Term of reference 5.5, the impact, if any, of any
7 inadequacies in planning, preparation and/or the
8 emergency response, including whether any inadequacies
9 undermined the ability of the response to save life
10 and/or contributed to the extent of the loss of life
11 that occurred.
12 NWAS is currently of the view that the majority of
13 its response to this incident was good. The experts
14 commissioned by the inquiry to consider the likelihood
15 of survivability have concluded that the injuries of all
16 but one person were unsurvivable with current advanced
17 medical treatment, even if speedier admission to
18 hospital had taken place. In relation to the remaining
19 individual, the experts' analysis found that he could
20 have potentially survived with earlier treatment,
21 application of effective bilateral tourniquets, but at
22 this stage it is not possible to say whether such early
23 treatment could have been provided.
24 Whilst NWAS accepts that mistakes and other
25 inadequacies hampered, at least to some extent, its

1 response to this incident, they did not undermine the
2 ability of the response to save life or contribute to
3 the extent of the loss of life that occurred.
4 Term of reference 7.3, survivability including
5 whether any inadequacies in the emergency response
6 contributed to individual deaths and/or whether any of
7 the deaths could have been prevented.
8 This part of the terms of reference relates to the
9 immediate cause and mechanism of each death. As
10 indicated above, the position of NWAS is that the
11 evidence disclosed to date does not support a conclusion
12 that any of the mistakes or inadequacies in relation to
13 its response to this incident contributed to any
14 individual deaths.
15 Further, and for the avoidance of doubt, NWAS does
16 not consider that it is possible to conclude that any of
17 the deaths could have been prevented by reference to any
18 of those mistakes or inadequacies.
19 Sir, in conclusion, all of those from NWAS who
20 responded to the incident did their utmost to provide
21 the best care and support they could in the most
22 distressing conditions, often putting their own safety
23 secondary to that of others. Overall, the majority of
24 the response by NWAS was good. However, some mistakes
25 were made by NWAS and its response to this incident

1 could have been enhanced in a number of respects. NWAS
2 regrets this and the fact that not all of the actions
3 and decisions were taken as would have been expected.
4 NWAS is a learning organisation and will seize any
5 opportunity to improve the care and other services it
6 provides to the people of Manchester, and the whole area
7 it covers, as identified through this inquiry process.
8 Finally, NWAS would like to take this opportunity to
9 condemn those responsible for this attack, to express
10 its gratitude to all those who helped in the response,
11 including its own staff, the other emergency agencies
12 and members of the public, and finally, and most
13 importantly, to pay tribute to the families of the
14 deceased and to the survivors for their continued
15 bravery and dignity.
16 SIR JOHN SAUNDERS: Thank you, Ms Roberts.
17 Mr Greaney.
18 MR GREANEY: Sir, that completes the opening statements that
19 were scheduled for today. The proposed timetable for
20 tomorrow, which is the final day of opening statements,
21 is as follows.
22 At 9.30 am we will hear from Ms Blackwell on behalf
23 of NHS England. At 10 am or thereabouts, we will hear
24 from Mr Warnock on behalf of the Greater Manchester
25 Combined Authority, GMCA. At about 11.30 am, we will

1 hear from Mr Smith on behalf of North West Fire Control,
2 NWFC. At about 12.45, we will hear from Mr Browne on
3 behalf of the University of Salford. And finally, at
4 about 2.15 pm, we will hear from Ms McGahey on behalf of
5 the Secretary of State for the Home Department.
6 SIR JOHN SAUNDERS: Thank you.
7 MR GREANEY: Thank you, sir.
8 (4.51 pm)
9 (The inquiry adjourned until 9.30 am on
10 Wednesday, 30 September 2020)
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