

OPUS2

Manchester Arena Inquiry

Day 13

September 30, 2020

Opus 2 - Official Court Reporters

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1 Wednesday, 30 September 2020
 2 (9.30 am)
 3 SIR JOHN SAUNDERS: Mr Greaney.
 4 MR GREANEY: Good morning, sir. First today we'll hear from
 5 Ms Blackwell on behalf of NHS England.
 6 SIR JOHN SAUNDERS: Ms Blackwell, good morning.
 7 Opening statement by MS BLACKWELL
 8 MS BLACKWELL: Sir, this is the opening statement on behalf
 9 of NHS England. I'm instructed and greatly assisted by
 10 Gerard Hanratty and Helen Simm of Browne Jacobson
 11 Solicitors .
 12 The devastating events that unfolded on 22 May 2017
 13 caused unimaginable suffering to the bereaved families
 14 and friends of those who tragically died in the bombing
 15 as well as the survivors . NHS England would like to
 16 express its deep and profound sorrow to all of those
 17 affected by these events. The appalling consequences
 18 rippled outwards from the time of the bombing and
 19 continue to be felt today.
 20 No one listening to the commemorative hearings
 21 delivered to this inquiry over the course of the past
 22 2 weeks could have failed to have been emotionally moved
 23 by them. It has been an honour to get to know more
 24 about those who died through the generous sharing of
 25 memories by their loved ones.

1

1 NHS England understands that the bereaved, the
 2 survivors and others affected from within and outside of
 3 the Greater Manchester community must be provided with
 4 the clearest understanding of what happened on the night
 5 of 22 May 2017, of the background to the bombing and
 6 what lessons have been and can be learned to reduce the
 7 risk of such tragedy being repeated.
 8 This opening statement is made in response to your
 9 request, sir, of 20 January of this year and in
 10 accordance with that request this statement is aimed at
 11 the informed listener and is composed of plain and
 12 direct language. It addresses each applicable term of
 13 reference so far as NHS England's responsibility is
 14 concerned.
 15 I would like to begin with an explanation of the
 16 organisation that is NHS England in an effort to assist
 17 all core participants to understand the framework within
 18 which it functions and its connection to other relevant
 19 agencies .
 20 NHS England oversees the budgeting, planning,
 21 delivery and day-to-day operation of the commissioning
 22 side of the National Health Service in England, as set
 23 out in the Health and Social Care Act 2012. Funding is
 24 allocated by NHS England to clinical commissioning
 25 groups who in turn distribute funding to NHS trusts and

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1 foundation trusts as well as community healthcare and
 2 primary healthcare providers for the provision of
 3 healthcare services specific to their local area.
 4 In addition to commissioning responsibilities ,
 5 NHS England is a category 1 responder under the Civil
 6 Contingencies Act 2004, the Contingencies Act, and has
 7 accountability under the NHS Act 2006, as amended, to
 8 the Secretary of State for Health and social care .
 9 The NHS Act requires NHS England to ensure that the
 10 clinical commissioning group and each service provider
 11 is properly prepared for dealing with a relevant
 12 emergency; that is an emergency which may affect either
 13 organisation .
 14 The generic emergency preparedness resilience and
 15 response, EPRR, role and responsibilities of NHS England
 16 include leading the planning for, responding to and
 17 recovery of the NHS in the event of an emergency.
 18 NHS England developed the EPRR framework 2015, the EPRR
 19 framework, to provide a structure within which all
 20 NHS-funded organisations could meet the requirements of
 21 the Civil Contingencies Act and the NHS Act as well as
 22 the NHS standard contract. This also includes
 23 organisations which are not designated under the Civil
 24 Contingencies Act, such as mental health trusts .
 25 The EPRR framework sets out strategic national

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1 guidance to be followed by, amongst others, NHS trusts
 2 and foundation trusts as well as providers of NHS-funded
 3 services . It should be noted, sir, that as from
 4 1 April 2019, NHS England and NHS Improvement have been
 5 working together as a single organisation to better
 6 support the NHS to deliver improved care for patients .
 7 Whilst the two organisations are still separate
 8 statutory bodies, they now have a single executive
 9 leadership team and a single operating model enabling
 10 a whole-system approach to implementing the long-term
 11 plan .
 12 NHS England is represented on each local health
 13 resilience partnership and local resilience forum to
 14 ensure integration of plans across the regions which
 15 deliver a unified NHS response. Under the
 16 Greater Manchester Accountability agreement
 17 NHS England's functions in relation to EPRR in
 18 Greater Manchester are discharged through the
 19 Greater Manchester Health and Social Care Partnership ,
 20 the partnership .
 21 Joint planning for health incidents takes place
 22 through the local health resilience partnership which
 23 supports the health sector's contribution to
 24 multi-agency planning through the local resilience
 25 forum. The Greater Manchester Resilience Forum, as you

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1 know, sir, sits at the heart of the civil protection
2 arrangements in Greater Manchester. A number of core
3 participants to this inquiry are also members of the
4 Greater Manchester Resilience Forum and these include
5 the North West Ambulance Service, the Greater Manchester
6 Police and the British Transport Police.

7 I would now like to say something about the duty of
8 candour which I know is close to the hearts of families
9 in this inquiry. In healthcare, the duty of candour is
10 a statutory duty, a duty to be honest and open with
11 patients or their families when an unexpected incident
12 within an NHS organisation appears to have led to or
13 could have led to serious harm.

14 This duty applies to all NHS bodies under the Health
15 and Social Care Act 2008 (Regulated Activities)
16 Regulations 2014, which came into force November 2014.

17 NHS England has a legal obligation to be transparent
18 and seek improvement wherever lessons can and ought to
19 be learned. It is in this spirit that NHS England
20 applied for core participant status in this inquiry and
21 has sought to engage positively with the inquiry team
22 throughout.

23 NHS England has complied fully with all disclosure
24 requests made of it and will continue to support the
25 inquiry.

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1 I now turn to address the terms of reference and
2 planning and preparation for responding to terrorist and
3 mass casualty incidents, term of reference 5(i).

4 Through the Greater Manchester Resilience Forum the
5 various agencies share information, coordinate and
6 collaborate to develop multi-agency plans. The
7 partnership leads on the development of the mass
8 casualties plan, which sets out that in the event of
9 a mass casualties incident, NHS England will exercise
10 its overall strategic and tactical command of NHS
11 resources in Greater Manchester through the partnership.
12 The partnership will access regional and national health
13 assistance as required.

14 The mass casualties plan also sets out arrangements
15 for training and exercise. Greater Manchester
16 Resilience Forum partners come together to form the
17 Training and Exercise Coordinating Group, which reviews
18 the priorities for training and exercising set by the
19 forum and leads in their development.

20 One such exercise was Exercise Socrates, also
21 referred to as Operation Socrates, held on
22 29 March 2017. This was a major incident exercise
23 jointly designed, developed and facilitated by Public
24 Health England and the partnership EPRR team.

25 It was one of a series of exercises funded by the

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1 Department of Health and Social Care. The aim was to
2 test the Greater Manchester Trauma Network plan in
3 response to a mass casualty incident involving traumatic
4 injuries in the Greater Manchester health system in
5 collaboration with partner agencies.

6 The scenario in this exercise was a simultaneous
7 suicide bombing and marauding terrorist firearm attack,
8 and the objectives were as follows.

9 To test the management and coordination of services
10 at the incident scene.

11 To explore the operational capabilities of the
12 Greater Manchester health system to manage a mass
13 casualty incident using the Greater Manchester Mass
14 Casualties Framework.

15 To promote an understanding of engagement between
16 the NHS and their multi-agency partners of the wider
17 implications of mass casualty events.

18 To explore the implications for mutual aid within
19 the region and the wider health systems.

20 To test the Greater Manchester health system
21 Command, Control, Communication and Coordination
22 procedures in coordination with the regional Command,
23 Control, Communication and Coordination procedures in
24 response to a mass casualty incident.

25 To test decision-making and recording and finally to

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1 identify any learning for future development and
2 improvements to inform the production of a network mass
3 casualty distribution plan.

4 Participants in this exercise were, amongst others,
5 NHS England, represented through the partnership, NWAS,
6 clinical commissioning groups, and various hospital
7 trusts. Exercise Socrates was evaluated in two ways: by
8 observers whilst the scenario was played out and during
9 subsequent debriefs. An exercise report was drafted as
10 a result of which it was the responsibility of EPRR
11 leads to produce an action plan through which an agreed
12 recommendation could be implemented and/or developed,
13 and this was done.

14 The setting-up and carrying-out of this exercise,
15 sir, was timely. Several witnesses who have given
16 written evidence to the inquiry speak to its importance
17 in providing them with a framework upon which they were
18 able to draw as matters unfolded on 22 May. To that
19 extent this exercise was a success and served its
20 purpose in increasing the knowledge and confidence of
21 those involved during the aftermath of the bombing.

22 This was not a unique exercise. Other similar
23 exercises had taken place in 2015 and 2016.

24 In preparation for this inquiry and following the
25 service of the experts' reports, core participants were

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1 given the opportunity to provide questions based upon
 2 the contents of those reports . One such question asked
 3 of the ambulance experts by the families focused upon
 4 Socrates . They asked:
 5 "Is there positive learning from the benefits of
 6 Operation Socrates, particularly in terms of the desired
 7 frequency of training exercises of this kind?"
 8 In response to this question, the ambulance experts
 9 agreed that this positive learning should be encouraged
 10 and stated that:
 11 "It would be beneficial to the NHS to consider the
 12 benefits from ensuring that such exercises are completed
 13 regularly with the appropriate frequency."
 14 This is being done. Exercise Socrates 2 took place
 15 on 18 September 2018. The scenario was a marauding
 16 terrorist attack, similar to that of the original
 17 exercise . The overall purpose was to support the
 18 further development of response plans, planning the
 19 Greater Manchester Trauma Network, and the ability of
 20 constituent organisations to cope with a mass casualty
 21 incident .
 22 Through testing casualty dispersal , reporting and
 23 communication tools, command structures and coordination
 24 of the response, lessons were identified to further
 25 improve the response to a mass casualty incident .

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1 Socrates 2 was also an opportunity to add to the
 2 national learning from the other trauma network
 3 exercises and further explore outcomes from the previous
 4 Socrates exercise and the arena attack .
 5 This time, the planning groups sought to include
 6 additional aspects such as resources , including
 7 specialist equipment and blood, the role of the hospital
 8 ambulance liaison officers , HALOs, and increasing
 9 hospital capacity .
 10 In November 2017, the NHS had introduced the concept
 11 of operations for the management of mass casualties to
 12 define a framework of response in which NHS England may
 13 direct NHS resources in the event of a mass casualty
 14 incident . This states that:
 15 "During a major incident , as defined in the
 16 NHS England EPRR framework, which results in mass
 17 casualties , organisations will be expected to deliver
 18 emergency care to those affected . In addition , it may
 19 be necessary for services to consider enhanced care or
 20 the expansion of these functions beyond normal service
 21 provision to deal with the surge in patients . All
 22 organisations are expected to ensure that they maintain
 23 appropriate safeguarding measures at all times,
 24 especially for incidents involving children or persons
 25 of interest ."

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1 So an additional aim of Socrates 2 was to orientate
 2 staff to this concept of operations and that was done.
 3 This exercise was evaluated in the same ways as
 4 previously done and was also well - received .
 5 Exercise Socrates 3 was held on 27 March 2019 to
 6 explore the practicalities of the ongoing acute hospital
 7 care phase and provision of psycho-social support
 8 following a mass casualties incident .
 9 This time, the exercise participants were presented
 10 with a similar scenario involving a marauding terrorist
 11 attack. The objectives focused on learning from the
 12 previous exercises and recommendations from the Kerslake
 13 Review, which, as you know, sir , was published following
 14 the Manchester Arena attack.
 15 The planning group also wanted to include aspects
 16 such as accelerated discharge procedures for acute
 17 hospitals and identify areas for improvement relating to
 18 self - presenters and psychological reports for
 19 casualties . The opportunity to include these aspects
 20 had not arisen during the previous two exercises .
 21 Socrates 3 was well-received by participants , who
 22 engaged fully with the scenario and subsequent
 23 discussions , and the participants noted that this was
 24 a useful exercise to allow discussion and promote
 25 further learning around the ongoing response to a mass

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1 casualty incident .
 2 Going forwards, these exercises will be arranged
 3 regularly and with appropriate frequency .
 4 The immediate and operational response to the
 5 detonation of the explosive device, terms of reference
 6 3(iii) and 5(iii), and the inter -agency liaison
 7 communication and decision-making, term of
 8 reference 5(iv).
 9 On-call personnel are available at every moment of
 10 the day and night to ensure that NHS England can
 11 effectively discharge its duties as a category 1
 12 responder under the Civil Contingencies Act. The role
 13 of the First On-call is to establish the nature of the
 14 alert and ensure that the most appropriate and effective
 15 management is established as early as practicable . The
 16 role of the Second On-call is take effective action to
 17 manage a critical and/or major incident either
 18 singularly or in conjunction with the clinical
 19 commissioning groups or multi-agency partners as
 20 appropriate .
 21 On 22 May 2017, the First On-call was Ben Squires,
 22 held of primary care operations, and the Second On-call
 23 was Colin Kelsey, head of urgent and emergency care
 24 transition and EPRR at that time.
 25 Both had an extremely strong record of training and

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1 exercising prior to the Manchester Arena attack. The
 2 immediate focus on the night was to establish the
 3 context and situational awareness of the incident and
 4 ensure that the NHS responders had the necessary
 5 resources and support to operate safely and effectively .
 6 This was done, in close collaboration with NWAS and
 7 multi-agency partners at the GMP Headquarters.
 8 At 23.10 hours the partnership team was alerted to
 9 the explosion at the Manchester Arena by NWAS and
 10 a major incident was declared at 23.13 hours.
 11 Colin Kelsey assumed the strategic commander role and
 12 attended the NWAS Regional Operations Coordination
 13 Centre to liaise with their strategic command.
 14 On arrival , he confirmed the activation of all
 15 Greater Manchester acute hospitals ' emergency
 16 departments and agreed the use of the Greater Manchester
 17 framework for patient dispersal in a mass casualty
 18 event. He later attended the Greater Manchester Police
 19 Force Headquarters to represent the NHS in the
 20 multi-agency response.
 21 The partnership command team worked closely with
 22 NWAS and the hospital emergency departments to
 23 coordinate the NHS throughout the night, which included
 24 liaison with other partners such as Transport for
 25 Greater Manchester, the Greater Manchester Fire and

1 Rescue Service and the Royal Oldham mortuary.
 2 Although a major incident standby was declared at
 3 05.10 hours on 23 May, Colin Kelsey remained at
 4 Greater Manchester Police headquarters for several
 5 hours, arranging for Greater Manchester providers to
 6 receive supportive calls and visits from VIPs.
 7 Relevant policies , systems and practices , term of
 8 reference 5(ii) , including inter -agency liaison , term of
 9 reference 5(iv) , and the impact of any inadequacies ,
 10 term of reference 5(v) .
 11 As you know, sir , command and control within the
 12 emergency services is exercised through a three - tier
 13 system categorised as the Gold/ Silver /Bronze hierarchy
 14 of command. This follows the Cabinet Office guidance,
 15 "Concept of Operations", which refers to these three
 16 tiers as: strategic , Gold; tactical , Silver ; and
 17 operational , Bronze. A commander is said to have a span
 18 of control commensurate with their particular tier of
 19 command or functional role .
 20 NHS England represents the NHS at the strategic
 21 level and attends the strategic coordinating group whose
 22 role is to set strategic direction , coordinate responder
 23 agencies and prioritise resources and, as a category 1
 24 responder, NWAS also attends such meetings.
 25 It is the role of the Tactical Coordination Group to

1 interpret strategic guidance, develop tactical plans and
 2 coordinate activities and assets . The hospital trusts ,
 3 for example, as well as NWAS occupy the tactical tier .
 4 Operational responders execute the tactical plan ,
 5 command a single service response and coordinate
 6 actions . The clinicians within the hospital trusts and
 7 paramedics occupy the operational tier .
 8 Prior to the Manchester attack there were several
 9 multi-agency plans in place involving NHS England acting
 10 through the partnership . These covered all relevant
 11 policies , systems and practices relating to an attack of
 12 the kind that took place at the Manchester Arena. These
 13 included the identification of locations and procedures
 14 for establishing and operating a suitable environment
 15 for managing such mass casualty emergencies.
 16 And following the Manchester Arena attack, there
 17 were a series of debriefs . In addition to the single
 18 agency debriefs , there were several multi-agency
 19 debriefing sessions in accordance with the mass
 20 casualties plan in order to encourage openness and
 21 promote learning .
 22 NHS England also facilitated clinical reviews , the
 23 aim of which was to promote discussion between NHS
 24 colleagues about the clinical response to the attack and
 25 the management of patients in an open environment to

1 promote learning and development. Particular expertise
 2 was shared in relation to blood-borne viruses and the
 3 treatment of blast injuries .
 4 The final Greater Manchester multi-agency debrief
 5 report of December 2018 makes clear that responders felt
 6 that overall preparedness was good. Further, that the
 7 thorough risk assessments led by the partnership had
 8 enabled the impacts to be fully understood, the correct
 9 capabilities to be put in place, and the response of the
 10 combined agencies on the night and in the days which
 11 followed to be comprehensive and very effective .
 12 Survivability , including whether any inadequacies
 13 in the emergency response contributed to individual
 14 deaths and/or whether any of the deaths could have been
 15 prevented, term of reference 7(iii) .
 16 Of the 22 who died, three individuals were
 17 pronounced dead at hospital . John Atkinson and
 18 Georgina Callander were both taken by ambulance to the
 19 Manchester Royal infirmary . Saffie -Rose Roussos was
 20 taken by ambulance to the Royal Manchester Children's
 21 Hospital . This was in accordance with the arrangements
 22 which had been planned for within the Greater Manchester
 23 framework for patient dispersal in a mass casualty
 24 event .
 25 Of these three, only John Atkinson's injuries are

1 said to have been potentially survivable . In terms of
2 NHS clinicians , we expect that the inquiry will hear
3 repeated praise of the dedication , commitment,
4 determination and diligence shown by all of those
5 involved in attempting to save the lives of those who
6 died.

7 Within moments of the arena attack happening, there
8 was an inpouring of clinicians , nurses and care
9 providers to these and other hospitals , all of whom
10 stopped what they were doing and rushed to their place
11 of work to see what they could do to help.

12 NHS England is an organisation which aims to
13 commission a comprehensive health service , available to
14 all , irrespective of gender, race, disability , age,
15 sexual orientation , religion or belief . It aspires to
16 the highest standards of excellence and professionalism
17 in the provision of high quality care that is safe,
18 effective and focused on patients ' needs.

19 NHS England works across organisational boundaries
20 and in partnership with other organisations in the
21 interests of patients , local communities and the wider
22 population . It is an organisation that is populated
23 with those who seek to save, cure, nurse and protect .

24 Whilst many within the NHS have been affected by the
25 events of 22 May 2017, it is those whose lives have been

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1 cut short and irrevocably damaged or altered that are
2 rightly at the centre of this public inquiry .

3 SIR JOHN SAUNDERS: Thank you, Ms Blackwell.

4 MR GREANEY: Sir, next we'll hear from Mr Warnock on behalf
5 of the Greater Manchester Combined Authority and he will
6 be dealing with the position of the Greater Manchester
7 Fire and Rescue Service .

8 SIR JOHN SAUNDERS: Thank you.

9 Mr Warnock.

10 Opening statement by MR WARNOCK

11 MR WARNOCK: Sir, I appear on behalf of the
12 Greater Manchester Combined Authority, as you've just
13 heard, along with my learned friend Ms Johnson. And
14 Ms Johnson had hoped to be present today, but for very
15 good reason has not attended, although she is watching
16 remotely.

17 Sir, I'm instructed by Berrymans Lace Mawer
18 Solicitors , and in court today with me I have Paul Tarne
19 of BLM and also the newly in post chief fire officer of
20 the Greater Manchester Fire and Rescue Service,
21 Mr Dave Russell.

22 SIR JOHN SAUNDERS: Thank you.

23 MR WARNOCK: Sir, as you've heard, the GMCA represents the
24 Greater Manchester Fire and Rescue Service, which
25 I shall refer to as "the GMFRS". On behalf of the GMCA

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1 and the GMFRS, we express our profound sympathy for the
2 families of those who died in what was a senseless ,
3 callous and horrific act of murder.

4 We pay tribute to the dignified and moving way in
5 which the families have honoured their loved ones over
6 the last 2 weeks. We have appreciated hearing and
7 watching the celebrations of the lives , interests and
8 aspirations of each of the 22 individuals who died in
9 this attack, and we recognise the bravery of those who
10 have shared so personally the immeasurable loss suffered
11 by the many people who loved them.

12 Sir, we also acknowledge the impact of this dreadful
13 event on those who were injured in the attack, many of
14 whose lives have been permanently changed by the
15 consequences of the explosion . We also recognise that
16 some have suffered both terrible personal injury and
17 also lost loved ones.

18 The families and injured deserve answers to the
19 questions which they have and we will do all we can to
20 help you provide them.

21 In relation to the Fire Service response on the
22 night, we say at the outset that GMFRS accepts and
23 agrees with the conclusions of the fire and rescue
24 expert, Mr Hall, that its initial actions in response to
25 the arena bombing were neither adequate nor effective .

19

1 It is unacceptable that it took over 2 hours for the
2 fire and rescue service to attend the arena. On behalf
3 of GMFRS we would like to say to the families and
4 victims that we are sorry that this happened.

5 The inquiry will hear evidence from many individuals
6 and individual GMFRS witnesses who still have profound
7 feelings of frustration and deep anguish that they were
8 not there to help. It is important that the reasons for
9 that failing are fully investigated . GMFRS would like
10 you, Mr Chairman, and the families to know that it
11 welcomes the aim of this inquiry to get to the truth of
12 what happened on the evening of the attack and to
13 scrutinise whether the measures GMFRS has put in place
14 since the attack are sufficient to protect Manchester
15 into the future .

16 We have set out in our written opening in some
17 detail an analysis of what we believe went wrong.
18 We have also filed a schedule of responses to the expert
19 report . Most of the experts' criticisms are either
20 accepted in full or in part, and where neutral, this is
21 because it touches areas where at present we do not
22 consider the evidence yields a clear answer.

23 In this oral opening, I am going to concentrate on
24 what we consider to be the key points . That is not to
25 say that other issues addressed in our written opening

20

1 are unimportant, but we will focus on what we consider
2 to be the main issues.

3 I will start by setting out some themes that we have
4 identified as explaining some of the difficulties
5 encountered in the response of the Fire Service. I will
6 then follow the terms of reference that apply to the
7 emergency response.

8 The first theme is incidents in the UK and Europe
9 in the months and years prior to the arena attack meant
10 national counter-terrorism focus prior to the bomb had
11 been on multi-centred marauding attacks. The fed into
12 local training and appears to have influenced the
13 decision-making of the duty national inter-liaison
14 officer, the NILO, and others across all the emergency
15 services to assume that other components to the attack
16 were likely.

17 This assumption combined with and perhaps
18 contributed to a failure to challenge and interrogate
19 information that tended to confirm that scenario.

20 Secondly, multi-agency training before the arena
21 attack that tested resilience for marauding terrorist
22 firearms attacks, or MTFA incidents, started from the
23 position of there being no rendezvous points, RVPs, and
24 forward command points. That failed to test a real
25 world situation where an event occurs spontaneously.

21

1 There were failures in communication, in particular
2 with other agencies and their control rooms.

3 Fourthly, there was an unforeseen gap in incident
4 command within the GMFRS, delaying these difficulties
5 being solved as quickly as they might have been.

6 Fifthly, the system in place expected too much of
7 one particular GMFRS role, the duty NILO, a potential
8 single point of failure.

9 And sixthly, we also question in paragraph 6 of our
10 written opening whether there may have been a lack of
11 embedded understanding in other organisations of what
12 help a fire and rescue service may provide in an
13 incident of this nature. Did responders and other
14 agencies think that because there was no fire, there was
15 no pressing need for a GMFRS response because they did
16 not have knowledge or understanding that the GMFRS is
17 not just a fire service but a rescue service as well?

18 The combined effect of these themes was a lack of
19 situational awareness on the part of the GMFRS. From
20 its first notification of the incident by North West
21 Fire Control, NWFC, GMFRS's response was driven by
22 a misinformed and skewed understanding of what was
23 happening. The information relayed to key GMFRS
24 personnel combined with their assumptions as to what
25 a terror attack would likely involve and led them to

22

1 assume that the bomb was one part of an ongoing
2 terrorist attack of a type which had recently occurred
3 in the UK, continental Europe and elsewhere.

4 Silence from partner agencies as the night went on
5 fed the assumption that the police were dealing with an
6 ongoing armed threat. Sir, no responsible fire officer
7 could send unarmed and unprotected personnel into what
8 they understood to be an ongoing gun or bomb attack and
9 indeed to do so would have been contrary to the
10 established guidance for dealing with such incidents.
11 However, the understanding itself was, it is now known,
12 completely wrong.

13 Sir, turning to your terms of reference, and firstly
14 the planning and preparation for terrorist and mass
15 casualty incidents, including inter-agency planning,
16 preparation and exercises prior to the attack.

17 Training. We would like the bereaved families to
18 know that prior to the attack GMFRS had taken the risk
19 of terrorist attacks and the need to respond to mass
20 casualty events extremely seriously. That it had done
21 so makes it all the more disappointing for all involved
22 that the organisation's response fell so far short when
23 the Manchester Arena bomb happened.

24 GMFRS had planned extensively and trained
25 extensively for terrorist and mass casualty incidents.

23

1 At the time it had a marauding terrorist attack
2 capability which was subject to an audit on 10 to
3 11 February 2016 by the Chief Fire and Rescue Service
4 Adviser. In all nine areas of relevance to GMFRS, it
5 was assessed as established.

6 The full extent of the training undertaken is set
7 out in our written opening and addressed in detail
8 in the evidence of individual witnesses, but we agree
9 with the inquiry team that two training exercises in
10 particular stand out for their relevance to the events
11 of 22 May 2017. The first is Winchester Accord and the
12 second is Hawk River.

13 Winchester Accord was a live play multi-agency
14 exercise conducted on 9 May 2016, involving an attack on
15 the Trafford Centre. What was supposed to happen was
16 that the police would declare Operation Plato,
17 triggering a response by the Fire and
18 Ambulance Services. In fact, as you have heard, neither
19 the GMFRS nor the NWS Ambulance Service HART team
20 received any contact from the GMP and attempts to
21 contact the police commanders proved unsuccessful.

22 The result was a delay of at least 1.5 hours in both
23 the Fire and Ambulance Services being deployed to the
24 Trafford Centre.

25 Sir, as has already been said, there are obvious

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1 striking parallels with what happened on the night of
 2 the arena incident, one difference being that the
 3 ambulance personnel did reach the arena but largely, it
 4 seems, by reason of the fact that Paramedic Ennis
 5 self-deployed and gained early situational awareness for
 6 that agency.

7 It has been suggested that experiences such as these
 8 gave rise to negative expectations on the part of some
 9 GMFRS personnel about what could be expected of the
 10 police. That evidence will, of course, be explored by
 11 the inquiry, but it would be wrong to conclude that this
 12 led GMFRS to be defeatist and simply resign itself to
 13 non-compliance with JESIP, the Joint Emergency Service
 14 Interoperability Principles, by the police.

15 On the contrary, GMFRS acted proactively to address
 16 these issues in the aftermath of Winchester Accord and
 17 we have referred in our opening at paragraph 30 to an
 18 email written promptly after Winchester Accord on
 19 13 May 2016, in which Mr John Fletcher, a manager of the
 20 GMFRS Contingency Planning Unit raised directly with his
 21 counterparts at GMP and NWS key concerns arising out of
 22 that exercise.

23 He pointed out that there seemed to be a lack of
 24 awareness on the part of police commanders about the
 25 capabilities of the Fire Service, including the help its

1 Special Response Unit could provide. At his
 2 instigation, further multi-agency commander training was
 3 organised. Its purpose specifically included improving
 4 knowledge across the agencies of GMFRS capabilities and
 5 the need for a tri-service joint assessment of risk
 6 process to identify zones and the limit of exploitation
 7 to enable specialist MTFA to deploy into warm zones.

8 The JOPs commander training took place on three
 9 dates in January and February 2017. It was the
 10 perception of GMFRS that the event was less
 11 well-attended by GMP than by GMFRS and NWS, and that is
 12 a perception the inquiry will no doubt wish to consider.

13 The second exercise was Hawk River. It was
 14 a tabletop exercise. One of the GMP force duty officers
 15 present -- and it is perhaps to highlight it was just
 16 one -- said during the discussion that during a live
 17 MTFA he would not have time to communicate with the Fire
 18 Service, and the only thing he would do would be to make
 19 contact with details of a forward control point, FCP.
 20 Unfortunately, as we know, not even a forward control
 21 point was communicated by the police to other agencies
 22 on the night.

23 Again, it would be wrong to think that nothing was
 24 done as a result of Hawk River. Following that
 25 training, GMFRS agreed with GMP that there should be

1 a standard operating procedure for a designated
 2 multi-agency Airwave channel to facilitate
 3 communications between agencies in the event of an
 4 incident.

5 Two officers from GMP were tasked with preparing the
 6 procedure and the protocol. Mr Ben Levy of GMFRS set up
 7 the necessary meeting with NWFC, Fire Control, and it
 8 took place on 10 April 2017. From that point, the only
 9 outstanding issue was ratification and implementation of
 10 the protocol by the police. Unfortunately, by the time
 11 of the incident, that had not yet taken place. The
 12 result was that although GMFRS and North West Fire
 13 Control monitored the channel on the night of the arena
 14 attack, it was not in fact being used by the police.

15 Sir, given that the same issues of an ability to
 16 communicate with the force duty officer and a lack of
 17 communication more generally arose on 22 May 2017, it is
 18 clear that lessons were not sufficiently learned from
 19 these exercises. In particular, the problems of
 20 reliance on the force duty officer had been identified
 21 but not corrected.

22 Whilst that was primarily an issue for the police,
 23 GMFRS acknowledges that more should have been done by it
 24 to consider alternative means of communication in the
 25 event that the force duty officer was not contactable,

1 as had happened during Winchester Accord.

2 The arena incident also highlighted another weakness
 3 in the training. In Winchester Accord, NWS and GMFRS
 4 were able to make deployments despite the difficulties
 5 encountered because the RVP and FCP had been agreed in
 6 advance of the exercise.

7 This was a weakness in the training because it did
 8 not replicate the spontaneous nature of a real event.

9 Sir, policies, systems and practices relevant to the
 10 above. We have identified key policies and guidelines
 11 in some detail in our written opening and we will not
 12 repeat the detail orally. Instead, we highlight three.

13 Firstly, the joint operating principles, as then in
 14 force, are clearly crucial from the point of view of
 15 establishing how the emergency services should have
 16 worked together on the night.

17 The other two documents of particular relevance are
 18 the National Inter-agency Liaison Officer Guidance and
 19 the GMFRS Operation Plato National Inter-agency Liaison
 20 Officer Guidance. In the National Inter-agency Liaison
 21 Officer Guidance, the NILO function is described in
 22 section 2 as an advisory role, and we quote:

23 "A trained and qualified officer who can advise and
 24 support incident commanders, police, medical, military
 25 and other government agencies on the FRS' operational

1 capacity and capability to reduce risk and safely
2 resolve incidents at which an FRS attendance may be
3 required."

4 At paragraph 2.5 of the same document, the guidance
5 says:

6 "Where possible, the NILO will not take over
7 incident command or take on other command functions.
8 The command responsibility will remain with the incident
9 commander and the NILO will act as a tactical adviser."

10 There is a limited exception to this, which permits
11 the NILO some discretion to make deployment decisions
12 for a time at the start of spontaneous incidents. Both
13 documents assume that the NILO would obtain situational
14 awareness from the police.

15 Sir, turning to the operational responses of the
16 relevant emergency services. We start with initial
17 notification. The inquiry will, of course, consider the
18 chronology in some detail, but the following points
19 about the initial notification received by GMFRS are
20 relevant.

21 Firstly, 9 minutes had elapsed before GMFRS was
22 notified of the explosion. That chronology comes from
23 this. The explosion detonated at 22.31, North West Fire
24 Control learned of it from the police at 22.35, but
25 contact was not made with GMFRS in the person of the

1 duty NILO until 22.40.

2 Various action cards, which are really plans
3 describing response to particular incidents, had been
4 agreed between NWFC and GMFRS. They are not cards as
5 such, they're really a series of computer prompts
6 setting out the steps to be taken in response to
7 different types of incident.

8 Originally, the operator at NWFC opened the
9 explosion card. Had that plan been followed, fire
10 appliances would have been deployed straight to the
11 arena. However, in a recent statement, the operator who
12 opened it, Mr David Ellis, says he was instructed by his
13 manager not to mobilise to the incident due to its
14 nature. That was an important decision.

15 Until recently, it had been our understanding that
16 North West Fire Control had then opened and followed the
17 bomb action card, which was intended to be used for
18 unexploded bombs. However, recent evidence filed by
19 NWFC suggests that may not have been the case, but
20 rather a managerial decision was taken that the
21 explosion card was not appropriate for the nature of the
22 incident, but no alternative action plan was opened.
23 Instead, senior officers in the control room considered
24 the nature of the incident was such as to require
25 guidance from the NILO.

1 GMFRS acknowledge and accept the criticism of the
2 fire experts that the action plans for an explosion and
3 a bomb were too similar and had the potential to
4 confuse. There was room for ambiguity as to what should
5 happen when a bomb had exploded, and the action plans
6 have been amended following this incident to remove
7 ambiguity.

8 Despite the ambiguity, a number of witnesses from
9 the GMFRS, and it is the expressed view of the fire
10 expert as well, consider that the explosion action card
11 was clear enough for it to have been the correct one to
12 follow, given that the initial reports to NWFC were of
13 an explosion which had taken place.

14 The inquiry will, of course, need to consider the
15 reasons why the explosion card was not followed and
16 whether or not any ambiguity in the action plans played
17 any part in that decision. The decision not to follow
18 the explosion action card may have resulted not from an
19 ambiguity in that plan but an understanding or belief
20 that the incident was part of a larger attack.

21 In this regard, NWFC in their recently filed
22 evidence have explained that they did not consider it
23 appropriate to mobilise directly to the incident because
24 they were concerned, given its scale, that there might
25 have been secondary devices or marauding terrorists.

1 The duty NILO, Mr Andy Berry, when he was contacted, did
2 not challenge those decisions but adopted the same
3 reasoning.

4 The training provided to both North West Fire
5 Control and the duty NILO at GMFRS may be of relevance
6 in this respect, as is the history of the nature of the
7 most recent terrorist attacks in the UK, Europe and
8 elsewhere, which had predominantly involved marauding
9 terrorists with more than one component to the attack.

10 The inquiry might consider that the decision not to
11 mobilise until such time as further information was
12 obtained from the police about what was going on was not
13 unreasonable. The assumptions made by both NWFC and
14 Mr Berry seemed well-founded when later NWFC received
15 a report of a gunshot wound at 22.45, and an active
16 shooter at 22.47, and this information was passed to
17 Mr Berry in a call he made to North West Fire Control at
18 22.48.

19 Turning to the rendezvous point, North West Fire
20 Control did not mobilise appliances to the
21 police-designated RVP prior to contacting Mr Berry.
22 They did inform Mr Berry that the police had identified
23 Cathedral Car Park as an RVP, but having considered it,
24 he discounted it.

25 Mr Berry will give evidence that he was concerned

1 that this might be an ongoing attack and his knowledge
2 of the proximity of Cathedral Car Park to the arena led
3 him to doubt whether it was a properly considered RVP.
4 He wanted to confirm it with the force duty officer in
5 accordance with the procedure which had been agreed with
6 Greater Manchester Police.

7 Sir, Mr Berry's decision not to mobilise resources
8 directly to Cathedral Car Park was an important one.
9 Although the evidence suggests that in fact Cathedral
10 Car Park was never in fact used as an RVP by any agency,
11 any fire appliances attending there would have gained
12 some situational awareness, and that's because of its
13 proximity to the arena.

14 With hindsight, when it is known that there was no
15 marauding terrorist, it is clear that the decision was
16 wrong, but Mr Berry did not have the benefit of
17 hindsight and he expected to be able to speak to the
18 force duty officer within a short period of time,
19 a conversation that, if it had happened, could have
20 allayed his concerns. Had the facts turned out to be
21 different and had there been an ambush waiting for
22 emergency responders who were deployed straight to the
23 car park, then the correctness of his decision would
24 look very different.

25 Based on what Mr Berry knew, we submit his decision

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1 to muster resources at Philips Park pending
2 a conversation with the FDO was a reasonable one, and
3 that is also the view expressed by the expert witness,
4 Mr Hall.

5 Unfortunately, as we know, despite repeated attempts
6 by Mr Berry, and indeed attempts by others within the
7 Fire Service, to contact the FDO, he could not get
8 through to him. The FDO says he made a conscious
9 decision not to call the GMFRS to the scene so as not to
10 bring on armed resources into the arena. GMP have very
11 properly accepted that was a wrong decision, which ran
12 contrary to joint operating principles.

13 The FDO also did not communicate this decision to
14 North West Fire Control or GMFRS.

15 Mr Hall says that once it became apparent the FDO
16 could not be contacted, there should have been
17 a re-think. Efforts should have been made, both by
18 North West Fire Control and GMFRS, through North West
19 Fire Control, to obtain situational awareness by other
20 means. We agree.

21 It would be easy but wrong to scapegoat Mr Berry for
22 that failure. In your opening, sir, you have said this
23 inquiry is not about scapegoating but about getting to
24 the truth and learning lessons, and that is plainly the
25 correct course. Submissions have been made to the same

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1 effect on behalf of the families.

2 The fact is that planning for an event of this
3 nature, both by GMFRS but also GMP, placed too much
4 reliance and expected too much of two officers, the
5 force duty officer at GMP and the NILO at GMFRS.
6 Dependence on contact between these two individuals
7 provided a critical point of failure in the sharing of
8 situational awareness in the event that the expected
9 communication between them did not take place.

10 The fact that Mr Berry had to travel some
11 considerable distance from his home to central
12 Manchester, a problem compounded by roadworks and
13 closures which he also had to navigate whilst dealing
14 with this incident, did not make his job any easier.
15 Moreover, the silence from other agencies needs to be
16 considered. This fed an assumption on the part of
17 Mr Berry and others at GMFRS that the police must be
18 busy dealing with an ongoing terrorist situation, which
19 would explain their lack of communication.

20 Sir, lack of incident command. GMFRS's planning
21 assumed that either a fire appliance would go directly
22 to the scene, in which case the most senior officer on
23 board would take command of the incident, or the NILO
24 would obtain a forward control point from the force duty
25 officer, in which case the NILO would become the

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1 on-scene commander at that location. Neither of these
2 things happened.

3 The relevant policies and guidelines did not provide
4 a clear command structure for a situation such as this,
5 where there was no on-scene presence and no communicated
6 FCP. The result was, I'm sorry to say, that no one from
7 GMFRS believed themselves to have command of the
8 incident and no one took charge of the response in its
9 initial stages.

10 GMCA accepts the criticism of Mr Hall that in the
11 early stages of the incident there was an absence of
12 leadership to assert operational grip on the incident.
13 That is clearly a serious failing. It was no one
14 individual's fault but arose from the fact that GMFRS's
15 planning, guidance and procedures had not provided for
16 a situation where no command structure was established
17 on the scene, either immediately or within minutes once
18 information from the force duty officer was obtained.

19 Grip did not begin to be applied to the incident
20 until the then Chief Fire Officer, Mr Peter O'Reilly,
21 having arrived at the command support room at about
22 23.50, and then discovering that no fire appliances had
23 been mobilised to the arena, managed to gain situational
24 awareness by making use of his personal contacts with
25 senior officials at NWAS.

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1 I should make clear it was not the Chief Fire
 2 Officer 's role to command the incident, but, as Mr Hall
 3 says, his intervention had the positive outcome of
 4 actually getting fire personnel to the scene.
 5 Since the attack, measures have been taken to ensure
 6 an effective command structure in the event of a similar
 7 attack, including the mobilisation of an assistant
 8 principal officer , which is an area manager or above, to
 9 take incident command at the RVP. It is anticipated
 10 that this should avoid a similar situation where no one
 11 is in charge of an incident of this nature arising
 12 again.
 13 Term of reference 5(iv) , the inter -agency liaison
 14 communication and decision-making between relevant
 15 emergency services and with others, including their
 16 adequacy and compliance with relevant planning,
 17 preparation , policies , systems and practices .
 18 GMCA has said from the outset of this process that
 19 it will take responsibility for its own failings and it
 20 does not seek to blame others for its own shortcomings.
 21 GMFRS acknowledges and accepts that but for the mistakes
 22 it made, Fire Service personnel would have attended the
 23 arena sooner. GMCA also recognises that on this
 24 dreadful night , no emergency responder or the
 25 organisation they worked for wanted to do anything other

1 than the best for those who were the victims of this
 2 callous act.
 3 We do not underestimate the immense pressure that
 4 police and ambulance responders at the arena were
 5 working under, and we recognise their fortitude and
 6 bravery. We also recognise the danger of hindsight when
 7 later analysing decisions that were made in the agony of
 8 the moment.
 9 It cannot be ignored , however, that inter -agency
 10 communication has long been recognised as a potential
 11 area of weakness when the emergency services are dealing
 12 with the particular challenges of a mass casualty
 13 terrorist incident . In the context where emergency
 14 services are supposed to work together, it is inevitable
 15 that inadequate joint working by other agencies ,
 16 particularly where they have a wider effect on the
 17 response of others, must be considered too. That's
 18 necessary if lessons are to be learned .
 19 The errors on the part of other agencies that GMCA
 20 identifies in this section are errors which the other
 21 agencies also identify and accept. We consider here
 22 their impact on GMFRS.
 23 None of the initial mobilisation decisions made by
 24 NWFC or GMFRS would have mattered had the other
 25 emergency services shared their situational awareness,

1 as was the expectation and responsibility under JESIP.
 2 Had the force duty officer spoken with Mr Berry and
 3 confirmed the RVP or given him an FCP, GMFRS would have
 4 been able to co-locate with the other agency incident
 5 commanders and make joined-up decisions in full
 6 knowledge of what was occurring at the scene.
 7 Several individuals in the other agencies' key
 8 command roles go as far as to state that they held the
 9 view that the attendance of the GMFRS was not needed,
 10 notably the force duty officer , the GMP tactical
 11 firearms commander, and the NWAS operational commander.
 12 That information was not shared with GMFRS at any level,
 13 preventing GMFRS from challenging the view and reminding
 14 the other agencies of both its specialist resources and
 15 its general rescue and casualty management capability.
 16 It is significant , however, that the failure in
 17 communication and information sharing within GMP was not
 18 limited to the FDO and GMFRS received virtually no
 19 contact from GMP at all prior to its arrival at the
 20 arena. Similarly , there were failures in communication
 21 with NWAS who were also obviously aware that GMFRS were
 22 not at the scene.
 23 Importantly, crucial developments were not
 24 communicated to GMFRS as they should have been by the
 25 control rooms or commanding officers of other agencies ,

1 in particular a declaration of a major incident by the
 2 British Transport Police at 22.39, the declaration of
 3 Operation Plato by the force duty officer at 22.47,
 4 which should have been shared immediately with NWAS and
 5 GMFRS, along with a METHANE report which GMP never
 6 issued , a METHANE report issued from the scene by NWAS
 7 at 22.54, and the METHANE report from the scene by the
 8 British Transport Police at 22.58.
 9 The experts have highlighted the importance of the
 10 fact that these matters were not shared on an
 11 inter -agency basis in their reports , and GMCA agrees
 12 with Mr Hall that communication of these would have had,
 13 and I quote:
 14 "... an almost instant and significant effect on the
 15 response from GMFRS and NWFC."
 16 In addition , GMP did not declare a major incident or
 17 issue any METHANE report, a failure described as
 18 a "serious omission" by the policing experts. It is no
 19 exaggeration , sir , to say that the inter -agency liaison ,
 20 communication and decision-making on the part of all the
 21 responding agencies fell very far short of what was
 22 expected under the JESIP principles and the multi-agency
 23 training prior to the event, and GMFRS regrets the part
 24 that its own shortcomings played in that overall
 25 failure .

1 The changes that have been made by GMFRS since the
2 arena attack. Since the attack GMFRS has worked both
3 internally and with the other emergency responders to
4 avoid a repeat of this situation in the future and
5 detailed evidence has been given to the inquiry about
6 this.

7 However, I would wish to highlight some of the key
8 changes implemented to date. Firstly, the tri-service
9 radio channel was implemented on 26 May 2017. It
10 enables the three emergency services to receive
11 simultaneous communications, including the sharing of
12 critical information. It is tested three times a day
13 between the relevant control rooms. It is always live
14 and is constantly monitored by NWFC.

15 Secondly, there are now a wider range of telephone
16 communications options to facilitate contact between the
17 GMFRS and GMP, with alternative contact methods agreed
18 in the event that primary methods are unsuccessful.
19 These include both voice calling and instant messaging
20 facilities. Methods of online communication are also
21 being trialled.

22 A NILO is now permanently co-located with the force
23 duty officer within working hours, fostering stronger
24 links and better communication between the roles.
25 Provision has been made for contact and the gaining of

1 situational awareness not only from the police but also
2 through the Ambulance Service NILOs.

3 Sir, I have already described the alterations that
4 have been made to GMFRS's command structure to ensure
5 that robust incident command is deployed quickly to an
6 incident, whatever the circumstances. And GMFRS has
7 worked with NWFC in making changes to the action cards.
8 Those changes are not limited to deployment decisions
9 but also include directions that particular senior
10 officers are automatically informed of an explosion to
11 avoid a scenario where a duty NILO is asked to make
12 command decisions whether at all or in a vacuum.

13 The major incident action card now also invites the
14 duty group manager to consider whether to deploy an
15 officer to NWFC to assist with the incident command
16 structure.

17 Changes have been made to the role of the NILO. The
18 duty NILO now stays in situ at their location and acts
19 as a remote tactical adviser, supported by other NILOs
20 who are deployed as required, with the nearest NILO
21 being mobilised to an incident.

22 Changes have been made to GMFRS training based on
23 lessons learned from this incident and these have been
24 tested in multi-agency exercises.

25 Finally, GMFRS has invested in additional stretchers

1 of a different design to Skeds, which can be mobilised
2 to support mass casualty evacuation.

3 Issue or term of reference 5(v), the impact of any
4 of the inadequacies in planning, preparation and/or the
5 emergency response, including whether any inadequacies
6 undermined the ability of the response to save life
7 and/or contributed to the extent of the loss of life
8 that occurred.

9 When something doesn't happen, one can, of course,
10 only hypothesise about what might have gone differently
11 if it had. However, it is the view of the GMFRS that
12 even the firefighters could not have saved a single
13 life, had they been mobilised to the incident they could
14 have provided meaningful practical assistance. They
15 would have been there to assist the Ambulance Service in
16 any way they were asked. They could have provided
17 comfort and help to those disorientated or injured.
18 They would have been a reassuring presence to assist
19 those who were lost and frightened. They would have
20 been there to do whatever they could to make the
21 situation easier for the victims of this atrocity, and
22 this is a service that they would have been willing and
23 anxious to provide.

24 GMP had, rightly or wrongly, declared the City Room
25 to be a hot zone. On a strict application of the joint

1 operating principles, GMFRS personnel, even the special
2 response teams, would not have been deployed into such
3 a zone. That said, it may well have been the case that
4 such zoning would not in practice have prevented
5 firefighters from entering the scene had they arrived
6 immediately after the explosion, just as the first
7 responders from the other emergency services did.

8 The inquiry is likely to hear evidence from
9 individual firefighters of their willingness to put
10 their own safety second if they felt they could have
11 rendered assistance to those injured and affected by the
12 bomb.

13 Any attending personnel would, however, have been
14 placed at the disposal of NWAS, it being the agency with
15 the statutory responsibility for and the primary
16 expertise in the management and treatment of casualties.
17 In this respect, it is relevant that the NWAS
18 operational commander, Mr Daniel Smith, did not consider
19 that further resources were necessary in the City Room
20 or in the casualty clearing station set up in
21 Victoria Station.

22 Indeed, had he considered otherwise, he had
23 specialist NWAS paramedic resource teams, the HART
24 teams, available and, as it was, as we've heard, only
25 two members of the available HART teams were in fact

1 deployed to the City Room, with others deployed to
2 assist in setting up the casualty clearing station and
3 others held at an RVP.

4 It has been suggested that GMFRS might have provided
5 additional stretchers for the removal of casualties from
6 the City Room. The stretchers carried by the SRT are
7 Skeds and these are designed for the rapid removal of
8 casualties from a hazardous zone, primarily by dragging
9 the Sked along the ground. They are not orthopaedic
10 stretchers, but they would undoubtedly have provided
11 greater dignity from those being removed from the
12 City Room than signage and railings, although they
13 probably would have been less suitable than the
14 equipment GMFRS understands was already available and
15 accessible to NWAS, particularly when regard is had to
16 the fact that to move casualties from the City Room to
17 the casualty clearing station required travelling down
18 a set of stairs.

19 The question has been raised as to whether, when the
20 Fire Service did eventually deploy to the arena, the
21 appropriate resources were sent. In particular, should
22 the technical and special response units have been sent?
23 The evidence is likely to be that by the time the Fire
24 Service arrived, any need for the additional specialist
25 capabilities of those resources had gone.

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1 In relation to those, sir, who so tragically lost
2 their lives, the nature of their injuries was such that
3 there does not seem to be any basis for a conclusion
4 that the earlier attendance of the GMFRS personnel would
5 have saved their lives.

6 Sir, some conclusions. GMCA and, in turn, GMFRS
7 wish to reiterate to the bereaved families their sincere
8 commitment to assist your inquiry with candour and
9 transparency to obtain the best understanding possible
10 of why the emergency response did not operate as it
11 ought to have operated on the night of the attack and to
12 continue to learn through this process.

13 Even if lives could not have been saved by the
14 earlier attendance of GMFRS on this occasion, GMCA
15 believes that the presence of its firefighters would
16 have improved the emergency response. It is also
17 important that failings are identified and the right
18 lessons learned so that the mistakes are not repeated
19 in the future.

20 Again, GMCA also wishes to pay tribute to the many
21 individual acts of bravery and exceptional care provided
22 by those working for its partner agencies and also arena
23 first-aiders and members of the public who were caught
24 up in and responded to this dreadful event.

25 GMCA recognises that all of those who attended the

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1 arena to provide an emergency response and those
2 supporting them in their control rooms did so with the
3 best of intentions, both to deal with the unknown and
4 ongoing threat to the people of Manchester that night,
5 and also to treat and evacuate the injured, innocent
6 members of the public affected by the bomb. That is,
7 of course, to be contrasted with the wicked and
8 deliberate actions of the bomber and his brother.

9 GMCA welcomes and hopes this inquiry will be able to
10 endorse the opinion of Mr Hall, the fire expert, that
11 having arrived at the scene, GMFRS firefighters and
12 officers made a positive contribution to the rescue
13 effort and that they continued to support the Greater
14 Manchester Police and other agencies over the following
15 days in a professional and collaborative way.

16 Sir, since the night of the attack, GMFRS has
17 reflected carefully and sought to identify the reasons
18 for the shortcomings in its response. It has filed,
19 from Assistant County Officer David Keelan, evidence
20 about the steps which have already been taken to change
21 practices, policies and procedures, but GMFRS remains
22 keen to learn whatever it can from this process to
23 improve the service that it provides in the future.

24 As a result, sir, it approaches this inquiry with an
25 open mind and a willingness to implement any further

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1 improvements to practice which may be identified.

2 SIR JOHN SAUNDERS: Thank you, Mr Warnock.

3 MR GREANEY: Sir, would you now rise, please? We'll resume
4 at 11.20, when we will hear from Mr Smith on behalf of
5 North West Fire Control. He will attend by a live link
6 for good reason.

7 SIR JOHN SAUNDERS: Thank you.

8 (10.51 am)

9 (A short break)

10 (11.20 am)

11 MR GREANEY: Sir, as I indicated before the break, we'll now
12 hear from Mr Smith on behalf of North West Fire Control.

13 SIR JOHN SAUNDERS: Thank you, Mr Smith.

14 Opening statement by MR SMITH

15 MR SMITH: Sir, as you know, I represent North West Fire
16 Control, assisted by my junior, Ms Danielle Gilmour, and
17 we are instructed by Mr Stephen Graham and
18 Mr Tristan Mearns-White of Ward Hadaway,
19 Newcastle-upon-Tyne and Manchester.

20 North West Fire Control would like to begin by
21 expressing its deepest sympathy to the families of the
22 deceased and to the survivors of this attack. We have
23 maintained a presence during the whole of the pen
24 portrait stage of the inquiry and we would like to
25 emphasise that we have listened with care to all of the

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1 portraits and the memories and sentiments that have been
 2 expressed. It is important to North West Fire Control
 3 that its approach to the evidence in the inquiry is
 4 undertaken with all of those who have been so deeply
 5 affected in mind.
 6 The company's aim is to consider how it can best
 7 serve to assist the inquiry and also to manage the
 8 interests of the company in the light of all the
 9 evidence that is to be received. In doing so,
 10 North West Fire Control will, as you will hear,
 11 acknowledge the failures for which it has been
 12 responsible.
 13 However, it will also be necessary for North West
 14 Fire Control to respond to criticisms that have been
 15 made concerning the actions taken by the control room
 16 staff on the night of the attack. It is Fire Control's
 17 hope that the families will recognise and understand
 18 that this course is in no way intended to diminish the
 19 importance of their evidence or the prominence that
 20 their interests have in the inquiry process.
 21 North West Fire Control's written opening statement
 22 cannot be delivered orally in its entirety in the
 23 timescale allotted by the inquiry; we wish to emphasise
 24 that we make no complaint about this. The expectation
 25 is that the inquiry requires focus and must operate

1 efficiently. Of necessity, therefore, much of the
 2 detail that has been set out in the uploaded written
 3 opening statement will necessarily need to be reduced in
 4 oral presentation.
 5 MR GREANEY: Mr Smith, I am very sorry to interrupt you, but
 6 you'll understand and accept that I wouldn't do so
 7 unless necessary. I'm told that there is a problem at
 8 Spinningfields. I'm very sorry to report that again.
 9 It's obviously important that those who are there --
 10 SIR JOHN SAUNDERS: Mr Smith, I am very sorry about this,
 11 we'll have to sort a technical problem out. We will
 12 come back as quickly as we can. We will also find out
 13 how much hasn't been heard of what you've already said
 14 so you can go back over it again if you'd be so kind.
 15 MR GREANEY: In fact in the time I have been on my feet, the
 16 problem has been resolved. What I don't know is how
 17 much of Mr Smith's... I'm told about 3 minutes has been
 18 missed and what I suggest therefore, if Mr Smith is
 19 content with this, is he simply starts again.
 20 SIR JOHN SAUNDERS: Are you happy to do that, Mr Smith?
 21 MR SMITH: Of course.
 22 SIR JOHN SAUNDERS: Thank you so much.
 23 MR SMITH: North West Fire Control is represented,
 24 of course, as you know, sir, by myself and Ms Gilmour,
 25 and we are instructed by Mr Stephen Graham and

1 Mr Tristan Meeers-White of Ward Hadaway of
 2 Newcastle-upon-Tyne and Manchester.
 3 North West Fire Control would like to begin by
 4 expressing its deepest sympathy to the families of the
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 18 In doing so, North West Fire Control will, as
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 5 cannot be delivered orally in its entirety in the
 6 timescale allotted by the inquiry; we wish to emphasise
 7 that we make no complaint about this. The expectation
 8 is that the inquiry requires focus and must operate
 9 efficiently. Of necessity, therefore, much of the
 10 detail that has been set out in the uploaded written
 11 opening statement will necessarily need to be reduced in
 12 oral presentation.
 13 Some important factual material has been allocated
 14 to two appendices to the written opening statement for
 15 this reason. Appendix 1 is an important detailed
 16 analysis of calls into and out of the control room
 17 during the period in question. The company's written
 18 opening statement and a brief supplemental statement
 19 will, we understand, be uploaded to the inquiry website
 20 in due course and will be available to be studied in
 21 detail.
 22 It therefore seems essential to us that we should
 23 concentrate at this stage only upon the principal
 24 aspects of North West Fire Control's written opening
 25 statement in order to meet that expectation.

1 Can I therefore turn to the function of
 2 North West Fire Control. North West Fire Control is
 3 a local authority controlled company. Its operations
 4 are located in a purpose built modern facility at
 5 Lingley Mere Business Park in Warrington. There are
 6 photographs of the layout of the control room available
 7 on the company's website.

8 The company was created as part of a government
 9 initiative to create regional control centres for the
 10 handling of emergency calls and the mobilisation of
 11 resources. It is owned by four public authorities
 12 which, in addition to their other duties, are
 13 responsible, under the provisions of the Fire and Rescue
 14 Services Act 2004, for discharging the functions of the
 15 fire and rescue services.

16 The four fire and rescue services for which
 17 North West Fire Control provides its emergency response
 18 service are Greater Manchester Fire and Rescue, Cheshire
 19 Fire and Rescue, Cumbria Fire and Rescue, and Lancashire
 20 Fire and Rescue, and of course, as you know, sir,
 21 Greater Manchester Combined Authority is the fire
 22 authority responsible for Greater Manchester Fire and
 23 Rescue Service.

24 Appendix 2 to the written opening statement sets out
 25 the principal terms of the agreement for services which

1 are relevant to the inquiry's terms of reference. It is
 2 sufficient at this stage to say that North West Fire
 3 Control was required under the terms of its service
 4 agreement to deal with emergency calls in accordance
 5 with the call-handling policy and procedures supplied to
 6 it from time to time by the Fire Authority, and
 7 similarly, to conduct mobilisation and incident support
 8 in accordance with the mobilising policy and procedures
 9 also supplied to it from time to time by the authority.

10 We submit that the inquiry will want to examine
 11 in the context of the terms of reference the efficiency
 12 of North West Fire Control's call-handling procedures
 13 and the extent of its workload. In the course of the
 14 6 months between January and June 2017, Fire Control
 15 handled a total of 60,123 emergency calls. The evidence
 16 of the independent fire expert, Mr Hall, is to the
 17 effect that his overall impression is that North West
 18 Fire Control was trained and ready to respond to any
 19 reasonable worst-case scenario eventuality, with
 20 a suitable number of properly trained staff on duty,
 21 supported by managers, either in the building or readily
 22 available to be recalled to ensure the smooth running
 23 and execution of their service agreements.

24 On the night of the Manchester Arena attack,
 25 Fire Control was in an operational position to respond

1 adequately and effectively to a major incident,
 2 including what was then known as an MTFA. Such is the
 3 opinion of the expert Mr Hall, expressed at paragraph 22
 4 of his report, and so North West Fire Control had
 5 adequately trained staff on duty, all of whom were
 6 familiar with the JESIP principles.

7 During every shift at North West Fire Control there
 8 are two team leaders in charge of the control room.
 9 These are experienced staff who have been trained in
 10 JESIP response. One is the duty team leader, the other
 11 is the administration team leader. There were a total
 12 of five control room operators on duty responsible for
 13 answering and responding to emergency calls together
 14 with an additional control room operator who had
 15 recently joined the company.

16 As a matter of routine, the minimum number of staff
 17 in the control room during a night shift, which is from
 18 7 pm until 7 in the morning, was 10 staff between 7 pm
 19 and 10 pm, and seven staff between 10 pm and 7 in the
 20 morning. North West Fire Control was, therefore,
 21 adequately staffed on the night of the incident.

22 I would like to turn now, if I may, to the
 23 organisational structure of the company and its
 24 obligations and duties.

25 It is of particular importance to emphasise that

1 North West Fire Control does not provide a command
 2 function. The manner in which Fire Control was and is
 3 required to respond to emergency calls is by way of the
 4 application of predetermined incident types and action
 5 plans. These are also referred to as action cards in
 6 various witness statements. These are preloaded on to
 7 Fire Control's mobilisation system, at the request of
 8 the fire and rescue services.

9 In addition to predetermined incident types and
 10 action plans, Fire Control is also supplied by the Fire
 11 Service with something known as ECM prompts, emergency
 12 call management prompts, which were for use in respect
 13 of certain predetermined incident types and action
 14 plans.

15 The ECM prompts provide the control room operators
 16 with a list of questions which the operator may ask of
 17 the caller in order to correctly mobilise to a specific
 18 type of incident. These ECM prompts were in fact,
 19 according to our submission, of no practical relevance
 20 to the response to the emergency calls being received
 21 into the control room on the night. Their content
 22 demonstrates that they're to be used for calls coming
 23 into the control room from members of the public rather
 24 than from other emergency responders' control rooms.

25 Once an incident type has been selected by the

1 control room operator, and an action plan has been
 2 activated and resources mobilised, all of the orders and
 3 directions Fire Service personnel are required to comply
 4 with then become the responsibility of the
 5 Greater Manchester Fire and Rescue Service commander in
 6 charge of the incident. If any additional resources are
 7 then required to be mobilised or locations changed,
 8 these would then be the subject of instruction by the
 9 incident commander acting through North West Fire
 10 Control.

11 It is also important to emphasise that
 12 North West Fire Control is not empowered to issue
 13 directions or orders to personnel in the Fire Service or
 14 to determine or challenge the management of any
 15 incident. Its function was to mobilise pumps, equipment
 16 and personnel in accordance with these predetermined
 17 attendance and action plans, which were selected on the
 18 basis of information received into the control room.

19 As a result, the primacy of all operational
 20 decisions remained with Greater Manchester Fire and
 21 Rescue Service. Of particular significance is the fact
 22 that certain action plans required North West Fire
 23 Control to obtain advice or guidance from the Fire
 24 Service NILOs before mobilising. One of these action
 25 plans was the Fire Service's "Bomb -- general" action

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1 plan. Others were the Fire Service's Operation Plato
 2 action plan, including a standby phase action plan and
 3 an implementation plan.

4 Where an action plan required North West Fire
 5 Control to inform and obtain advice from a NILO, all
 6 decisions in relation to further deployments and
 7 mobilising were the responsibility of the NILO, not that
 8 of North West Fire Control. In such circumstances,
 9 Fire Control was required to mobilise only in accordance
 10 with the NILO's instruction. At the time of these
 11 events, the action plans for "Bomb -- general" and those
 12 for "Operation Plato -- MTFA" required Fire Control to
 13 inform the duty NILO by way of initial action and to do
 14 so before mobilising, with the result that all command
 15 decisions relating to further deployment and
 16 mobilisation were passed to that officer.

17 North West Fire Control would then only mobilise on
 18 receipt of orders from the NILO. NILOs are required to
 19 have a detailed understanding of MTFA joint operating
 20 principles. They are security cleared, highly trained
 21 and qualified managers who can advise and support other
 22 agencies in terms of the service's fire and rescue
 23 capability.

24 Sir, can I turn to the action plan current at the
 25 time of the incident. Available to the inquiry on the

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1 Magnum portal are action plans for a number of specific
 2 incident types which were current at the time of the
 3 incident. The first one that I want to deal with was
 4 entitled "BG3115 explosion" and this action plan
 5 required North West Fire Control to send a Technical
 6 Rescue Unit and a specified number of pumps directly to
 7 the scene.

8 I would ask if it would be possible to put on the
 9 screen {INQ004404/1}. You will see, sir, that the
 10 initial actions required of North West Fire Control were
 11 to send a Technical Rescue Unit, a number of pumps, a
 12 station manager, and to send the duty NILO. Obviously,
 13 that document is going to be considered in some detail
 14 in the course of the inquiry and it can come off the
 15 screen now.

16 That action plan provided by Greater Manchester Fire
 17 and Rescue Service to the inquiry lists a number of
 18 triggers, which include gas bomb cylinders, chemicals
 19 and impact and includes references to an ECM call prompt
 20 which is headed "Explosions and entrapments", and this
 21 is the second of the three documents that I'd like the
 22 inquiry to see on the screen, please, at {INQ034361/1}.

23 That document was plainly, in our submission, for
 24 use in different circumstances to those which occurred
 25 on the night. This call prompt had no practical

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1 relevance to an exploded bomb in circumstances such as
 2 these where the information was provided to
 3 North West Fire Control by other emergency responders,
 4 in this case Greater Manchester Police and the
 5 Ambulance Service.

6 If the second page could just be put up
 7 {INQ034361/2}. That sets out the detail of the ECM call
 8 prompt "Explosions and entrapments". Thank you.

9 The third document that I would be grateful to be
 10 put on the screen is the action plan BG3065, "Bomb --
 11 general", under {INQ004360/1}. This action plan, as the
 12 inquiry will see, required North West Fire Control to
 13 inform the duty NILO -- and these are the words:

14 "Request guidance on actions to be carried out
 15 before proceeding further (pre-mobilisation)."

16 The action plan provided to the inquiry also
 17 referenced an ECM call prompt headed "Bomb threat".
 18 This call prompt had no relevance to an exploded bomb.

19 Thank you. That can be removed from the screen,
 20 please.

21 There are other action plans available on
 22 Fire Control's system provided by Fire and Rescue
 23 Service relating to Operation Plato headed
 24 "Operation Plato -- marauding terrorist firearms attack,
 25 active shooter", and these involved a standby phase

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1 action plan, an implementation phase and a marauding
 2 terrorist firearms attack stand-down phase.
 3 As far as the standby phase is concerned, this
 4 action plan required North West Fire Control, if a call
 5 was not received from GMP, to inform the duty NILO to
 6 obtain the address of the incident and to seek advice.
 7 After the attack at Manchester Arena,
 8 Greater Manchester Fire and Rescue Service produced
 9 revised action plans, some of which have been further
 10 updated and amended. The first of these was an action
 11 plan headed "Bomb -- general", and that action plan
 12 required Fire Control, in the event that an explosion
 13 had occurred, to change the incident type to "BG3115 --
 14 explosion".
 15 The second revised action plan was the
 16 Fire Service's incident type action plan "BG3115 --
 17 explosion". This action plan now required Fire Control
 18 in the event that a bomb had exploded, and following the
 19 requirement in the new action plan "Bomb -- general", to
 20 send a Technical Rescue Unit, pumps and a station
 21 manager to the scene and inform the duty NILO. There
 22 were a number of other additional or revised action
 23 plans provided relating to Operation Plato.
 24 I would like to turn to the practical effect of the
 25 changes and the inferences to be drawn from them. The

1 result of these changes is that the revised action plan
 2 for an incident type involving a bomb which has exploded
 3 requires Fire Control to mobilise to the scene and
 4 removes the requirement of North West Fire Control to
 5 obtain instructions from the duty NILO before
 6 mobilising.
 7 This, submits North West Fire Control, represents
 8 a significant change in the response required of
 9 Fire Control in the event of a bomb having exploded and
 10 which North West Fire Control contend was clearly not
 11 the situation at the time of the incident.
 12 In this context, the inquiry may wish to explore the
 13 reasons why it was deemed necessary for the Fire Service
 14 to revise their action plan after the incident in the
 15 light of the fact that it has been contended, and we'll
 16 deal with this in detail in due course, that
 17 Fire Control should have followed the action plan for
 18 explosion.
 19 The inquiry may wish to consider that if the route
 20 which should have been followed was clearly expressed in
 21 the existing plans, there would have been no requirement
 22 to amend them.
 23 North West Fire Control contend that in the light of
 24 the information received into the control room on the
 25 night, that a bomb had exploded, the action plan then

1 current for an explosion was not the appropriate action
 2 plan to be followed. The most appropriate action plan,
 3 in the absence of a METHANE message or communicated
 4 declaration of Operation Plato, was that for "Bomb --
 5 general".
 6 The actions required to be taken in the form in
 7 which they were expressed in the action plans current
 8 at the time of the incident were, we submit, not clear
 9 and unambiguous in their terms.
 10 The inquiry may wish to examine the wording of each
 11 one of these action plans in more detail as the evidence
 12 progresses. It is of significance that an action plan
 13 for an exploded bomb had never been supplied to
 14 North West Fire Control by the Fire Service and
 15 therefore no such plan had been loaded on to
 16 Fire Control's computer-aided despatch system.
 17 The Operation Plato action plan all required
 18 Fire Control to contact and take advice from the duty
 19 NILO as the first action, as did the "Bomb -- general"
 20 action. This is the course that was followed.
 21 In evidence supplied to the inquiry in writing so
 22 far, General Manager John Fletcher of the Fire Service
 23 has observed that no particular criticism is directed to
 24 North West Fire Control in relation to their decision.
 25 He points out that:

1 "They deliver a service that we ask them to deliver,
 2 which is based on call handlers following a series of
 3 action plans for multiple incident types, which can be
 4 confusing."
 5 His suggestion that the Fire Service had more
 6 experienced call handlers who had a greater familiarity
 7 with the Fire Service's own procedures and the geography
 8 of Greater Manchester is misplaced.
 9 The duty team leaders who made the decision to
 10 inform the duty NILO on the night were both experienced
 11 in control room procedures. One of them,
 12 Michelle Gregson, had worked for Lancashire Fire and
 13 Rescue service from 2004, and the other, Lisa Owen, was
 14 a call handler at Greater Manchester Fire and Rescue
 15 Service from 2010.
 16 Of particular significance in this context is
 17 a draft MTFA mobilisation emergency response guidance
 18 dated 27 February 2017, which Greater Manchester Fire
 19 and Rescue Service had prepared and circulated prior to
 20 the incident. The purpose of the document is expressed
 21 to be one of giving guidance for the actions required by
 22 officers undertaking various roles to support
 23 a marauding terrorist firearms attack. The document was
 24 expressly relevant to North West Fire Control's
 25 operatives as well as NILOs and others.

1 The document recognised the:
 2 "... rapidly changing and unique features of this
 3 type of attack require a more dynamic and collaborative
 4 approach to that adopted in standard major incident
 5 planning ..."
 6 Significantly , its terms, if implemented, would have
 7 required North West Fire Control, on notification , to
 8 obtain as much information as possible and to inform the
 9 duty NILO as a priority and obtain specific operational
 10 instructions from the duty NILO. This was consistent
 11 with the predetermined action plans in place at the time
 12 for both "Bomb -- general" and Operation Plato standby
 13 and implementation phases.
 14 In one moment, I'm going to come to deal with the
 15 response by the control room to the emergency calls , but
 16 before I do so I'd like to deal with some apparently
 17 inconsistent evidence relating to the response by the
 18 control room, of which you, sir , are aware and which has
 19 already been uploaded to the portal .
 20 Before we deal with the control room's response to
 21 the emergency calls , it is necessary to point out that
 22 there is some potential for confusion arising from
 23 references in the Kerslake Report and in witness
 24 accounts provided by North West Fire Control's employees
 25 in relation to the descriptions of the physical action

1 taken by the control room staff after an incident log
 2 had been commenced that night at 22.38.48, and the
 3 explosion action plan had been accessed by the control
 4 room operator, Mr David Ellis .
 5 Contrary to what is said in some of the material and
 6 evidence that has been gathered, the control room
 7 operators at North West Fire Control did not open the
 8 action plan for "Bomb -- general". Only the action plan
 9 for explosion was opened, and this was at 22.38.51.
 10 No other action plan was opened until 00.58.12, when
 11 the control room opened the action plan for
 12 Operation Plato stand by phase as the data establishes .
 13 It is not disputed that the action plan for an explosion
 14 was not followed after it had been opened and that the
 15 control room staff considered that the action plan for
 16 an explosion was not applicable to the nature of the
 17 incident based on the information that was coming into
 18 the control room.
 19 In particular , as has been made clear, the explosion
 20 action plan would have required North West Fire Control
 21 to mobilise resources to the incident , which was
 22 something that was not done. Instead, the team leaders
 23 in the control room took the first action that would
 24 have been required of them had they followed the "Bomb
 25 -- general" action plan , which was to inform the duty

1 NILO before mobilising and to await guidance before
 2 proceeding further .
 3 The scope for confusion in the evidence relates to
 4 the issue of whether the control room staff either
 5 opened or followed the action plan for "Bomb -- general"
 6 and what is meant by those terms in the various
 7 documents and statements in which they've been
 8 referenced .
 9 Of course, sir , you will determine the facts , but
 10 the evidence of a duty team leader Michelle Gregson and
 11 Lisa Owen, and the duty operations officer ,
 12 Janine Carden, is to the effect that in the light of the
 13 information coming into the control room, the team
 14 leaders decided that the duty NILO should be informed
 15 and that resources would not be mobilising other than
 16 under his instruction . This action corresponds with the
 17 first action that would have been required of
 18 North West Fire Control under the "Bomb -- general"
 19 action plan, which was current at that time and with
 20 which the control room team leaders were familiar .
 21 Whether the control room staff actually followed the
 22 "Bomb -- general" action plan in the sense that they
 23 followed the sequence of events set out in the plan is
 24 a matter which may have to be explored in more detail in
 25 evidence. Some of the control room staff have, as you

1 know, sir , recently provided further statements to
 2 reflect what they will say is a more accurate account of
 3 this important aspect of the events, the investigation
 4 into which, it is submitted, falls squarely within the
 5 inquiry's terms of reference 3(iii) and 5(iii) .
 6 In addition , the witness Janine Carden, the
 7 operations manager who arrived in the control room at
 8 11.05 that night in response to being notified of the
 9 incident , has provided further information and an
 10 additional statement is to be taken from her by the
 11 inquiry team.
 12 Sir, I turn to the response by the control room
 13 under terms of reference 3(iii) and 5(iii) . The control
 14 room received two initial calls from the emergency
 15 services , which provided the basic information necessary
 16 to permit Fire Control's control room staff to make
 17 a decision in relation to mobilisation of tenders and
 18 personnel. The first of these calls was, as you've
 19 heard, from Greater Manchester Police. It was initially
 20 unconnected with the attack at Manchester Arena. The
 21 call commenced at 22.32 and in the course of that call ,
 22 at 22.34.44, Greater Manchester Police asked
 23 North West Fire Control:
 24 "Have you been told about an explosion in the city
 25 centre?"

1 The control room operator, David Ellis , said that
 2 they had not. He closed down the unconnected incident
 3 which had initiated the call , leaving the telephone line
 4 with the police open.
 5 At 22.35.15 the police then informed Mr Ellis that
 6 they had just been told that there had been an explosion
 7 in the foyer area of the Manchester Arena and, at
 8 22.35.50, that a bomb had exploded at the arena. Almost
 9 immediately, some details of casualties were relayed to
 10 Fire Control by Greater Manchester Police.
 11 At 22.37.20, the police informed Fire Control that
 12 it was believed that there were 30 or 40 casualties but
 13 that that was unconfirmed.
 14 At 22.38.51, the control room operator David Ellis
 15 opened the explosion action plan and, at 22.39.20, told
 16 the police , after consulting with Lisa Owen, one of the
 17 duty team leaders , that North West Fire Control was
 18 going to inform the duty NILO before mobilising . This
 19 telephone call was eventually closed down at the request
 20 of Greater Manchester Police at 23.01.12.
 21 The second of these calls came in to Fire Control's
 22 control room at 22.37 from the Ambulance Service. It
 23 was taken by Fire Control's control room operator
 24 Joanne Haslam and the call informed North West Fire
 25 Control -- these were the words:

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1 "... the bomb has gone off, by the way."
 2 North West Fire Control passed to the
 3 Ambulance Service at 22.38.58 the information concerning
 4 the number of casualties that had been provided to them
 5 by Greater Manchester Police. During this call ,
 6 Joanne Haslam made a number of requests for further
 7 information from the Ambulance Service including , at
 8 22.42.13, a request for any further information to the
 9 fire crews.
 10 At 22.43.11, the Ambulance Service reported to
 11 North West Fire Control that they were receiving reports
 12 of people being shot:
 13 "There is a [report] of a shooter ... a shooter going
 14 on as well ."
 15 At 22.44.29, a caller reported that there were
 16 60 casualties .
 17 At 22.45.14, a caller reported:
 18 "I have just been informed that there's an active
 19 shooter."
 20 At 22.46.23, Fire Control sought and received from
 21 the Ambulance Service confirmation for the purposes of
 22 recording details on the incident log that they had had
 23 reports of a bomb that had exploded, that there were 60
 24 casualties , and there was an active shooter. It is
 25 apparent from the transcript that Joanne Haslam

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1 continued to provide information to the
 2 Ambulance Service. This took the form of road closure
 3 details , details of a rendezvous point provided by
 4 Greater Manchester Police outside the cathedral .
 5 At 22.48.28, the Ambulance Service enquired whether
 6 there was any further information and Fire Control was
 7 able to report that they did have further information
 8 that had just been put on the log of shrapnel wounds.
 9 This call was closed down at 22.49.28.
 10 According to the brief statement provided by
 11 Joanne Haslam to Greater Manchester Fire and Rescue
 12 Service for use by Greater Manchester Police at the time
 13 of the initial investigation , at a point approximately
 14 47 seconds into the call received from the
 15 Ambulance Service, she informed the team leaders ,
 16 Michelle Gregson and Lisa Owen, that North West Fire
 17 Control had just received a call from the police and
 18 that David Ellis had created an incident log . She
 19 provided them with the remainder of the information
 20 which had come from the Ambulance Service.
 21 It's important to appreciate also that within the
 22 time parameters of these two calls , North West Fire
 23 Control made its first call to the duty NILO, Station
 24 Manager Berry, at 22.40 hours. That call was made by
 25 Michelle Gregson.

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1 At 22.40.10, Fire Control, through her, reported the
 2 fact to Mr Berry that there had been an explosion at the
 3 Manchester Evening News Arena, and I'm going to quote
 4 from the transcript :
 5 "... it's already detonated... the police that we've
 6 got on the line are saying it is a bomb... there's been
 7 30 casualties reported so far ... the rendezvous point at
 8 the moment is the car park area outside the cathedral ...
 9 I've just phoned you while we're still on to the police .
 10 Would it be all right for you to get in touch with them?
 11 Obviously we are not mobilising at the moment... can you
 12 just speak to them and we'll hang fire ..."
 13 At 22.41.58, Michelle Gregson, the line remaining
 14 open, informed Station Manager Berry that they had just
 15 got a member of the public on the telephone and they
 16 were just getting some more information in and she said
 17 to Station Manager Berry, "But I don't know if you want
 18 that at the moment." Station Manager Berry indicated
 19 that he did not and he then gave the following
 20 instructions to North West Fire Control. These were his
 21 words:
 22 "Just give me four pumps to standby or rendezvous at
 23 Philips Park for now. I'll speak to the Force Duty
 24 Officer ."
 25 At 22.44, Rochelle Fallon , control room operator,

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1 left a voicemail on Station Manager Berry's mobile
 2 telephone making him aware of reports that people had
 3 been shot. The member of the public to whom
 4 Michelle Gregson was referring was Mr Hosken. His call
 5 was received by the control room operator Dean Casey at
 6 22.41. He reported that there had been a big blast and
 7 that there were people with shrapnel in the neck and
 8 back. At 22.42.25, Mr Hosken asserted that:
 9 "Looking at the people, I would suggest it's a dirty
 10 bomb of some description."
 11 A NILO, as I've already indicated, has a degree of
 12 security clearance, which North West Fire Control's
 13 operators and team leaders do not have. NILOs are
 14 security cleared, trained and qualified managers who can
 15 advise and support other agencies on the Fire and Rescue
 16 Service capability to reduce risks and safely resolve
 17 incidents. They can be provided with restricted and
 18 sensitive information. There would, we submit, be no
 19 expectation from the team leaders and duty operations
 20 manager at Fire Control that communications between the
 21 duty NILO and the force duty officer would necessarily
 22 be shared with Fire Control or passed over the Airwave
 23 radio.
 24 It follows from the above that within less than
 25 4 minutes of the information coming into the control

1 room that a bomb had exploded, the two team leaders made
 2 the decision that before North West Fire Control would
 3 mobilise, the duty NILO was to be informed. When he was
 4 informed, Station Manager Berry gave a clear instruction
 5 that four pumps were to standby or rendezvous at
 6 Philips Park and he used these words, "for now".
 7 He indicated, as you've heard, he would speak to the
 8 force duty officer. This was a clear instruction from
 9 the duty NILO to Fire Control. And from that point
 10 onwards, Fire Control complied with the duty NILO's
 11 requirements and with instructions from other senior
 12 officers at Greater Manchester Fire and Rescue Service.
 13 Four tenders were mobilised to Philips Park
 14 Fire Station. Both Michelle Gregson and Lisa Owen were
 15 of the opinion that Station Manager Berry's instructions
 16 constituted the action that they would also expect in
 17 these circumstances.
 18 At 22.44, Lisa Owen contacted the duty operations
 19 manager for NWFC, Janine Carden, and informed her that
 20 North West Fire Control had not mobilised to the
 21 incident scene and that Station Manager Berry required
 22 four appliances to muster at Philips Park and that he
 23 had not authorised anyone to proceed to the incident.
 24 At 23.05, Janine Carden arrived at the control room.
 25 Her statement and the statements provided by

1 Michelle Gregson and Lisa Owen, we submit, establish
 2 very clearly that, having regard to the information
 3 coming into the control room, this incident appeared to
 4 be an MTFA incident and that the action plan for
 5 Operation Plato's implementation phase would have
 6 required Fire Control to take the steps that it had
 7 taken.
 8 The data available from the control room establishes
 9 what action was taken in the control room and the times
 10 and this will be of significance to the inquiry when
 11 considering the issue of the potential for confusion
 12 in relation to the steps taken with the predetermined
 13 action plans described in some of the witness statements
 14 that have been provided by North West Fire Control
 15 personnel.
 16 Sir, I turn to terms of reference and 5(iii) in
 17 particular, the adequacy of the control room's response.
 18 The evidence relating to the qualifications and
 19 experience of the control room staff who were on duty
 20 at the time of the incident establishes that they were
 21 possessed of the necessary expertise and training to
 22 equip them to make the correct decisions in the light of
 23 a demanding and fast-moving situation. They were
 24 properly trained for this type of emergency.
 25 Janine Carden, the operations manager, was the

1 day-to-day specific point of contact with
 2 Greater Manchester Fire and Rescue. She had already
 3 demonstrated her capability in the course of what are
 4 known as MTFA audits and training for precisely such an
 5 event. This is evidenced by the fact that in early
 6 February of 2016, Greater Manchester Fire and Rescue
 7 Service hosted a visit arranged by the Chief Fire
 8 Officers' Association, the purpose of which was to
 9 determine the level of preparedness of the fire and
 10 rescue service for an MTFA incident.
 11 By an email of 12 February 2016, the Fire and Rescue
 12 Service, through both group manager John Fletcher and
 13 Assistant Chief Fire Officer Dave Keelan, expressed
 14 their admiration for Janine Carden's contribution to
 15 that exercise. These are the relevant words of that
 16 email:
 17 "I believe Dave Keelan will be emailing you later on
 18 the same subject. I just wanted to pass on my
 19 appreciation for the efforts of Janine yesterday with
 20 the assurance visit. From the feedback given by the
 21 auditors, she gave a stellar performance with her level
 22 of knowledge, not just around the mobilising but also
 23 the wider MTFA incident implications."
 24 Janine Carden had informed the head of
 25 North West Fire Control, in a series of emails

1 associated with this , that the staff should all have her
 2 knowledge already.
 3 Therefore, and it follows from the above, acting on
 4 the initiative of its team leaders, Michelle Gregson and
 5 Lisa Owen, North West Fire Control took the decision to
 6 inform the duty NILO and not to mobilise to the scene
 7 but instead to await further instructions from the Fire
 8 and Rescue Service. This decision was endorsed by
 9 Janine Carden, the duty operations manager, when she
 10 arrived at North West Fire Control and was briefed by
 11 the team leaders in relation to the information received
 12 into the control room and the actions that they had
 13 taken. These decisions were consistent with the initial
 14 requirement that would have been imposed on Fire Control
 15 by the Fire and Rescue Service's predetermined action
 16 plan for a "Bomb -- general" on Fire Control's
 17 computer-aided despatch system, which, had it been
 18 followed , would have required North West Fire Control's
 19 personnel to have taken the steps that they actually
 20 took, namely:
 21 "To inform the duty NILO, request guidance on
 22 actions to be carried out before proceeding further --
 23 bomb general."
 24 These decisions were also consistent with the
 25 information coming into the control room.

1 North West Fire Control contend that this decision
 2 was the correct one to take. This will , of course, be
 3 a matter for the inquiry to determine and that will be
 4 done in the light of the evidence, but for the time
 5 being North West Fire Control takes issue with the
 6 proposition that has been advanced by some witnesses and
 7 by the independent fire expert, Mr Hall, that North West
 8 Fire Control should have mobilised tenders and personnel
 9 to the scene and should have followed the explosion
 10 action plan on their system.
 11 That proposition , advanced as it is by Mr Hall at
 12 paragraphs 45 to 47 of his addendum report, and by the
 13 Chief Fire Officer , Peter O'Reilly , who was duty
 14 principal officer at the time, in paragraph 114 of his
 15 statement, is, North West Fire Control submit, entirely
 16 misconceived.
 17 This may seem to be an ambitious submission by North
 18 West Fire Control, involving , as it does, serious
 19 challenge to the opinion of an experienced senior fire
 20 officer and to that of an independent expert in
 21 fire control , but it is our duty to give clear notice
 22 that the stance adopted by these witnesses in this
 23 respect will be submitted, on North West Fire Control's
 24 behalf, to be unsustainable and unrealistic .
 25 It is also important to add that, in Mr Hall's

1 addendum report, Mr Hall states that :
 2 "A decision to choose one action plan over another
 3 is down to the individual assessment made at the time by
 4 the operator and/or the duty team leader."
 5 And that:
 6 "North West Fire Control operators would be best
 7 placed to provide a rationale for why that decision was
 8 taken based on any training they had received ."
 9 These comments in particular , we submit, require
 10 close examination in the course of evidence by the
 11 inquiry .
 12 The reason why Fire Control contends that this
 13 proposition is entirely misconceived is that, given the
 14 nature of the incident and the risk to Fire Service
 15 personnel of a potential deployment to an MTFA hot zone,
 16 the team leaders were conscious, as a result of their
 17 training , that Fire Service personnel could be placed at
 18 risk of fatality or serious injury as a result of being
 19 mobilised to the scene without further information
 20 concerning the seriousness of the threat and the risk .
 21 Fire Control did not have that information and was
 22 in no position to determine the appropriateness or
 23 otherwise of deploying pumps and personnel to the scene
 24 of an exploded bomb. They knew an incident of this
 25 nature and casualties on this scale required the

1 mobilising displayed by the Fire Service. The "Bomb --
 2 general" Operation Plato action plan required the duty
 3 NILO to be contacted as a first step and that in the
 4 absence of instructions to do so, North West Fire
 5 Control should not mobilise to the scene.
 6 Within less than 4 minutes of the receipt of the
 7 information that a bomb had exploded at the arena, the
 8 duty NILO had been appraised of the situation , including
 9 the number of casualties and the police rendezvous
 10 point.
 11 Shortly thereafter , reports were received from both
 12 the police and the Ambulance Service of a possible
 13 shooting as well and of an active shooter and it would
 14 have been obvious that North West Fire Control would
 15 expect that the situation would result in the
 16 transmission of a METHANE message by one or more of the
 17 emergency services and that Operation Plato could be
 18 expected to be declared by the police .
 19 In fact , if multi-agency communications worked as
 20 they should have done in accordance with JESIP
 21 principles , North West Fire Control would have been
 22 informed that Operation Plato had been declared while
 23 both of the initial calls from the police and the
 24 Ambulance Service were in progress and the lines
 25 remained open.

1 That information could have been conveyed to Station
 2 Manager Berry, who was unable to contact the force duty
 3 officer . In such circumstances, Fire Service personnel
 4 could not under any circumstances be mobilised directly
 5 to the incident . Janine Carden's statement to the
 6 inquiry demonstrates the reasons for the decision and
 7 I will , if I may, quote from part of her statement:
 8 "The incident appeared to be an MTFAs incident and
 9 the actions for this would require us to inform the duty
 10 NILO and to await further instruction . At the time of
 11 this incident , the action plan for the Operation Plato
 12 implementation phase required of us those steps . The
 13 agreed process was clear : that we were not to mobilise
 14 any resources until confirmation from the NILO had been
 15 received , confirming which resources were required and
 16 where they were to be mobilised ."
 17 After Station Manager Berry was contacted and
 18 provided GMFRS's instructions to Fire Control ,
 19 Fire Control took all steps required of them by the Fire
 20 Service and this is established by the real evidence
 21 available from the recording of calls coming into and
 22 out of the control room .
 23 Appendix 1 to the written opening statement consists
 24 of analysis of calls into and out of the control room
 25 from the time at which information that a bomb had

1 exploded at the arena was received by Fire Control ,
 2 22.35.50, until the point at which pumps and personnel
 3 were mobilised to the scene, 00.25.02.
 4 It's necessary to point out that Station
 5 Manager Berry has considerable experience in the
 6 management of MTFAs situations. After the arena attack ,
 7 he took on responsibility for the MTFAs lead following
 8 the departure of Neil Gaskell to the Home Office on
 9 secondment. He was responsible for training and
 10 implementation of the new joint operating principles .
 11 His training and experience is incorporated in his
 12 statement and other documents .
 13 North West Fire Control contend that he could have
 14 been in no doubt that his advice was being sought by
 15 Fire Control when the team leader Michelle Gregson spoke
 16 to him at 22.40, and he was told that Fire Control was
 17 not mobilising at the moment .
 18 The inquiry may wish to explore in evidence with
 19 Station Manager Berry the accuracy of a claim that he
 20 has made in paragraph 52 of his witness statement that
 21 normally Fire Control would follow their action plan and
 22 that would mean sending the resources specified in the
 23 predetermined attendance listed on that action card
 24 straight to the address of the incident . He should be
 25 aware that there are several action cards. His

1 assertion that it is not the role of the NILO to
 2 determine what initial resources are sent because they
 3 are already determined by the action card requires
 4 detailed scrutiny since that is precisely the role of
 5 the NILO in respect of the action cards which were on
 6 the computer-aided despatch system for use in respect of
 7 bombs and MTFAs, as already explained.
 8 Likewise , his statement that he wished he had
 9 challenged what he was being told by Fire Control is
 10 inconsistent with his experience and position . The
 11 inquiry may wish to consider in this context his
 12 acknowledgement in his written evidence that on the
 13 basis of what he had been told:
 14 "This was a terrorist incident ."
 15 And that:
 16 "From the outset my thought process was that this
 17 was a terrorist attack ."
 18 The inquiry may also wish to consider whether what
 19 has been said in paragraphs 65 and 70 of Station
 20 Manager Berry's statement is an attempt by him to dilute
 21 his responsibility for the obligation to communicate the
 22 necessary decisions in relation to mobilisation ,
 23 including any command structure, to North West Fire
 24 Control's control room .
 25 The former Chief Fire Officer , Peter O' Reilly ,

1 arrived at Greater Manchester Fire and Rescue Service
 2 headquarters shortly before midnight. Mr O'Reilly has
 3 provided evidence to the inquiry that in the course of
 4 a meeting held with the Mayor of Greater Manchester on
 5 24 May 2017, when the passage of time between the
 6 initial call and the deployment of the first fire tender
 7 to the scene was discussed , the initial information
 8 GMFRS had received led to the decision not to deploy to
 9 the scene but to use Philips Park as a muster point .
 10 He explained that the information that the Fire
 11 Service had been given was that there was an explosion
 12 and an active shooter, and he records in his evidence
 13 that he informed the Mayor of Greater Manchester of the
 14 following :
 15 "We discussed that if this information had been
 16 accurate and we had deployed directly to the scene,
 17 there was a risk that firefighters could have been shot
 18 or involved in a secondary explosive attack ... I told
 19 the mayor that as a firefighter it would kill me if
 20 I found out that we could have saved more people by
 21 getting there quicker but I also knew that the Fire
 22 Brigades' Union and the Health and Safety Executive
 23 would have had me in the dock if firefighters had been
 24 sent directly to the scene and had been killed by
 25 a terrorist ."

1 The inquiry may wish to press the former Chief Fire
 2 Officer in relation to the conversation he held with the
 3 Mayor of Greater Manchester. The inquiry legal team may
 4 also wish to ask the former Chief Fire Officer what his
 5 evidence would have been had North West Fire Control
 6 deployed tenders and personnel to the scene and they'd
 7 been fatally injured by a terrorist act.

8 The inquiry may also wish to (inaudible: distorted)
 9 requirement that is clearly referenced in JESIP
 10 documentation for the need to have regard to the safety
 11 of fire crews and personnel.

12 None of the senior officers involved in this
 13 incident at any time asked Fire Control to take any
 14 different steps to the one that they had taken. None of
 15 them questioned the action taken at the time. Further,
 16 had Chief Fire Officer O'Reilly disagreed with the
 17 mobilising decision that had been made by North West
 18 Fire Control, namely to contact the duty NILO and seek
 19 advice, he would undoubtedly have said so. He was free
 20 to authorise other and different action and he was
 21 overseeing a situation in the hands of the NILOs, who
 22 were, in the early stages, the incident commanders.

23 North West Fire Control called Station Manager Berry
 24 at 22.40. They called General Manager Dean Nankivell at
 25 22.52. The inquiry may wish to consider whether the

1 evidence of these witnesses in seeking to suggest that
 2 there were failures in Fire Control's mobilising
 3 response to the incident and, with the greatest respect
 4 to them and their experience, has retrospectively
 5 generated criticism of the actions of Fire Control for
 6 the purposes of deflecting criticism from themselves.
 7 Regrettably, this issue needs to be tackled in the
 8 course of the inquiry.

9 In particular, none of these witnesses have
 10 confronted in evidence the issue of how the explosion
 11 action card can be interpreted as applicable to an
 12 exploded bomb in the form in which it had been loaded on
 13 to Fire Control's computer-aided despatch system. These
 14 are all, it is submitted, areas of investigation that
 15 should be ventilated in the course of the inquiry.

16 There are 12 important conclusions we submit are
 17 capable of being drawn from an examination of the
 18 transcripts of calls coming into and going out of the
 19 control room, constituting as they do the best evidence
 20 of the communications passing between Fire Control and
 21 Fire Service personnel and the actions that Fire Control
 22 took in response to the incident.

23 The inquiry will consider the whole of evidence
 24 of course, but Fire Control offer the following
 25 conclusions, which, we submit, appear to be compelling

1 in the light of this material.

2 First, that Fire Control's team leaders,
 3 Michelle Gregson and Lisa Owen, who were on duty at the
 4 material time, took the decision, upon receipt of the
 5 information conveyed in the calls from Greater
 6 Manchester Police and the Ambulance Service, not to
 7 mobilise resources to the scene of the incident but
 8 instead to immediately inform the duty NILO, Station
 9 Manager Berry, and obtain his instruction.

10 Second, that decision was endorsed as an appropriate
 11 one by Janine Carden, the operations manager, after she
 12 arrived in the control room at 11.05.

13 Third, the North West Fire Control control room
 14 personnel did not either open or follow the "Bomb --
 15 general" action plan which was on their that systems and
 16 provided to them by GMFRS. The action they took was to
 17 adopt the first step by way of actions which that plan
 18 required, which was to inform the duty NILO. This was
 19 in accordance with the training and experience that the
 20 team leaders had and their knowledge of what would be
 21 required in the event of an MTFA or a declaration of
 22 Operation Plato.

23 Fourth, although the control room operator,
 24 David Ellis, opened the explosion action card after
 25 first being notified of the incident, that plan was not

1 followed after the two team leaders were consulted.

2 Five, at 22.40, approximately 4 minutes after
 3 Fire Control was first notified of the fact that a bomb
 4 had exploded, Michelle Gregson, the duty team leader,
 5 informed the duty NILO of the information that had been
 6 received from Greater Manchester Police and informed him
 7 that Fire Control was not mobilising at that moment.
 8 Station Manager Berry impliedly endorsed that decision.
 9 He gave instructions to Fire Control, which was to
 10 mobilise pumps to Philips Park Fire Station and
 11 indicated that he would speak to the force duty officer.
 12 He did not thereafter convey to Fire Control the ensuing
 13 and frustrating continuous failure which he experienced
 14 in attempting to contact the force duty officer.

15 Six, at 22.40.44, North West Fire Control informed
 16 Station Manager Berry that the declared rendezvous point
 17 at the moment was the Cathedral Car Park. Station
 18 Manager Berry made the decision not to deploy to that
 19 rendezvous point. If deployment of personnel and pumps
 20 to that rendezvous point had taken place within the
 21 average response time of Fire Control and the Fire
 22 Service, both the Fire Service and Fire Control would
 23 have been provided with a degree of situational
 24 awareness from the incident commander on the ground and
 25 would later have become aware of the updated rendezvous

1 point at Hunts Bank at 22.54.
 2 Seven, from the point at which instructions were
 3 received from Station Manager Berry, North West Fire
 4 Control acted entirely in accordance with the
 5 instructions provided to them by Greater Manchester Fire
 6 and Rescue Service. These instructions were provided by
 7 the NILOs, Berry, Meakin and Levy, and from the duty
 8 group manager, Dean Nankivell, who established himself
 9 in the command support room at Fire Service Headquarters
 10 at 11.30 pm. The Assistant Chief Fire Officer and the
 11 Chief Fire Officer, Peter O'Reilly, joined him there
 12 shortly thereafter.
 13 Eight, the instructions given to North West Fire
 14 Control included a requirement to mobilise pumps,
 15 Technical Rescue Unit and MTFA capability to
 16 Philips Park Fire Station.
 17 Nine, as the transcripts will show, North West Fire
 18 Control was specifically instructed not to mobilise to
 19 the scene. They acted in accordance with those
 20 instructions. Once later instructed to mobilise to the
 21 scene, Fire Control again acted in accordance with their
 22 instructions.
 23 Ten, throughout the period embraced by the first
 24 call to North West Fire Control by Greater Manchester
 25 Police until the mobilisation of pumps and personnel to

1 the scene, Fire Control was not provided with sufficient
 2 information to permit them to have shared situational
 3 awareness and, in particular, Fire Control received only
 4 three direct calls providing them with information.
 5 These were from Greater Manchester Police, the
 6 Ambulance Service and one member of the public. There
 7 was one call from British Transport Police, which was
 8 not such as to provide them with any relevant
 9 information.
 10 Eleven, North West Fire Control was not informed
 11 that Operation Plato had been declared at 22.47 and did
 12 not receive any METHANE message informing them that
 13 a major incident had been declared.
 14 Importantly, conclusion 12, the North West Fire
 15 Control control room failed to actively elicit
 16 sufficient information from any of the emergency
 17 services, whether that was by way of enquiring whether
 18 Operation Plato had been declared or whether any
 19 emergency responder had sent any METHANE message or
 20 otherwise. They had failed to elicit sufficient
 21 information from any of the emergency services to permit
 22 them to share that situational awareness with
 23 Greater Manchester Fire and Rescue Service, and we
 24 immediately acknowledge that failure on behalf of
 25 North West Fire Control.

1 Sir, I come to the final part of our oral opening
 2 statement, which deals with failures in communication,
 3 terms of reference part 5(iv), 5(v) and 7(iii).
 4 North West Fire Control monitored the GMP channel
 5 from approximately 23.34 at the suggestion of General
 6 Manager John Fletcher. They were reasonably entitled to
 7 conclude that the other emergency responders would be
 8 using it to share information. This channel was not
 9 used to convey any significant information between the
 10 emergency service responders. The only transmission
 11 made on the talk group was at 1 minute after midnight
 12 when Greater Manchester Police conducted a radio check
 13 to see whether any of the other emergency services were
 14 monitoring the channel.
 15 North West Fire Control was the only emergency
 16 service to respond and confirm that the talk group was
 17 being monitored. The inquiry will be alive therefore to
 18 the criticism that in these circumstances, and in the
 19 knowledge that this was a major incident in which
 20 a METHANE message and declaration of Operation Plato
 21 could be expected, North West Fire Control was not more
 22 proactive in seeking out relevant information in order
 23 that the Fire Service could have situational awareness.
 24 The Kerslake Panel report concluded that
 25 North West Fire Control's control room was placed in an

1 information vacuum that they were not used to. Because
 2 Fire Control did not actively seek further information,
 3 the report concluded that they were dependent upon the
 4 limited information coming into the control room from
 5 other responders. Although Fire Control was in contact
 6 with GMFRS senior staff, as the analysis of the calls in
 7 appendix 1 of the written opening statement
 8 demonstrates, the evidence available to the inquiry
 9 shows that the Fire Service and Fire Control did not
 10 have situational awareness, with the result that
 11 relevant information could not be passed to and from
 12 Fire Control and the Fire Service.
 13 The Kerslake Panel report concluded that it was
 14 insufficient for North West Fire Control to be merely
 15 monitoring the Airwave channel. Operators should have
 16 been actively using the channel to draw METHANE
 17 information from other responders. The company accepts
 18 that criticism, as carefully set out in the
 19 Kerslake Panel report.
 20 The available evidence leads to the conclusion North
 21 West Fire Control's control room did not enquire of
 22 other responder agencies whether a METHANE message had
 23 been passed or whether any of them were aware of the
 24 declaration of Operation Plato. The first enquiry by
 25 the NILOs in relation to Operation Plato came at 00.15

1 from General Manager Levy. Station manager Lawlor
2 mobilised to the multi-agency command module at
3 GMP Headquarters at 00.10 and first discovered that
4 Operation Plato had been declared at 00.15, when he was
5 informed by Superintendent Hill of Greater Manchester
6 Police.

7 North West Fire Control acknowledges and admits its
8 failure to proactively seek more information from
9 emergency responders on the ground in order to achieve
10 more situational awareness both within Fire Control and
11 the Fire Service. It will be a matter for the inquiry
12 to determine whether, had Fire Control made enquiries of
13 other responder agencies, they would in fact have been
14 provided with sufficient information to have in turn
15 informed the three NILOs and subsequently the Chief Fire
16 Officer and those under his command of the true state of
17 affairs on the ground and thereby to have had the
18 necessary situational awareness to have allowed
19 personnel to have been deployed at an earlier stage to
20 the scene.

21 The head of North West Fire Control,
22 Sarah-Jane Wilson, explained in her written evidence
23 lodged with the inquiry that in the course of the
24 briefing that took place in the control room following
25 her arrival at 00.01, she was informed that there had

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1 been no declaration of a major incident or of
2 Operation Plato and that no METHANE message had been
3 passed and that Janine Carden, operations manager, would
4 have expected Operation Plato to have been declared.

5 Ms Wilson reached the conclusion that because
6 resources were being held at rendezvous points and
7 because the police were in command of the incident, the
8 police would be carefully controlling who had access to
9 the scene. It did not occur to her at that time that
10 other emergency responders held necessary information
11 which was not being shared with the Fire Service and
12 should have been. Such a failure, she has pointed out,
13 ran contrary to the MTFA mutual assistance mobilising
14 arrangements, though the inquiry must be reminded that
15 part of those arrangements placed an obligation on Fire
16 and Rescue control centre, where there were indicators
17 of an unfolding Operation Plato, that it must be
18 communicated to the other local emergency services'
19 control centres.

20 North West Fire Control acknowledges that the
21 information received in the control room in fact did
22 indicate an unfolding Operation Plato event, as the
23 operations manager and team leaders also believed, and
24 as their evidence shows they appreciated.

25 The evidence provided by the head of Fire Control,

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1 Sarah-Jane Wilson, is that she was unaware that
2 communications on the ground had failed to the extent
3 that they had until she saw the publication in final
4 draft of the Kerslake Report. In particular, she did
5 not imagine that on the night the other emergency
6 services would have failed to pass critical information
7 such as the major incident declaration, METHANE message
8 and Operation Plato declaration.

9 That belief is understandable. The NILOs and the
10 Fire Service command support room had their own channels
11 of communication with other responder agencies, which
12 was not routed through North West Fire Control.

13 Further, the staff of Fire Control in the control
14 room, including senior management once they arrived,
15 expected that inter-agency communications were taking
16 place and that the absence of a deployment of resources
17 to the scene was agreed between the Fire Service, the
18 Ambulance Service and Greater Manchester Police.

19 Whatever criticisms are to be levelled at
20 North West Fire Control in the course of the inquiry,
21 they need to be balanced against the level of
22 communication failures which the evidence demonstrates.

23 One issue for the inquiry, therefore, in the context
24 of the terms of reference part 5(v) and 7(iii) is what
25 information ultimately and on the facts as in due course

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1 found would have been likely to have been passed to
2 North West Fire Control if they had been more proactive
3 in seeking answers from the other emergency responders'
4 control rooms and what the consequences would or might
5 have been in terms of earlier assistance with
6 casualties.

7 A study of the evidence of senior officers at the
8 Fire Service shows that they were personally unable to
9 obtain adequate information even though they were
10 seeking to do so independently of the Fire Control.

11 The inquiry will also wish to consider in the
12 context of a systemic failure in coordinating the
13 response of the emergency services what part the
14 respective agencies played in terms of their
15 contribution to that state of affairs.

16 Finally, we would like to say this. North West Fire
17 Control has taken action in light of these events to
18 ensure that its control room is proactive in seeking
19 information from the emergency responders for the
20 purposes of achieving shared situational awareness. The
21 head of North West Fire Control was herself instrumental
22 in devising Fire Control's own major incident action
23 plan, which is available on Magnum and which is to be
24 applied in conjunction with the revised arrangements for
25 24-hour monitoring of the talk group that is now in

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1 place.
2 The North West Fire Control major incident action
3 plan provides detailed guidance to control room
4 operators to ensure that they actively seek information
5 from police and ambulance controls and that they're able
6 to identify and co-locate multi-agency rendezvous
7 points.

8 I need to stress on behalf of North West Fire
9 Control once more: in so doing, North West Fire Control
10 has recognised and acknowledged its failings on the
11 night and it has taken measured and responsible steps to
12 ensure that such failings are not repeated.

13 Thank you, sir.

14 MR GREANEY: (Inaudible: no audio) at 2 o'clock when we'll
15 hear the opening statement on behalf of the University
16 of Salford.
17 (12.54 pm)

18 (Lunch adjournment)
19 (2.10 pm)

20 SIR JOHN SAUNDERS: Mr Greaney.

21 MR GREANEY: Sir, we are now going to hear the penultimate
22 opening statement, that being the opening statement of
23 the University of Salford delivered by Mr Browne.

24 SIR JOHN SAUNDERS: Thank you.
25 Mr Browne.

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1 Opening statement by MR BROWNE
2 MR BROWNE: I appear with Andrew Hartley, who is to my
3 right. He is general counsel of the University of
4 Salford and the director of legal and compliance.

5 We are assisted by a team of excellent solicitors
6 from Hill Dickinson: Iain Campbell, Joseph Cooper and
7 Laura Scott.

8 At the outset, sir, on behalf of the entire
9 university, I want to express our sincere condolences to
10 the families and loved ones of those who died in the
11 bombing and to all of those injured in or otherwise
12 affected by it.

13 The university continues to be committed to
14 assisting the inquiry in its work to the fullest extent
15 required of it.

16 The university was shocked and appalled to learn
17 that Salman Abedi was one of its registered students,
18 and recognised that an appropriate and necessary
19 response would be to review the adequacy and
20 effectiveness of its duties under Prevent and its
21 structures and mechanisms around student welfare,
22 support and engagement; I will return to the Prevent
23 duty later in this opening.

24 You, sir, and the families, rightly have an
25 expectation that corporate core participants will

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1 discharge their duty of candour in all of their dealings
2 with this inquiry. In summer 2017, and so very soon
3 after the atrocity, the university established its
4 independent review and subsequently shared its report
5 widely. It has continued in a spirit of openness and
6 transparency in the manner in which it has engaged with
7 the inquiry.

8 Just some words about the university, if I may. The
9 university has a very distinct history, local identity
10 and tradition. It has been part of the fabric of the
11 city of Salford for almost 125 years. Following the
12 establishment of the Royal Technical Institute of
13 Salford in 1896, the university was established as
14 a higher education institution through its Royal Charter
15 granted in 1967.

16 The university's history and evolution has been
17 intertwined with that of the city of Salford from its
18 earliest days. It has been consistently devoted to
19 encouraging people from all backgrounds to offer a route
20 into higher education, to raise educational aspiration,
21 and attainment. 99% of its students are state educated,
22 25% come from low-income families, 28% have BTEC as
23 their highest qualification on entry and, in 2018, 50%
24 of its students came from Greater Manchester, with 61%
25 of its graduates staying in Greater Manchester for

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1 further work or study.

2 In 2017, the university offered a range of degree
3 subjects across seven schools, including the business
4 school where Salman Abedi was registered. At this stage
5 we provide a relatively brief introduction to
6 Salman Abedi's time at the university.
7

8 At the time of the attack, Salman Abedi was
9 a second-year student in the business school. He had
10 been studying for a BSc on the business and management
11 programme. The contents of his UCAS application record
12 his academic achievement and a personal statement. UCAS
13 is the Universities and Colleges Admission Service, a
14 UK-based organisation whose role it is to operate the
15 application process for British universities. On this
16 form, he did not declare any criminal convictions and
17 there was nothing remarkable whatsoever about his
18 application.

19 Prior to the attack, the university had no knowledge
20 of any of the behavioural problems which it is said that
21 Salman Abedi displayed when he was a student at either
22 Burnage Media and Arts College or Manchester College.

23 His academic career at the university was, up to the
24 end of the first term of his second year and beginning
25 of the second term, unremarkable. No approaches were
made by him to the university's Ask Us student welfare

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1 and support services . There were no student
2 disciplinary cases or referrals for him. He appears not
3 to have actively participated in student or other
4 university societies .

5 His first year was completed satisfactorily . It is
6 acknowledged that his academic progress began to
7 deteriorate in his second year, culminating in his
8 effective disengagement from academic life in or around
9 January 2017.

10 At that time, his school's student progression
11 administrator attempted to communicate with him to
12 encourage him to re-engage with his studies , but without
13 success. What we now know is that he failed to log on
14 to university IT systems after March 2017.

15 The university notes from the evidence given in the
16 trial of Hashem Abedi that, in the months prior to the
17 attack, he and Salman Abedi used a number of different
18 mobile phones. This would have likely made any further
19 attempt by the university to contact Salman Abedi
20 difficult if not impossible as it had one mobile phone
21 number for him. No doubt given his attempts to cover
22 his tracks , he would likely not have taken any further
23 calls even if made.

24 If the university had commenced formal proceedings
25 against Salman Abedi based on his disengagement and

1 non-attendance, there is every likelihood that these
2 would only have concluded at the end of the 2017
3 academic year in or around June 2017. This is because
4 it is the examination board that sits at the end of the
5 year which makes the final decision as to the withdrawal
6 of a student from the university .

7 What is clear is that prior to the arena attack, the
8 university had no reason whatsoever to suspect that
9 Salman Abedi had been radicalised or had been drawn into
10 terrorism . It is especially important to note, we
11 respectfully submit, that at no time did Greater
12 Manchester Police or the security services provide any
13 information to the university whatsoever about him. In
14 particular , the university received no information that
15 the authorities considered he may have been radicalised
16 or had been drawn into terrorism or was of any other
17 concern to them.

18 Indeed, in his witness statement at paragraph 258,
19 Senior Investigating Officer Barraclough notes that the
20 materials relating to Salman Abedi recovered from the
21 university had been assessed and nothing of relevance to
22 the criminal investigation was found.

23 A brief word, if I may, sir , about university life
24 and a contrast with school. Independence of learning is
25 an important distinguishing feature of university - level

1 education, compared to school and further education .
2 This is evidenced in the guidance that UCAS gives to new
3 applicants when they say:

4 "You won't be prompted or hassled by tutors . After
5 years of structured learning in school with teachers
6 setting homework for you and helping you to plan project
7 work, this might be a bit of a shock to the system."

8 It is therefore important to recognise that the vast
9 majority of university students are young adults and
10 higher education is very much an adult environment in
11 which students are expected to take responsibility for
12 managing their own course attendance and learning
13 arrangements.

14 In this way, unlike at school, attendance of
15 students at particular teaching sessions such as
16 specific tutorials and lectures is not legally
17 compulsory. Furthermore, in higher education, student
18 to staff ratios are usually much higher than at school,
19 which may mean university staff do not have consistent
20 and regular personal contact with any individual
21 student.

22 The approach of the university's policies and
23 procedures in this area is to encourage attendance and
24 engagement. Consequently, it will be unsurprising to
25 hear that a university does not routinely supervise and

1 monitor the behaviour of its students .

2 It is a fact of academic life that a proportion of
3 students will drop out despite the best efforts of
4 academic staff . At Salford this , is approximately 5%
5 per year .

6 Turning to an overview of Prevent. Under the
7 Counter-terrorism and Security Act 2015, universities
8 are required to:

9 "... have due regard to the need to prevent people
10 from being drawn into terrorism ."

11 This is commonly known as the Prevent duty.

12 Prevent is one of the four strands of the
13 Government's CONTEST strategy. Prevent was extended to
14 other sectors , including higher education, through the
15 2015 Act.

16 The Government's 2015 guidance confirmed that
17 section 26 of the Act placed the Prevent duty on certain
18 bodies and they included local government, criminal
19 justice , education and childcare , health and social
20 care, and police in the exercise of their functions .

21 The 2015 Act states that the authorities , subject to
22 the provisions , must have regard to its 2015 guidance
23 when carrying out the duty. The duty does not stipulate
24 how a specified authority must comply. It is important
25 to note that Prevent is not part of the criminal justice

1 system and does not require the higher education sector
 2 to play a direct part in crime prevention .
 3 The other elements of the CONTEST strategy are:
 4 Pursue, that is the police and security service 's role
 5 to stop terrorist attacks by detecting , prosecuting and
 6 otherwise disrupting those who plot to carry out attacks
 7 against the UK; Protect, which is to strengthen
 8 protection against a terrorist attack in the UK
 9 primarily through the work of police , border security
 10 and those engaged in the transport system, national
 11 infrastructure and public places ; and, finally , Prepare,
 12 reflecting the role of local and Central Government and
 13 the emergency services to mitigate the impact of
 14 a terrorist attack, thereby increasing the UK's
 15 resilience .
 16 Prevent is the only element of CONTEST that applies
 17 to higher education .
 18 The role of the police and security services in
 19 CONTEST, including the Prevent element, is pivotal and
 20 crucial as is reflected in the National Policing
 21 Counter-terrorism Strategy and as detailed in the
 22 statement of Shaun Hipgrave of 27 January this year ,
 23 paragraphs 9 to 12 and 20. Universities are not in
 24 a position to act as law enforcement agencies, rather
 25 the approach of universities to Prevent is centred on

1 protecting the welfare of individuals , it is on
 2 identifying individuals , in this case students,
 3 perceived as having a vulnerability and who may
 4 therefore need support and advice to help steer them
 5 away from a route that could lead to radicalisation and
 6 other extreme behaviour .
 7 The term "due regard", as used in the 2015 Act, does
 8 not impose a positive obligation on authorities like
 9 universities to prevent persons from endorsing terrorism
 10 or from committing terrorist acts, neither does it
 11 require universities to conduct surveillance on their
 12 students. Rather, due regard means that the authorities
 13 should place an appropriate amount of weight on the need
 14 to prevent people being drawn into terrorism when they
 15 consider all the other factors relevant to how they
 16 carry out their usual functions .
 17 For a university to be assessed to be having due
 18 regard to the Prevent facility it must have proper
 19 policies and processes in place which respond to the
 20 statutory guidance and it must be able to demonstrate
 21 that it is actively implementing these policies .
 22 Safeguarding is a key principle underpinning policy
 23 and practice because Prevent is primarily seen as
 24 a welfare issue. If Prevent is to be effective then
 25 it is necessary, indeed fundamental, that there is

1 properly integrated multi-agency working.
 2 A key part of the Prevent strategy is Channel. This
 3 is the route by which an organisation will refer an
 4 individual , with their consent, to a multi-agency panel.
 5 Through this panel, support and assistance is provided
 6 to the individual to help steer them from a path that
 7 could otherwise lead into criminality and even
 8 terrorism .
 9 It will seek to identify those at risk of being
 10 drawn into terrorism , assess what that vulnerability
 11 might be, and then provide appropriate targeted support
 12 for those referred to them. To be effective , this
 13 requires that there is a positive and constructive
 14 multi-agency working between the police , local
 15 authorities , social and health services , the justice
 16 system and, where appropriate , universities .
 17 This can then take the form of case planning with
 18 levels of intervention designed to meet the need in the
 19 individual case. It is important to note that Prevent
 20 is only relevant where it can be used to steer
 21 a vulnerable individual down a path away from
 22 radicalisation . If that person has already been
 23 radicalised , then it is not an issue for Prevent;
 24 rather, it becomes a matter for law enforcement under
 25 the Pursue element of CONTEST.

1 It is of course a matter for this inquiry to
 2 determine if a Prevent referral should or could have
 3 been made in respect of Salman Abedi and others and, if
 4 so, what was the appropriate time to have made such
 5 a referral . However, an important question is also
 6 whether a Prevent referral could ever have been the
 7 right course if the radicalisation of Salman Abedi and
 8 Hashem Abedi had been so deep-rooted that a referral
 9 could or would not have made a difference .
 10 Turning then to the university 's approach to
 11 Prevent. Until 2018, the Higher Education Funding
 12 Council for England, known as HEFCE, was the regulator
 13 of higher education in England and Wales. Under the
 14 2015 Act, between 2015 and 1 April 2018, HEFCE had the
 15 responsibility for monitoring implementation of
 16 the Prevent duty by universities .
 17 In line with HEFCE guidance, most universities,
 18 including Salford , identified the risks pertinent to
 19 their own context and developed appropriate tailored
 20 responses. As I have already explained , Prevent is
 21 primarily seen as a welfare issue since , as stated , the
 22 university 's duty is to seek to identify vulnerable
 23 people and help prevent them from being radicalised .
 24 In practical terms, the identification of vulnerable
 25 students has been embedded into the university 's Ask Us

1 well-being team, the university's single channel for
 2 handling all student welfare and support issues .
 3 On receiving a referral , the well-being team will
 4 triage the matter and direct it to the most appropriate
 5 area of management, differentiating a student's needs,
 6 welfare issues and/or other vulnerabilities towards
 7 teams more able to deal with the issue .
 8 In this way, should the well-being team identify
 9 a vulnerability that a student is at risk of
 10 radicalisation , a referral will be made for
 11 consideration as to whether or not a Channel referral is
 12 appropriate . The university understood its Prevent duty
 13 clearly and were concerns to be raised that an
 14 individual was at danger of radicalisation it would
 15 seriously consider making a Channel referral . HEFCE and
 16 its successor regulator , the Office for Students, has
 17 consistently assessed the university as having due
 18 regard for the Prevent duty .
 19 Turning to state agencies . Under the terms of the
 20 Security Service Act 1989, MI5 has a statutory
 21 responsibility to ensure the protection of national
 22 security from a number of threats including terrorism .
 23 MI5 is responsible in the UK for the collection ,
 24 assessment, dissemination and exploitation of
 25 intelligence from its own sources or other sources on

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1 its behalf . It has the lead role over national security
 2 intelligence in the UK and in countering threats to UK
 3 interests overseas .
 4 In addition , the police play a significant role in
 5 the disruption of terrorist activities and networks . In
 6 his witness statement provided to you, Mr Chairman,
 7 dated 15 July 2019, DCS Dominic Scally deals with
 8 certain important matters concerning Salman Abedi's
 9 movements and what was known by the security services
 10 about him: at paragraphs 100 to 104, what was known
 11 about Salman Abedi by NWCTU and MI5 from December 2010
 12 up to 2017; at paragraphs 105 to 108, details of his
 13 prison visits ; at paragraphs 109 to 111, details of his
 14 trip to Istanbul in May 2016; and at paragraphs 112 to
 15 114, the fact that Salman Abedi was closed as a subject
 16 of interest by MI5 during July 2014 .
 17 Within SIO Barraclough's witness statement, at
 18 paragraphs 226, 228, and 313 to 314, he references
 19 Salman Abedi's repeated trips between the UK and Libya .
 20 The university were wholly unaware of any of the
 21 matters concerning Salman Abedi as set out by DCS Scally
 22 and/or DCS Barraclough . Similarly , those matters set
 23 out in the witness statement of security service
 24 Witness X at paragraphs 83 to 114 concerning MI5's
 25 knowledge of Salman Abedi as an open/closed subject of

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1 interest , his contacts and travel abroad were matters
 2 wholly unknown to the university .
 3 In particular , the university did not know, since
 4 this information was not shared with it , that from
 5 mid-2015 onwards MI5 received information on
 6 Salman Abedi on several occasions, which included
 7 conflicting information as to his espousal of pro-ISIL
 8 views. Similarly , the university did not know since
 9 this information was not shared with it , details of
 10 Salman Abedi's family and/or history and/or if it were
 11 the case the radicalising influences his father or
 12 brothers had upon him. If it was the case that it was
 13 known to the police and/or security services that
 14 Salman Abedi had links to a serious crime group in
 15 South Manchester, that too was information unknown to
 16 the university . It is, we observe, plain that the
 17 university was in no position to have considered that
 18 Salman Abedi might have been radicalised as he was
 19 and/or to take any steps to make a Prevent referral .
 20 Turning then to the university's independent review
 21 if I may, please . This was established in August 2017
 22 and continued to meet until February 2018. The review
 23 panel made certain findings based upon the evidence it
 24 had seen . For present purposes they can be summarised
 25 in this way .

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1 In his second year Salman Abedi began to disengage
 2 from studies during autumn 2016. By the beginning of
 3 2017, and in particular at the time of his examination
 4 on 13 January 2017, he appeared fundamentally disengaged
 5 with his course . In the examination sat on
 6 13 January 2017, he made no attempt to answer any of the
 7 questions on the paper . He left the examination room
 8 at the earliest permitted time, and received a 0% mark
 9 for that paper .
 10 There was clear evidence, had the strands been taken
 11 together , that Salman Abedi had fundamentally disengaged
 12 from his course by the beginning of 2017. The review
 13 panel considered what, if anything, was known by the
 14 university about Salman Abedi and what, if any, action
 15 it could or should reasonably have taken in the light of
 16 that knowledge .
 17 In dealing with this question , there were certain
 18 important matters to which the panel drew attention .
 19 There are six .
 20 Firstly , at no stage did GMP, via CTU or otherwise,
 21 notify the university that Salman Abedi was a person of
 22 interest to them .
 23 Secondly, at no stage did the university have any
 24 information or evidence whatsoever to suggest
 25 Salman Abedi was or might be at risk of being drawn into

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1 terrorism .
 2 Thirdly, from the evidence the panel saw and read,
 3 the consistent theme was that the university did not
 4 have students who presented with extreme political
 5 and/or religious views and opinions .
 6 Fourthly, as would be expected, there appeared to be
 7 good and harmonious relations between staff and
 8 students . Student welfare was at the heart of
 9 the Prevent agenda. The Faith Centre and the chaplains
 10 who work there did and continue to do good, important
 11 work. Inclusivity to all faiths was and remains a key
 12 part of the message they deliver .
 13 HEFCE was satisfied by the university and its
 14 self -assessment in its 2016 Prevent duty report that the
 15 university had had due regard to its Prevent duty .
 16 However, notwithstanding all of the above, the panel
 17 were satisfied that having regard to the extent of
 18 Salman Abedi's disengagement, particularly from the
 19 point in time of 13 January 2017 onwards, there was
 20 a missed opportunity by the business school staff to
 21 communicate to Salman Abedi's personal tutor and/or the
 22 student progression administrator and/or student support
 23 services as to the extent of his lack of engagement.
 24 Had that taken place, then the panel would further
 25 have expected that contact would or should have been

1 made, or at least attempted, with Salman Abedi to
 2 address the possible reasons for this lack of
 3 engagement. However, what the panel could not say was
 4 what, if any, difference this would have made to how
 5 Salman Abedi engaged at the university thereafter . In
 6 particular , the panel stated that it could not know
 7 whether, had effective contact been made with him,
 8 Salman Abedi would have proffered a plausible , or any,
 9 explanation for his disengagement, performance, or what
 10 that explanation might have been. To make any
 11 suggestions in this regard would, in the panel's view,
 12 have been speculative .
 13 The most it could say was that there was a missed
 14 opportunity for university staff to attempt intervention
 15 in order to consider the reasons for his academic
 16 disengagement and what, if any, support and, if needed,
 17 welfare services could then have been offered . In the
 18 light of what we now know from Hashem Abedi's trial, it
 19 seems, at best, unlikely that Salman Abedi would have
 20 responded to any such attempt.
 21 Even had a decision been made to invoke the
 22 provisions of the attendance policy and a point was
 23 reached where Salman Abedi's registration was cancelled ,
 24 the panel found it could not possibly be known within
 25 that time frame what might then have taken place and it

1 could not be known what Salman Abedi's reaction to that
 2 would have been. Had the university terminated his
 3 studies for non- participation he might have sought to
 4 appeal that decision . If so, it could not be known what
 5 the outcome of any such appeal would have been.
 6 Therefore the panel stated it had no evidence to
 7 enable it to say that, even had the attendance policy
 8 cancellation of registration provisions been invoked,
 9 Salman Abedi would have not remained a student at the
 10 university on 22 May 2017.
 11 In its February 2018 report with recommendations,
 12 the review panel issued recommendations to the
 13 university largely around the further strengthening of
 14 its already established systems of student safeguarding ,
 15 support and welfare . All those recommendations have
 16 been accepted and implemented by the university and are
 17 referred to in its lessons learned statement filed with
 18 the inquiry on 5 June this year .
 19 With regard to the inquest and the public inquiry ,
 20 the university has consistently sought to engage
 21 positively and constructively with them, seeking
 22 interested person core participant status at an early
 23 stage. It has co-operated with the inquiry in an open
 24 and transparent manner. It disclosed the reports ,
 25 statements and other documents it had collected as part

1 of its independent review in a complete and
 2 non- selective manner, as was acknowledged by the inquiry
 3 in its update note of 4 October 2019.
 4 Sir, in conclusion of this opening statement, the
 5 shock and sadness suffered by the entire community as
 6 a result of Salman Abedi's hideous actions endures
 7 at the university today. It continues to put the
 8 welfare of its students at its centre, with further
 9 developments being introduced each year. It also
 10 continues to positively discharge its Prevent
 11 obligations and play an active role regionally in this
 12 field .
 13 It is, we respectfully observe, clear that at the
 14 time of the tragedy the university had no information or
 15 material , nor had it received any communication to
 16 suggest that Salman Abedi had been radicalised or was
 17 being drawn into terrorism . Had the university had any
 18 information or material to this effect , or any
 19 information that Salman Abedi was likely to commit the
 20 heinous attack which he did, it undoubtedly would have
 21 acted on it .
 22 SIR JOHN SAUNDERS: Thank you, Mr Browne.
 23 MR GREANEY: Sir, finally so far as chapter 5 is concerned,
 24 we'll hear the opening statement of the
 25 Secretary of State for the Home Department delivered by

1 Ms McGahey.
 2 Opening statement by MS McGAHEY
 3 MS McGAHEY: Sir, I represent the Home Secretary and I make
 4 this statement on behalf of the Home Office and MI5.
 5 Other government departments who are not core
 6 participants have, through the Home Secretary's legal
 7 team, submitted witness statements and documents to the
 8 inquiry .
 9 On behalf of all of these departments and all the
 10 members of this legal team, may I offer our sympathies
 11 to the families and friends of those who lost their
 12 lives . The desperate sadness of the pen portraits has
 13 brought home to everyone the overwhelming grief that
 14 these families have had to bear .
 15 The horrific attack on the arena has also caused
 16 immense suffering to others who were in the City Room
 17 that night , to those who were injured and to those who
 18 now care for and support those who survived and those
 19 who are bereaved . There may be nothing that will make
 20 their suffering any less , but if there is anything, it
 21 may be the knowledge that changes have been made since
 22 May 2017 and that those changes will save other lives
 23 and the vital work of this inquiry is to understand not
 24 just what happened but why and how it happened and to
 25 ensure we all learn all that we possibly can from this

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1 tragedy . The Home Secretary and all of the government
 2 departments involved are wholly committed to supporting
 3 the inquiry in these aims .
 4 In these submissions I will address first issues
 5 relating specifically to MI5 and then, in the second
 6 part, issues relating to the Home Office more widely .
 7 In respect of MI5, as everyone will understand,
 8 it is not possible to give a detailed account on every
 9 point because to do so would jeopardise national
 10 security , but every effort has been made to address each
 11 issue meaningfully .
 12 In a speech delivered in October 2017, the then
 13 director - general set out MI5's approach to the terrorist
 14 attacks that had occurred earlier that year . He said :
 15 "Throughout our history, MI5 has been all about
 16 innovating to meet the changing threat and the shifting
 17 technological environment . We review every major
 18 operation and learn from our successes and when an
 19 attack happens we are determined, using the harsh light
 20 of hindsight , to squeeze out every last drop of learning
 21 that we can to be the very best we can be now and in the
 22 future ."
 23 That approach has been the basis of the response of
 24 MI5 to the numerous reviews and investigations into the
 25 attacks perpetrated in 2017 . The internal reviews that

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1 were conducted by MI5 and Counter-terrorism Policing
 2 after the 2017 attacks in Manchester and London,
 3 overseen by Lord Anderson, were rigorously and intensely
 4 self - critical . The final reports were the products of
 5 months of work compiling all the relevant material and
 6 painstakingly analysing all facts and the systems
 7 engaged .
 8 Everybody engaged in the reviews was driven by
 9 a genuine desire to understand what had happened and
 10 ensure that lessons were learned in the hope that
 11 lessons from all of the attacks would give the UK
 12 intelligence community and their police counterparts the
 13 best possible chance of preventing future attacks .
 14 However, everybody understands that these reviews
 15 are not a substitute for the work of this inquiry ,
 16 which, with the advantage of its oversight of the whole
 17 picture , will look again closely at the matters
 18 considered by the reviews .
 19 The Government recognises that the inquiry provides
 20 an important opportunity to learn from this tragic
 21 event . We need to do everything possible to improve the
 22 ability of all those concerned with the safety of the
 23 public to protect the people of this country and to
 24 protect our way of life .
 25 For this reason and to ensure that, to the greatest

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1 extent possible , the bereaved families are able to gain
 2 a full understanding of the circumstances in which those
 3 they loved lost their lives , MI5 has provided complete
 4 cooperation to the inquiry , including unfettered access
 5 to all the relevant material that it holds . The
 6 chairman and counsel to the inquiry have acknowledged
 7 that cooperation on a number of occasions during the
 8 course of this investigation and MI5 is grateful to you
 9 for that , sir .
 10 But it wants to give these reassurances directly to
 11 the bereaved families and all of those affected by this
 12 terrible attack . Firstly , material has been withheld
 13 from disclosure to core participants only where that has
 14 been necessary in order to protect national security .
 15 We cannot disclose information when that disclosure
 16 could damage the ability of the security agencies to
 17 prevent another attack .
 18 Secondly, the inquiry has been given full and
 19 unrestricted access to all the material that has been
 20 withheld from disclosure to core participants and
 21 arrangements have been made to ensure that the inquiry
 22 has been able to undertake a rigorous and critical
 23 examination of all of that material .
 24 Thirdly, the conversion of the original inquests
 25 into a statutory inquiry means that it will be possible

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1 for counsel to the inquiry thoroughly to test this
2 evidence in a way that would not have been possible had
3 the inquests remained as they were, as inquests .

4 Fourthly, there has never been any question of MI5
5 approaching this investigation or any of the other
6 investigations into the terrorist attacks of 2017 with
7 a defensive mindset or any ambition to avoid scrutiny .
8 The need to protect national security imposes
9 constraints on what can safely be disclosed , but within
10 those constraints MI5 welcomes the scrutiny of its
11 actions and methodologies that this investigation has
12 brought and will continue to bring .

13 It is obviously in everybody's interests to learn
14 lessons or to look at doing things in different ways
15 that would make another attack less likely or less
16 deadly .

17 MI5 understands that there will be people who doubt
18 that it has disclosed everything . The very nature of
19 MI5's work is secretive -- it has to be -- and the fact
20 we cannot make everything public inevitably increases
21 suspicion . But there is no question of secrecy being
22 used to conceal failure . The inquiry team has access to
23 everything . As you, sir , have already indicated , if you
24 identify failure , you will say so publicly .

25 The families and the public are asked to put their

1 faith in you, sir , as the chairman and in the inquiry 's
2 lawyers . The inquiry team know that MI5 has given them
3 unprecedented access to very sensitive information . The
4 inquiry team have been given the reviews written after
5 the attack and given all the documents referred to in
6 those reviews . The inquiry lawyers have had the chance
7 to check that they have a full set of documents and to
8 ask questions if they think there's missing material or
9 gaps in the evidence .

10 Counsel to the inquiry will be able, although in
11 a closed session , to question the MI5 witnesses
12 thoroughly . Counsel to the inquiry and all the core
13 participants will be able to question Witness J in
14 public as well . MI5 has nothing to hide from this
15 inquiry ; successive directors general have said that in
16 public .

17 The security agencies will never be able to stop
18 every attack , but when an attack does happen, it is
19 still a cause of immense shock and sadness to those
20 whose job it is to try to prevent them . MI5 welcomes
21 any recommendation or guidance that would increase the
22 chances of detecting and stopping another attack plan .

23 MI5 hopes that these clear commitments will provide
24 some reassurance to the bereaved families and to all
25 those concerned with the inquiry . Full cooperation has

1 been given and full cooperation will be maintained until
2 the conclusion of this investigation .

3 These terms of reference require the inquiry to
4 consider whether the attack by Salman Abedi could have
5 been prevented by the authorities and what, if anything,
6 was known by MI5, the police and others about the
7 attack . The starting point is to consider what was
8 known to MI5 about Salman Abedi before the attack .

9 He was known to MI5 at the time of the attack .
10 He was a closed subject of interest , about whom some
11 intelligence and information had been received over
12 a period of around 6.5 years . At the time of the attack
13 he had been identified for further low level
14 investigation to identify whether he had reengaged in
15 Islamist extremist activity . Much of the detail cannot
16 be addressed outside of closed hearings because to do so
17 would damage national security .

18 But the summary here which reflects the evidence
19 that can be given in public is underpinned by the
20 extensive work undertaken by MI5 and counter-terrorism
21 police to collate the relevant material as part of the
22 post-attack review process , the analysis of that
23 material in the course of the review , and the
24 substantial further work that's been undertaken for the
25 purposes of this inquiry .

1 The first time that MI5 received information about
2 Salman Abedi was on 30 December 2010 . MI5 had made
3 a trace request of the North-west Counter-terrorism Unit
4 Police for information about a person who was a subject
5 of interest , an SOI, at the time . Abedi was linked to
6 one of the addresses relevant to the trace request and
7 so his name, address, date of birth and information that
8 he'd been stopped and searched by police in 2010 with
9 nothing suspicious found were returned to MI5 .

10 There was no indication from that information that
11 he posed any threat to national security . He was not
12 therefore subjected to any investigative scrutiny at
13 that time .

14 In December 2013, an individual referred to as
15 Subject of interest A, or SOI A, was under investigation
16 because of his suspected involvement in planning travel
17 to Syria for extremist purposes . The investigation
18 ascertained that a telephone number registered to
19 Salman Abedi was in contact with A and he, Abedi, was
20 himself opened as an SOI in March 2014 because of his
21 status as a contact of A .

22 Salman Abedi remained open as an SOI until
23 July 2014 . Efforts were made in particular to establish
24 the nature of his relationship with SOI A and whether he
25 might pose a threat to national security . The decision

1 to cease active investigation of Salman Abedi was based
2 on his lack of engagement with individuals of interest ,
3 including SOI A.

4 In the time between him being opened and closed as
5 a subject of interest , MI5 and the North-west
6 Counter-terrorism Unit had seen no intelligence
7 indicating that he posed a threat to national security .

8 In 2015, Salman Abedi was identified as the owner of
9 a telephone number which had been seen previously in
10 contact with another subject of interest , SOI B. B had
11 previously been linked to Al Qaeda and was under
12 investigation in connection with his facilitation of
13 travel of other people to Syria. MI5 also held
14 intelligence that Salman Abedi had met SOI B in person
15 on a number of occasions. Nothing within the
16 information held in connection with his contact with B
17 was considered to show that Salman Abedi posed or might
18 pose a threat to national security so he was not opened
19 as an SOI.

20 Whilst MI5 considers that Salman Abedi's extremist
21 ideology is likely to have been influenced by his
22 contact with SOI B, it is also MI5's assessment that
23 it is unlikely that SOI B was involved in or otherwise
24 knew about Salman Abedi's attack planning.

25 Also in 2015, MI5 received information that

1 Salman Abedi was in contact with a subject of interest ,
2 SOI C. C was a long-standing subject of interest
3 because of his previous affiliation with an extremist
4 group in Libya. MI5 assesses that SOI C may have had
5 some radicalising influence on Salman Abedi but holds no
6 information to suggest that C was involved in or
7 otherwise knew about Salman Abedi's attack planning.

8 In October 2015, Salman Abedi was opened and closed
9 as an SOI in the course of a single day. This was
10 because of a misunderstanding concerning information
11 that indicated links to a senior figure in
12 Islamic State, also known as ISIL. The information
13 indicated that Salman Abedi was a second-level contact,
14 in other words a contact of a contact of the ISIL
15 individual . But he was opened as an SOI on the basis
16 that he was a first - level contact. Once that
17 misunderstanding was identified , he was closed as
18 an SOI, and no investigative actions were taken during
19 the short time that he was an open SOI.

20 On three subsequent occasions, Abedi was identified
21 as a second-level contact of a subject of interest .

22 Firstly in April 2016. That subject of interest was
23 under investigation on the basis that he provided
24 financial support to a member of ISIL in Syria .

25 Secondly, in January 2017. The subject of interest

1 was under investigation on the basis that he was linked
2 to ISIL and because of information that indicated he had
3 previously travelled to Syria .

4 Thirdly, in April 2017. The SOI was under
5 investigation on the basis of his links to a recruiter
6 and facilitator for ISIL in Libya.

7 As Salman Abedi was only ever identified as
8 a second-level contact of these individuals , he was not
9 opened as an SOI on any of these occasions and there was
10 no intelligence to indicate that he was engaged in
11 attack planning or otherwise posed a threat to national
12 security .

13 MI5 was also aware that Salman Abedi had visited
14 a known extremist prisoner on more than one occasion .
15 In respect of the first visit , MI5 and the North-west
16 Counter-terrorism Unit actively sought information on
17 the nature of his visit to this prisoner . This did not
18 result in any intelligence that was assessed to justify
19 opening Salman Abedi as an SOI.

20 MI5 received information that Salman Abedi had
21 travelled to Libya on a number of occasions from 2011
22 onwards. It was known that he had family in Libya and
23 so there was nothing inherently suspicious about these
24 trips . Information was also received in relation to his
25 travel to Saudi Arabia during the Hajj.

1 On two occasions information was received that gave
2 MI5 cause to consider that Salman Abedi might be
3 travelling to Syria , but on both occasions checks were
4 conducted and showed that he had not. In neither case
5 did MI5 assess that the information indicated that he
6 posed a threat to national security .

7 From mid-2015 onwards MI5 received information on
8 Salman Abedi on several occasions. This included
9 conflicting information about his holding pro-ISIL
10 views. But again, it was assessed that this information
11 did not indicate that he posed a threat to national
12 security .

13 On two separate occasions in the months prior to the
14 attack, intelligence was received by MI5 about him. The
15 intelligence was assessed at the time to relate to
16 possibly innocent activity or to non- terrorist
17 criminality on his part. In retrospect , this
18 intelligence was highly relevant to the planned attack,
19 but the significance of it was not fully appreciated
20 at the time.

21 That is a summary of MI5's knowledge of Salman Abedi
22 and of his activities prior to the attack insofar as it
23 is possible to provide this summary in public. In
24 short , he came to MI5's attention on a number of
25 occasions over the course of several years before the

1 attack and, for a brief period in 2014, he was subject
 2 to an investigation as a subject of interest . He was at
 3 times identified as a first - level contact of a number of
 4 SOIs and as a second- level contact of a number of other
 5 SOIs. Consideration was given to the possibility that
 6 he might be interested in travelling to Syria for
 7 extremist purposes, but that was discounted.

8 I will turn next to the steps that were taken and
 9 were not taken in relation to him before the attack.
 10 Before doing that, it's helpful to address briefly the
 11 investigative framework within which MI5 operates.

12 MI5's active investigations are prioritised
 13 according to the threat the activity under investigation
 14 is assessed to pose. There are five priority levels .
 15 The majority of MI5's investigative efforts are
 16 necessarily allocated to the highest priority current
 17 investigations , but there are no strict rules as to what
 18 resources should be allocated to a particular
 19 investigation . Actions are taken based on what is
 20 judged to be necessary and proportionate and on the
 21 balance of risk against other investigations . Priority
 22 levels are tested frequently at a senior management
 23 level and can be altered at any time.

24 Subjects of interest within most investigations are
 25 also prioritised . They are assigned a tier , which

1 reflects the importance of subjects of interest within
 2 that investigation at any one time. Tier 1 are the main
 3 targets of the investigation . Tier 2 are key contacts
 4 of the main targets . Tier 3 are subjects of interest
 5 through a context of tier 1 or tier 2 subjects of
 6 interest and are likely to be involved only in marginal
 7 aspects of the activities under investigation .

8 Not every contact of a tier 1 or tier 2 subject of
 9 interest is made a tier 3 SOI. Many contacts will be in
 10 no way associated or even potentially associated with
 11 the activity under investigation . Everybody, including
 12 those planning terrorist attacks, will have innocent
 13 contacts, friends , family , work colleagues, neighbours
 14 who know nothing at all about that person's terrorist
 15 activities . There is an element of investigative
 16 judgment involved in deciding whether a particular
 17 individual should be a tier 3 subject of interest .
 18 Tiers of SOIs can also change regularly during the life
 19 of an investigation .

20 Subjects of interest are closed when they no longer
 21 meet the threshold for investigation , such as where
 22 it is assessed that they are not or are no longer
 23 engaged in activity of national security concern. The
 24 effect of closure is that the former subject of interest
 25 will not be proactively investigated . Although there

1 have been some changes to the closure process
 2 implemented since the attack, the essential process of
 3 risk assessment and joint working with police partners
 4 remains.

5 At the time, the process required the investigator
 6 to consider and assess the residual risk that the closed
 7 subject of interest posed and the decision to close the
 8 subject of interest would normally be signed off by the
 9 investigative line manager. Where there was police
 10 involvement in the relevant operation or investigation ,
 11 this assessment would be conducted in conjunction with
 12 a police colleague .

13 The residual risk associated with that closed
 14 subject of interest would be assessed and identified as
 15 high, medium, low or no risk . When Salman Abedi was
 16 closed as a subject of interest , the management of the
 17 record for a closed SOI who had been assessed as low or
 18 no risk was the responsibility of the investigator for
 19 whom the investigation was assigned before it was
 20 closed. If that person moved on, responsibility would
 21 go to their successor in the role . If new intelligence
 22 was received about a closed subject of interest , the
 23 investigator who hold held the file would consider
 24 whether further action should be taken. Depending on
 25 the assessments made for the new intelligence , that

1 closed SOI might have been re-opened as an SOI.

2 The position has since changed in that
 3 responsibility for closed SOIs assessed to be of lower
 4 risk is now assigned to the relevant regional station
 5 and new intelligence on closed SOIs will be sent to
 6 a regional triage area for assessment. These changes
 7 are designed to mitigate against the risk that
 8 intelligence on closed subjects of interest could,
 9 because of competing and higher priority demands on the
 10 responsible investigator 's time, remain unassessed.

11 However, this was not an issue that arose in
 12 Salman Abedi's case. All intelligence was considered
 13 and assessed by those responsible for his record prior
 14 to the attack.

15 A decision , as you know, sir , was made to close
 16 Salman Abedi as a subject of interest in 2014. MI5
 17 assesses that the investigative actions taken
 18 in relation to Abedi when he was opened as an SOI in
 19 March 2014 and the decision to close the file in
 20 July 2014 were reasonable on the basis of the
 21 information available at the time.

22 When he was closed as an SOI, he was deemed low risk
 23 and he was not referred to Prevent.

24 MI5 also assesses that the decisions taken in the
 25 light of the further intelligence concerning

1 Salman Abedi's travel and his associations with other
 2 subjects of interest were reasonable and understandable
 3 when judged in the light of the information available
 4 at the time.
 5 Further information, as I have said, was then
 6 received in the months prior to the attack. As for
 7 these two occasions in the months before the attack when
 8 information was received which can now be seen as
 9 relevant to the attack, MI5 has of course given very
 10 careful consideration as to whether different decisions
 11 could or should have been taken in response to this
 12 information and whether any different decisions might
 13 have led to detection of the attack planning. As the
 14 inquiry will know, these matters will be subject to
 15 detailed analysis in the course of the closed hearings.
 16 Sir, you'll reach your conclusions on these
 17 questions when you have heard the evidence and we do not
 18 seek to pre-empt your analysis. Lord Anderson in the
 19 conclusion to his report observed that:
 20 "MI5 and Counter-terrorism Policing got a great deal
 21 right. Particularly in the case of Manchester they
 22 could have succeeded had the cards fallen differently."
 23 The fact that Lord Anderson considered that the
 24 cards might have fallen differently plainly calls for
 25 the most rigorous scrutiny of what was known, what might

1 have been done differently, and what impact such action
 2 might have had.
 3 In the light of its internal review, MI5's
 4 assessment is that the decision not to re-open
 5 Salman Abedi as a subject of interest on the basis of
 6 the information obtained in the months before the attack
 7 was a finely balanced one, but it was understandable in
 8 all the circumstances.
 9 However, MI5 also considers that there were certain
 10 aspects of the information that came to its attention in
 11 the months before the attack which could have been
 12 handled differently and, if they had been, that
 13 different handling might have helped the investigative
 14 team in their decision-making.
 15 However, the extent to which the different handling
 16 of that information might have affected the team's
 17 subsequent decision-making is highly uncertain. It is
 18 also the case that the opportunities for detecting
 19 Salman Abedi's attack planning would have been very
 20 limited indeed.
 21 Two learning points identified in the Manchester
 22 post-attack review related to the process for reviewing
 23 closed subjects of interest and the analysis as to
 24 whether they merit further investigation. On
 25 3 March 2017, Salman Abedi hit a priority indicator

1 under a process code named Clematis on the basis of
 2 information that had been received in mid-2016. As
 3 I have explained, subjects of interest are closed when
 4 they no longer meet the threshold for investigation,
 5 essentially when it's assessed that they not or are no
 6 longer engaged in activities of national security
 7 concern.
 8 However, further intelligence received in respect of
 9 a closed subject of interest may cause that closed SOI
 10 to be re-opened, and in addition, MI5 operates the
 11 Clematis process to identify closed SOIs who are
 12 potentially worthy of further investigation. Clematis
 13 is designed to identify emerging and residual threats by
 14 identifying specific indicators to highlight closed SOIs
 15 for potential further investigation.
 16 Closed SOIs who hit specific triggers were at the
 17 time then referred to separate process codenamed
 18 Daffodil to consider the use the limited investigative
 19 tools to look at that individual further.
 20 This indicator triggered in respect of Salman Abedi
 21 did not relate to any intelligence connected to the
 22 attack. It was triaged and MI5 assessed that he met the
 23 threshold for further investigation under Clematis.
 24 Further checks were then conducted, which led the
 25 Clematis team to assess that he was overseas, probably

1 in Libya. On 8 May 2017, the Clematis team assessed
 2 that he should be referred to Daffodil for further
 3 low-level investigative enquiries to identify whether he
 4 had re-engaged in Islamist extremist activity. The
 5 meeting to consider the potential referral to Daffodil
 6 was scheduled for 31 May 2017.
 7 The fact that the Clematis process had identified
 8 Salman Abedi as an individual who potentially merited
 9 further investigation at the time of the attack does
 10 show that the system itself was working. MI5 does,
 11 though, acknowledge that the trigger for the Clematis
 12 assessment was information that had been received many
 13 months before Salman Abedi was identified for further
 14 consideration on 3 March 2017 and that this indicates
 15 a potential area for improvement.
 16 The specific reasons for the delay cannot be
 17 explained in public because of the damage that doing so
 18 would cause to national security, but it is right to say
 19 that part of the explanation lies in the significant
 20 challenges posed by the very large cohort of closed
 21 subjects of interest for MI5 and counter-terrorism
 22 police.
 23 There is not, and nor should there be, a standard
 24 inflexible approach to dealing with information received
 25 about closed SOIs. Actions taken need to be

1 proportionate to the threat described and the new
 2 information received and to the threat that the
 3 individual is assessed to pose in order that resources
 4 are appropriately deployed as between live
 5 investigations and closed SOIs and as between differing
 6 risks within the closed SOI pool.

7 Since the attack, MI5 has implemented changes
 8 designed to improve timescales in the Clematis process
 9 as recommended in the operational improvement review.
 10 A team with responsibility for closed SOI policy was set
 11 up and all closed SOIs are now categorised into risk
 12 bands which helps in prioritising the allocation of
 13 resources .

14 MI5's assessment at this time is that improvements
 15 to the closed SOI process have improved timescales
 16 in relation to the Clematis process .

17 The second issue identified by about the Manchester
 18 post-attack review concerns Salman Abedi's travel and
 19 the use of the tools available to MI5 to monitor the
 20 travel of an individual of potential concern. MI5,
 21 working with its partners, has access to
 22 a well-established toolkit to enable identification and
 23 disruption of travel conducted by subjects of interest .
 24 In particular , MI5 works closely and exchanges
 25 intelligence with police and UK ports.

1 This partnership allows MI5 to request that the
 2 police undertake specific actions in relation to
 3 individuals arriving at or leaving the UK. These
 4 include requests to be notified of an SOI's travel and
 5 requests for consideration to be given to stopping
 6 a subject of interest under schedule 7 of the
 7 Terrorism Act 2000, although the decision whether to
 8 exercise that power rests with the police .

9 Collectively , the use of any part of MI5's ports and
 10 travel toolkit on a subject of interest is referred to
 11 as putting that subject of interest on ports action .
 12 There was an opportunity to place Salman Abedi on ports
 13 action following his travel to Libya on 15 April 2017.
 14 It is MI5's assessment that although Salman Abedi was
 15 a closed subject of interest at the time, this was
 16 a missed opportunity, which, had it been taken, would
 17 have triggered an alert when he returned to the UK
 18 shortly before the attack. This could have enabled him
 19 to be questioned and searched at the airport by
 20 counter-terrorism police on 18 May 2017.

21 Even if Salman Abedi had been placed into travel
 22 restrictions there may still not have been sufficient
 23 time to identify or act on his attack planning.
 24 Nonetheless, MI5's review concluded that Salman Abedi
 25 should have been put on ports action following his

1 travel to Libya in 2017. It was noted that under the
 2 practice as it stood at the time, placing an individual
 3 such as Abedi on ports action would have been considered
 4 an exceptional step to take and so the review identified
 5 the need to look again at MI5's guidance regarding the
 6 use of these travel tools to ensure that they are
 7 deployed in appropriate cases and that too high
 8 a threshold is not applied .

9 MI5 is acutely conscious that the question of
 10 whether action could have been taken that would or might
 11 have made a difference to the tragic outcome in this
 12 case is a matter of central relevance to this inquiry
 13 and of profound concern to the bereaved families . It is
 14 important this issue is rigorously addressed, not only
 15 to determine whether this attack could have been
 16 prevented but also to learn lessons which may assist in
 17 preventing future attacks .

18 Mr Roussos said to the inquiry that lessons should
 19 have been learned from 9/11 and 7/7, and that it would
 20 be wrong if lessons were still being learned now. MI5
 21 understands exactly why he said that. This inquiry may
 22 well investigate whether there were failures to learn
 23 from past attacks. The security services learn lessons
 24 from every attack and from those terrorist plots that
 25 they have been able to stop. However, the threat from

1 terrorists is constantly evolving so the learning on the
 2 part of the security services has to be continuous and
 3 when looking at the work done to prevent attacks,
 4 including work that's been successful in stopping them,
 5 it is important to understand the enormous challenges in
 6 assessing intelligence , trying to work out what that
 7 risk is, who poses the greatest risk and seeking to
 8 predict what individuals are going to do next.

9 The intelligence picture is always fragmentary and
 10 deliberately obscured. Individuals such as
 11 Salman Abedi, who seek to carry out attacks of this
 12 sort, go to great lengths to disguise their true
 13 intentions and camouflage their actions. It is always
 14 difficult and often impossible to distinguish between
 15 activity that relates to ordinary criminality and that
 16 which may indicate a threat to national security . And
 17 information which seems to point clearly in
 18 one direction with hindsight may well have been subject
 19 to a number of completely different interpretations
 20 at the time it was received .

21 Lord Anderson in his report endorsed this
 22 description by the then director-general of the work of
 23 MI5's investigative teams in assessing raw intelligence .
 24 They are constantly making tough professional judgements
 25 based on fragments of intelligence , pinpricks of light

1 against a dark and shifting canvas.
 2 That is an accurate characterisation of MI5's task
 3 in assessing intelligence relating to the many thousands
 4 of open and closed subjects of interest who at any given
 5 point in time may pose a potential threat to national
 6 security. There are closed subjects of interest who are
 7 not subject to active investigation and for whom there's
 8 likely to be very little in the way of context in which
 9 to judge the significance of an individual piece of
 10 information. The challenges are particularly acute.

11 Working through the evidence with these
 12 considerations in mind will clearly be a complicated and
 13 demanding task, and MI5 does not presume to pre-empt
 14 your conclusions, sir. But this is an issue of central
 15 importance. The families have absolutely properly asked
 16 the institutional core participants to give a candid
 17 account now of their position as to whether mistakes
 18 were made which might have affected the outcome and the
 19 key conclusions of MI5 on the issues of preventability
 20 can be summarised in the following way.

21 There is inevitably a high degree of uncertainty in
 22 speculating as to the sequence of events that might have
 23 flowed from the taking of a particular decision at
 24 a particular stage in the chronology. Even if
 25 Salman Abedi had been placed on ports action or if an

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1 investigation into his activities had been opened
 2 earlier, it would have been extremely challenging to
 3 obtain coverage that would have provided prior insight
 4 into the attack plan. In its rigorous review after the
 5 attack, MI5 did not identify any points where
 6 a different course of action would have been likely to
 7 lead to a different outcome.

8 It concluded that even if Salman Abedi had been
 9 re-opened as a subject of interest, successful
 10 pre-emption of his plot would have been unlikely. In
 11 particular, firstly, even if the Clematis process had
 12 identified Abedi earlier as a closed subject of interest
 13 who merited further consideration, and even if
 14 a decision had been taken to open an investigation into
 15 him, it would have taken time to build up coverage and
 16 the allocation of resources to the investigation would
 17 have had to be prioritised against other
 18 investigations open at the time, of which there was
 19 a large number, both live investigations and suspended
 20 ones.

21 Secondly, similar issues arise from an analysis of
 22 what might have happened had an investigation been
 23 opened on either of the two occasions on which
 24 intelligence was received about Abedi in the months
 25 before the attack. He travelled to Libya on

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1 15 April 2017 and returned only on 18 May 2017.
 2 It would have been more difficult to obtain information
 3 on him while he was in Libya and establishing sufficient
 4 depth of coverage over the very short period between his
 5 return on 18 May 2017 and the attack 4 days later would
 6 have been extremely difficult.

7 These conclusions are not intended to, and they do
 8 not, detract from MI5's recognition that there were
 9 areas for improvement brought to light by the intense
 10 scrutiny applied by the operational improvement review
 11 and by the external reviews of the totality of records
 12 relating to Abedi that were held by MI5. A number of
 13 these I have summarised and they're addressed in more
 14 detail in Witness J's evidence, in particular
 15 Lord Anderson's report, the Intelligence and Security
 16 Committee report, the Government response to the ISC
 17 report, and Lord Anderson's implementation stocktake.

18 MI5 is fully committed to assisting the inquiry in
 19 its work and it will continue to provide the inquiry
 20 with all the material and information that it requires.
 21 There must be full accountability for the work done
 22 before the attack and it is vital to learn anything that
 23 would help to stop another tragedy.

24 Sir, I will turn now to the Home Office more widely.
 25 The Home Office is the lead government department with

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1 responsibility for counter-terrorism. One of its key
 2 aims is to reduce terrorism. Its work involves
 3 strengthening protection against a terrorist attack by
 4 improving security and resilience across the UK's public
 5 spaces, transport and infrastructure, and by reducing
 6 illicit access to the material needed for an attack both
 7 in the UK and at UK borders.

8 It also works to mitigate the impact of a terrorist
 9 attack, seeking to save lives, reduce harm and aid
 10 recovery quickly by ensuring a coordinated response
 11 across the emergency services.

12 The Office for Security and Counter-terrorism, which
 13 is known as OSCT in the Home Office, leads on
 14 developing, coordinating and implementing the UK's
 15 counter-terrorism strategy known as CONTEST.

16 OSCT is responsible for overseeing cross-government
 17 work under the four strands of CONTEST, which are
 18 Prevent, Pursue, Protect and Prepare. All of those
 19 strands have some relevance to the matters under
 20 investigation in this inquiry.

21 Prevent aims to reduce the terrorism threat the UK
 22 faces, essentially by supporting vulnerable individuals
 23 to stop them from becoming terrorists or from supporting
 24 terrorism. Its objectives are firstly to tackle the
 25 causes of radicalisation and respond to the ideological

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1 challenge of terrorism . Secondly, to safeguard and
 2 support those most at risk of radicalisation through
 3 early intervention , identifying them, and offering
 4 support. And thirdly , to enable those who have already
 5 engaged in terrorism to disengage and rehabilitate .
 6 Section 26 of the Counter-terrorism and Security Act
 7 2015 places a duty on specified authorities , such as the
 8 police , local authorities and prison governors , to have
 9 due regard to the need to prevent people from being
 10 drawn into terrorism . This is known as the Prevent
 11 duty.
 12 The second element of CONTEST is Pursue, which also
 13 aims to reduce the terrorism threats we face by
 14 detecting , prosecuting and disrupting those who plot to
 15 carry out attacks against the UK or UK interests
 16 overseas . The deployment of investigative and
 17 disruptive counter-terrorism and immigration powers and
 18 the prosecution regime form part of the Pursue strategy .
 19 The third element, Protect, is a multi-layered
 20 strategy that aims to reduce the UK's vulnerabilities to
 21 terrorist attack. Its key objectives are to detect and
 22 deal with suspected terrorists and harmful materials
 23 at the border, to reduce the risk to and improve the
 24 resilience of global aviation , other transport sectors
 25 and critical national infrastructure most at risk to

1 terror attacks , to reduce the vulnerability of crowded
 2 places , specific vulnerable groups and high- profile
 3 individuals , and to detect and prevent terrorist access
 4 to and use of materials , knowledge and information that
 5 could be used to conduct attacks .
 6 The fourth, Prepare, aims to mitigate the impact of
 7 a terrorist incident if it occurs. Its objectives are
 8 to deliver a coordinated multi-agency response to all
 9 types of terrorist attack, to ensure that the UK has
 10 a full range of options to respond to current and future
 11 threats , and to minimise the impact of terrorist attacks
 12 on people, services and communities.
 13 The topics that I address in these submissions all
 14 sit under one of these strands and all ultimately are
 15 the responsibility of the Home Office. In practice ,
 16 this means that the Home Office sets policy objectives
 17 and, in some cases, provides directional guidance on the
 18 implementation of those policies , although the actual
 19 operational work is done by others .
 20 In these submissions I will seek to explain the
 21 Home Office's role in developing the policies and
 22 strategies that are relevant to this inquiry and I will
 23 seek to set out any strategic issues that have been
 24 identified as a result of the circumstances of this
 25 attack.

1 The Channel programme is part of the Prevent
 2 strategy and it is a voluntary programme that aims to
 3 ensure that targeted support is provided to people who
 4 have been identified as being vulnerable to being drawn
 5 into terrorism . It operates by way of panels run at
 6 a local level by local authorities and police and are
 7 required to have regard to statutory guidance issued in
 8 2015 in exercising their functions known as the
 9 Channel guidance. If an individual consents to be and
 10 is accepted into the support programme via Channel, then
 11 Prevent interventions would be available to support that
 12 person.
 13 The potential intervention activities are
 14 wide-ranging, and can include anything from education
 15 and housing support to mentors, to cognitive and
 16 behavioural support. The intervention activities that
 17 are offered in any given case would be determined by the
 18 panel's assessment at the time about the level of risk
 19 and vulnerability , and by what is available locally .
 20 Manchester is, and was in 2017, a priority area for
 21 Prevent-related activity which means that it received
 22 and receives additional Home Office funding. The local
 23 activities of Prevent are delivered by local authorities
 24 who have the awareness and understanding of the risks of
 25 radicalisation in their areas. These authorities work

1 with key agencies such as the police and specifically
 2 counter-terrorism units . The activities of the Prevent
 3 team all look to raise awareness in the community of the
 4 risk and help people to identify concerns and understand
 5 how and where to seek support .
 6 The vast majority of these activities engage a wide
 7 range of communities and groups and, as such, would not
 8 be considered to be individually targeted Prevent
 9 interventions . The Prevent work available to target
 10 specific individual or family members is the channel
 11 programme.
 12 Neither Salman Abedi nor any member of his immediate
 13 family was ever the subject of a referral to Prevent.
 14 As a result , there was no opportunity for Salman Abedi's
 15 threat , or that of any of his immediate family members,
 16 to be managed through the Channel programme. It's not
 17 possible to say whether referring Salman Abedi to
 18 Prevent might have made a difference , or indeed whether
 19 he would have been eligible for interventions . However,
 20 the London and the Manchester attacks have highlighted
 21 the scale of the challenge of detecting individuals who
 22 may be inspired to commit terrorist attacks in the UK
 23 and the pace at which plots can move to acts of
 24 violence . This knowledge places a renewed importance on
 25 improving our understanding of individuals who are

1 vulnerable to radicalisation , who are or who have been
2 of interest to the security and intelligence agencies,
3 but who are not under active investigation .

4 As a result , a number of actions have been
5 identified to improve the scale of and the effectiveness
6 of Prevent. These seek to achieve better information
7 sharing about individuals vulnerable to radicalisation ,
8 to ensure more systematic referrals to Prevent as
9 subjects of interest and closed SOIs, and to increase
10 the number of referrals to Prevent desistance and
11 disengagement programme. The emphasis is on a more
12 effective local response that should facilitate more
13 effective early interventions .

14 In particular , MI5, Counter-terrorism Policing and
15 the Home Office have established a multi-agency approach
16 building on the multi-agency centre pilot that uses
17 a new domestic operational model to consider the wide
18 range of needs and vulnerabilities that individuals may
19 have.

20 This new model sees MI5 and Counter-terrorism
21 Policing sharing more information with a broader range
22 of partners , including local authorities , in order to
23 develop a better collective understanding of the risk
24 posed by subjects of interest and to consider potential
25 options supporting the individual in moving away from

1 extremism.

2 Such a model is anticipated to provide better
3 support for the individual . This is particularly
4 important given the identified shift in terrorist threat
5 away from highly sophisticated , well-planned attacks to
6 low- sophistication , lone actor attacks .

7 Explosive precursors are also a key issue to be
8 considered. Improvised explosive devices , or IEDs, is
9 the name given to home-made bombs. They are often, as
10 in this case, manufactured from commonly available
11 household chemicals and common household items such as
12 nails or nuts and bolts. These ingredients are known as
13 explosive precursors . Salman Abedi and Hashem Abedi
14 were able to acquire the precursors that they required
15 to make their IED and to do so undetected.

16 The Office for Security and Counter-terrorism has
17 a chemical, biological , radiological and explosive ,
18 known as CBRE, Protect team. This team is responsible
19 for both developing and implementing policy to prevent
20 and detect terrorist acquisition of explosive
21 substances, their precursors and the equipment required
22 to manufacture them. It is not possible to prevent all
23 purchases of precursor chemicals as some are required
24 for ordinary use in the home. But a range of measures
25 is in place to make it harder for individuals to buy the

1 substances that are most likely to cause harm or make it
2 harder for them to acquire them without detection .

3 Legislation restricts the sale of specified
4 precursors , known as regulated explosive precursors , to
5 the public . These can be purchased by professional
6 users who need the chemicals for purposes associated
7 with their trade or business or profession only .
8 Anybody who wants to import, acquire, possess or use
9 regulated explosive precursors must hold a licence to do
10 so. Members of the public who apply for a licence are
11 subject to robust background checks against police ,
12 crime and intelligence databases. It is a criminal
13 offence to supply a regulated substance to a member of
14 the public or for a member of the public to import,
15 acquire, possess or use a regulated substance unless
16 that member of the public has a licence permitting that
17 activity . Offences are punishable by up to 2 years in
18 prison as well as or instead of an unlimited fine .

19 Enforcement of the restrictions on the sale of
20 regulated explosive precursors is carried out on an
21 intelligence -led basis by the police . The CBRE team
22 work closely with retailers to ensure that sellers
23 understand their legal obligations . Retailers who
24 seriously or persistently fail to meet their obligations
25 face prosecution .

1 There's also a list of reportable explosive
2 precursors set out in legislation . These precursors do
3 not require a licence to purchase but suppliers are
4 required to report any transaction or proposed
5 transaction of reportable explosive precursors or
6 regulated explosive precursors that they have reasonable
7 grounds to believe to be suspicious .

8 A transaction is suspicious if the supplier has
9 reasonable grounds for suspecting that the substance is
10 intended for the illicit manufacture of explosives . The
11 CBRE team provide sensitive guidance to assist suppliers
12 in determining whether a transaction is suspicious .

13 Offences relating to the failure to report
14 a suspicious transaction or a significant loss or theft
15 are punishable with an unlimited fine and with up to
16 3 months in prison .

17 None of the chemicals purchased to make the
18 explosive used in the attack was regulated in May 2017,
19 so no licence was needed to purchase them. They were,
20 however, all reportable explosive precursors so they
21 were subject to the requirement to report transactions
22 if those transactions were deemed to be suspicious .

23 Since the attack, a number of measures have been
24 taken to improve the control and sale of explosive
25 precursors and to increase the probability that

1 suspicious transactions will be identified , processed
 2 and acted upon. In particular , sulphuric acid, which
 3 was one of the precursors used in the IED is now
 4 a regulated explosive precursor . The proposal to make
 5 it regulated had first been made by the Home Office to
 6 the European Commission in 2015 and, following the
 7 Manchester attack, that process was accelerated .

8 Three precursors have been added to the list of
 9 reportable explosive precursors and, on 11 July 2019,
 10 the European Commission published EU regulation
 11 2019/1148 on the marketing and use of explosives . This
 12 regulation clarifies and strengthens controls on
 13 explosive precursors , including stronger controls on
 14 sulphuric acid and on verifying professional users . It
 15 also introduces a 24-hour period within which
 16 a suspicious transaction must be reported, obligations
 17 on retailers to train their staff and concrete actions
 18 that retailers must take and which authorities can
 19 inspect to ensure compliance and effective
 20 implementation. The UK heavily influenced this new EU
 21 regulation .

22 As part of the inquiry 's work, it will also consider
 23 the security arrangements within and outside the arena,
 24 the planning , preparation , arrangements and
 25 communications between the security providers , and the

1 adequacy of those arrangements.
 2 The security of any venue is ultimately the
 3 responsibility of the owners, the operators, the event
 4 organisers and/or the public authorities responsible for
 5 it , but the state does provide support to venues
 6 identified as crowded places in determining the measures
 7 to take to protect against the risk of a terrorist
 8 attack .

9 The Crowded Places Work Programme, which is part of
 10 the Protect strand of the UK's counter- terrorism
 11 strategy and is overseen by OSCT, aims to improve
 12 protective security and preparedness at crowded places
 13 and in doing so to reduce vulnerability to attacks .
 14 Crowded places encompass a number of different public
 15 locations including large event venues such as the
 16 arena .

17 From July 2012 until 2018, the Crowded Places
 18 Working Group, CPWG, oversaw the development of strategy
 19 and associated programmes for crowded places . In 2018,
 20 the Protective Security and Preparedness Steering Group,
 21 the PSPSG, was created and it took over the
 22 responsibilities of the working group, which was
 23 disbanded .

24 The CPWG working group was chaired by the head of
 25 Protect and Prepare within the Office for Security and

1 Counter-terrorism . This working group met every 2 or
 2 3 months. It operated at a high strategic level , as
 3 does its replacement. It is not concerned with
 4 individual locations . Counter-terrorism Policing was
 5 then and continues to be responsible for preventive and
 6 protective activity at individual locations .

7 The inquiry has already heard from others something
 8 about the role of police counter- terrorism security
 9 advisers . The Police National Counter-terrorism
 10 Security Office and a network of these highly trained
 11 CTSAs are responsible for developing specific guidance
 12 and developing protective security advice to locations .
 13 The guidance and advice are prepared with reference to
 14 physical and personnel security measures and to guidance
 15 and advice developed by the Centre for the Protection of
 16 National Infrastructure , which is the government
 17 authority responsible for protective security advice to
 18 the UK national infrastructure .

19 The police liaise with the private and public owners
 20 of sites and assets which may require protective
 21 security measures. Fundamentally, the advice and
 22 guidance are provided to ensure that owners and
 23 operators are aware of all plausible terrorist threats ,
 24 know what steps to take to reduce vulnerability to
 25 terrorist attack and to prepare for an attack and can

1 develop action plans of mitigating activity .

2 While every crowded place is potentially vulnerable
 3 to attack, some location are considered to be more
 4 attractive than others to attackers . CTSA efforts are
 5 prioritised at these high- profile locations to ensure
 6 that the resources are there to improve protective
 7 security if improvement is needed. Counter-terrorism
 8 Policing is responsible for identifying prioritised
 9 locations and keeping the list up to date. There are
 10 different tiers of priority afforded to different
 11 locations which will guide, although not determine, the
 12 level of input and support the locations will receive
 13 from CTSAs; the CTSAs bring their own judgement and
 14 experience to bear on the work needed.

15 CTSAs approach priority site owners and operators to
 16 provide advice on the terrorist threats and the ways in
 17 which to mitigate them. The owners and operators
 18 themselves decide on the appropriate and proportionate
 19 mitigation measures to take and they implement a plan of
 20 improvement activity to increase protective security or
 21 preparedness as advised by the CTSA.

22 The responses of operators and owners of these
 23 locations are varied . Some choose not to meet a CTSA
 24 following the offer to provide assistance and advice .
 25 Even where the owners or operators do choose to engage

1 with the CTSAs, there is a broad range of responses as
 2 to what action plans they choose to implement and how
 3 quickly they implement any measures. The
 4 Manchester Arena was a prioritised crowded place at the
 5 time of the attack and this remains the case. It is
 6 clear from the evidence served that the CTSAs regularly
 7 engaged with the arena before the attack and after it.

8 The Home Office allocates funding annually to
 9 Counter-terrorism Policing through the CT policing
 10 grant. The funding is based on budgets proposed by the
 11 Counter-terrorism Policing Headquarters and approved by
 12 the Home Secretary.

13 In respect of crowded places this funding is for the
 14 delivery of free, impartial, independent and
 15 threat-informed advice and guidance regarding the
 16 terrorist threat and what constitutes appropriate and
 17 proportionate mitigations. These are delivered by the
 18 CTSAs, counter-terrorism awareness advisers, engagement
 19 events, and a range of online training tools and
 20 guidance.

21 The majority of the potential issues that arise in
 22 respect of the arena security preparations and
 23 arrangements appear to be matters of operational
 24 delivery rather than strategy. But the 2017 attacks
 25 demonstrated that crowded places continue to be

1 attractive targets for terrorists and that strategic
 2 changes were required.

3 The changes that have been made to the Crowded
 4 Places and Spaces Strategy since the 2017 attacks have
 5 been addressed in detail in the response to the
 6 Chief Coroner's prevention of future deaths report
 7 following the Westminster Bridge attack inquests dated
 8 February 2019, also in the response to the
 9 recommendations by the Intelligence and Security
 10 Committee dated January 2019, and in response to the
 11 Chief Coroner's prevention of future deaths report
 12 following the London Bridge inquests, dated
 13 January 2020.

14 The changes of particularly relevance to the issues
 15 identified in this case are those made to the volume of
 16 material and advice available and to the way in which
 17 the advice is disseminated. I can provide a summary of
 18 the key changes.

19 Firstly, Counter-terrorism Policing has started
 20 a programme of engagement days which provide advice and
 21 guidance for audiences from a range of parties
 22 responsible for crowded places.

23 Secondly, a new and revised range of
 24 counter-terrorism training is now available for
 25 managers, front of house and other staff at crowded

1 places and that's delivered through bespoke sessions by
 2 CTSAs. This training is designed to provide delegates
 3 with a better understanding of the threats from
 4 terrorism and the simple security measures that can be
 5 taken to protect a business or organisation, such as how
 6 to spot hostile reconnaissance or how to develop
 7 a contingency plan to be used in the event of an attack.

8 An e-learning training awareness programme has been
 9 broadened so it's freely available to all. That covers
 10 spotting signs of suspicious behaviour and what to do if
 11 an attack should take place.

12 Significant new advice and guidance continues to be
 13 provided by Counter-terrorism Policing and the Centre
 14 for the Protection of National Infrastructure.

15 As I have said, following the 2017 attacks, the
 16 Home Office did consider that changes were needed to the
 17 crowded places strategy, in particular in the light of
 18 the circumstances of the attacks on Westminster Bridge
 19 and London Bridge. However, insofar as changes are
 20 relevant to the circumstances of the Manchester attack,
 21 these were primarily aimed at ensuring those responsible
 22 for venues had greater awareness of and access to
 23 counter-terrorism information, guidance and training.

24 The crowded places strategy at the time of the
 25 attack ensured that people responsible for locations

1 such as the arena could be provided with tailored
 2 specialist support according to the priority level.
 3 That is still true today. The strategy is, as you would
 4 expect, reviewed and revised after every attack and
 5 in the light of the operational experience of those who
 6 contribute to the Protective Security and Preparedness
 7 Steering Group. But the Home Secretary believes that
 8 the strategy in place at the time of the attack was
 9 adequate and appropriate.

10 Many people will know of Figen Murray's campaign for
 11 the introduction of Martyn's Law, a law that would seek
 12 to provide better protection from terrorism for the
 13 British public. The government is in support of
 14 Ms Murray and her campaign to improve protective
 15 security and awareness.

16 In February 2020, the Security Minister announced
 17 that the government planned to consult on a new Protect
 18 duty which would impose a legal duty on those who own or
 19 manage public spaces and venues to consider the risk of
 20 terrorist attack and to take reasonable measures to
 21 protect the public from such an attack. Because of the
 22 COVID-19 pandemic, that consultation was postponed.
 23 However, the Home Office intends to proceed with that
 24 consultation as soon as it can.

25 I turn now to the question of emergency response.

1 It is a key objective of Prepare to ensure that the
 2 emergency services are able to deliver a coordinated
 3 multi-agency response to all types of terrorist attack
 4 in order to mitigate the impact of those attacks. The
 5 objectives of the OSCT's attack response policy, which
 6 is known as ARP, are to ensure that the blue- light
 7 emergency services have the planning, capabilities and
 8 capacity to respond to terrorist attack.

9 ARP works with the emergency services and other
 10 government departments to formulate policies for the
 11 response to terrorist attack. These policies focus
 12 primarily on the ways in which the agencies work
 13 together in the immediate aftermath of an attack. ARP
 14 also seeks to capture and consider learning for future
 15 incidents.

16 ARP also work closely and collaboratively with the
 17 local resilience forums that bring together local
 18 partners to plan and prepare for localised incidents and
 19 large scale emergencies. LRFs are integral to the local
 20 response to and recovery from a terrorist attack. The
 21 Office for Security and Counter-terrorism, the Cabinet
 22 Office and the Ministry for Housing, Communities and
 23 Local Government jointly provide local resilience forums
 24 with guidance on the response to a marauding terrorist
 25 attack to ensure that they understand the nature of such

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1 an attack and how the emergency services will respond.
 2 Through a national counter- terrorism exercise programme
 3 their plans and capabilities are regularly tested.

4 Terrorist events such as the 7/7 London bombings, as
 5 well as a number of other significant incidents that
 6 were not related to terrorism, led to an identified need
 7 to improve the joint working between the emergency
 8 services.

9 You have already heard a great deal, sir, about the
 10 joint emergency services interoperability programme or
 11 JESIP. It was initially developed in 2012 as a two-year
 12 programme aimed at improving how the police, fire and
 13 ambulance services work together when responding to
 14 major incidents. The programme recognised that the
 15 emergency services need joint working guidance and
 16 principles of joint working models to improve the
 17 sharing of information and to help commanders make
 18 decisions quickly and they needed improved shared
 19 situational awareness. The programme developed these
 20 capabilities. The initial JESIP training programme was
 21 the largest joint training programme ever completed by
 22 the emergency services and it trained over
 23 12,000 police, fire and ambulance personnel.

24 JESIP as a programme formally ended in
 25 September 2014 and moved into a period of consolidation.

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1 In April 2015 it was renamed as the Joint Emergency
 2 Services Interoperability Principles and its objective
 3 was to ensure that the capability built by the programme
 4 was sustained, developed and embedded in the emergency
 5 services.

6 Until April 2019, JESIP was overseen by the Attack
 7 Response Policy team for the vast majority of the time.
 8 Although JESIP is not specifically focused on
 9 counter- terrorism, it is most relevant during major
 10 incidents involving large numbers of fatalities and
 11 significant numbers of emergency services personnel.
 12 JESIP underpins much of the emergency services'
 13 specialist capabilities, ensuring that responders can
 14 adequately plan, prepare and work together to respond
 15 range of incidents, including terrorist attack.

16 In parallel, since the terrorist attacks in Mumbai
 17 in 2008, the OSCT has worked with the police and other
 18 emergency services to develop a strong police- led
 19 capability to deal with large- scale firearms attack,
 20 including attacks using explosive devices or a terrorist
 21 siege in the UK.

22 A firearms attack presents a particularly
 23 significant challenge to responders, both in terms of
 24 saving lives and responder safety. A response has
 25 therefore been designed against a reasonable worst-case

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1 scenario of an attack using firearms known as
 2 a marauding terrorist firearms attack, but it is
 3 flexible and scalable so it can be used as needed for
 4 attacks using less sophisticated weapons, now referred
 5 to as marauding terrorist attacks. The aim of the
 6 approach is to ensure that the emergency services have
 7 the multi-agency planning, capabilities and capacity to
 8 respond to a firearms attack and to variants of such an
 9 attack.

10 Each emergency service is responsible for its own
 11 single- service doctrine, but together they have produced
 12 two pieces of multi-agency doctrine: the "Joint doctrine
 13 interoperability framework for major incidents" and
 14 "Responding to marauding terrorist firearms attack and
 15 terrorist siege: joint operating principles for the
 16 emergency services", known as JOPs.

17 Both documents are branded with the JESIP brand,
 18 which means they're built on JESIP principles. The
 19 Attack Response Policy team has coordinated this work
 20 through OSCT and therefore acts as the overall owner of
 21 both.

22 Edition 2 of the joint doctrine was published
 23 in August 2016 and is still in existence. Edition 3 of
 24 the JOPs was extant at the time of the Manchester attack
 25 and has since been revised twice.

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1 ARP works with subject matter experts from the
 2 emergency services to provide tools and products, such
 3 as guidance documents and videos, that enable them to
 4 embed the joint doctrine and the JOPs into their local
 5 services .
 6 In the JOPs, Operation Plato is defined as the
 7 agreed national identifier for the response to a
 8 no-notice marauding terrorist firearms attack. Only the
 9 police can declare an Operation Plato and activate the
 10 multi-agency response. The JOPs state:
 11 "Information on a suspected marauding terrorist
 12 firearms attack should be shared amongst emergency
 13 service control rooms immediately. The police are
 14 responsible for formally declaring that a marauding
 15 terrorist firearms attacks is occurring and that the
 16 response, Operation Plato, will be used."
 17 Changes have been made since 2017. The London and
 18 the Manchester attacks in that year demonstrated that
 19 JESIP had become a critical element of the emergency
 20 response to a major incident , but that further work was
 21 needed to refine and improve it .
 22 After the attack both the JOPs and the police
 23 single - service guidance were revised . This work was
 24 coordinated by the Home Office and involved multi-agency
 25 and cross-government input. The changes took into

1 account all of the learning from the 2017 attacks,
 2 including that provided by the Kerslake Report.
 3 The changes that have been made including, firstly ,
 4 that Operation Plato is now the identifier for an
 5 ongoing marauding terrorist attack rather than
 6 a marauding terrorist firearms attack reflecting the
 7 broad range of the nature of recent attacks and the JOPs
 8 have been retitled to reflect the change.
 9 Secondly, the importance of the underlying JESIP
 10 principles have been reinforced .
 11 Thirdly, updated scripts have been added to assist
 12 with the use of zoning when it's needed.
 13 Fourthly, greater emphasis has been placed on the
 14 importance of joint working, swift risk assessment, and
 15 situational awareness.
 16 Fifthly , the layout and the content of the JOPs has
 17 been simplified .
 18 At the time of the attacks , JESIP was overseen by
 19 the ARP team in OSCT but in April 2019 direct oversight
 20 moved to the emergency services .
 21 I will turn now to prison visits . The Joint
 22 Extremism Unit, known as JEXU, is a joint Prison Service
 23 and Home Office unit which was established in April 2017
 24 to be the strategic centre for all counter- terrorism
 25 work in prisons . The inquiry requested information

1 about any visits made by Salman Abedi to prisons before
 2 the attack . These enquiries were coordinated by JEXU
 3 and involved searches across national databases as well
 4 as targeted requests of prison establishments .
 5 On 26 February 2015 and 18 January 2017,
 6 Salman Abedi visited a convicted terrorist offender . On
 7 both occasions he visited with others. A further visit
 8 booked for 16 March 2017 did not take place .
 9 Every prisoner in the UK is placed in one of four
 10 categories , A to D. The category reflects the level of
 11 security necessary to hold that prisoner , with
 12 category A being the highest . The purpose of
 13 categorisation is to help manage the threat posed by
 14 each offender . Three main factors are considered during
 15 the categorisations process: their risk of escape, their
 16 risk to the public if they were to escape, and their
 17 risk to the security of the prison . The categorisation
 18 of offender will determine the level of security
 19 necessary to manage them.
 20 The offender visited by Salman Abedi was
 21 a category B prisoner . Because of this , that prisoner
 22 was not subject to the approved visitor scheme which
 23 operates for category A prisoners . Offenders who are on
 24 that scheme can receive visitors only from
 25 a pre-approved list authorised by the prison governor .

1 For prisoners in categories B to D there is no routine
 2 vetting of visitors , other than for prisoners where
 3 there are child safeguarding or harassment concerns .
 4 There are approximately 80,000 prisoners in England
 5 and Wales and there is a finite capacity of the police
 6 to vet proposed visitors . However, resources are
 7 deployed where necessary to manage the risks posed by
 8 the most high-risk offenders , including convicted
 9 terrorist offenders . Additionally , any infringement on
 10 a prisoner 's or a visitor 's right to respect for
 11 a private and family life must be justified as being
 12 necessary and proportionate in the circumstances. Such
 13 an infringement might arise in the event of delays to
 14 the scheduling of visits pending completion of
 15 potentially lengthy security checks.
 16 Nonetheless, the operational improvement review
 17 recognised that work was ongoing to see how the scheme
 18 could be used more effectively by the time of the report
 19 of Parliament's Intelligence and Security Committee,
 20 OSCT and explained that JEXU and the Prison Service were
 21 exploring the feasibility of extending the approved
 22 visitor scheme. This intention was supported by the
 23 ISC.
 24 The Prison and Probation Service have now undertaken
 25 a comprehensive review of the way in which

1 communications with prisoners, including visits, are
2 controlled. That review includes an evaluation of the
3 arrangements supplied to terrorist and other high-risk
4 extremists in prison. The Prison Service will act on
5 the recommendations of that review.

6 We hope that this opening statement will help
7 everybody involved in the inquiry to understand the
8 Home Secretary's involvement in and responsibility for
9 so many of the issues engaged by the inquiry's terms of
10 reference. Some of the Home Secretary's role is
11 strategic and some is operational. The Home Secretary
12 approaches this inquiry knowing that a huge amount of
13 work has already been done at all levels to learn the
14 lessons from the attack and to make changes that should
15 help our ability to detect, prevent and mitigate against
16 the appalling consequences of terrorist activity. All
17 Government departments are mindful and hopeful that the
18 overarching view of the inquiry will help us to identify
19 more that could and should be done.

20 The main responsibility for horrifying terrorist
21 attacks lies squarely with those who commit them, those
22 who further a warped ideology deliberately set out to
23 take innocent lives and to ruin other lives forever. It
24 is the job of government and of the emergency services
25 to prevent those attacks, if we can, and to respond to

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1 them when they happen.

2 When we look back at the response to a major attack
3 of this sort, it will almost always be true that there
4 were some things that could have been done better or
5 differently. There will be changes that could and
6 should be made to improve responses in the future. The
7 Home Secretary and MI5 want to learn everything that can
8 be learned, but nothing should be taken away from the
9 courage of those who responded on the night, who saw
10 scenes that those of us who were not there can barely
11 imagine, and who put their own lives in danger in
12 a desperate attempt to save others. We hope that the
13 work of this inquiry will stop at least some others from
14 seeing a similar scene and will save more people from
15 the loss of life, the injuries and the grief of those
16 involved at the arena.

17 Thank you, sir.

18 SIR JOHN SAUNDERS: Thank you, Ms McGahey.

19 Can I just say thank you to all the core
20 participants for their opening statements. They have
21 assisted and they will continue to assist in narrowing
22 the issues on which I will need to make findings.

23 I just want to make a few comments on one aspect of
24 the submissions and that is what has been said about the
25 use of hindsight in this inquiry. I have been

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1 encouraged not to use hindsight when deciding whether
2 the correct decisions were made on 22 May by those who
3 were caught up in events, both before and after the
4 explosion. My present position is that it would be
5 unfair to use hindsight when making assessments of their
6 actions in that situation. As far as I can, I shall try
7 and put myself in the position of the person whose
8 decisions I am considering and the situation in which
9 they were. But in addition to making those assessments,
10 I have the job of making recommendations as to how
11 things might change in the future to try and minimise
12 the risk of a similar event happening in the future and,
13 if it does, how to minimise the consequences.

14 In arriving at appropriate recommendations, it is
15 not only inevitable but also necessary that I should
16 look at these events with the benefit of hindsight.
17 I am saying that now so that if people wish to make
18 further submissions as to what will be the correct
19 approach if they disagree with that approach, then they
20 are of course at liberty to do so.

21 Mr Greaney.

22 Housekeeping

23 MR GREANEY: Sir, thank you very much. That then concludes
24 chapter 5 of the inquiry's oral evidence hearings. May
25 I move on to deal with an issue of procedure, please?

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1 SIR JOHN SAUNDERS: Thank you.

2 MR GREANEY: Sir, as everyone knows, the health crisis has
3 worsened since the beginning of the inquiry's oral
4 hearings on 7 September. The UK COVID-19 alert level is
5 now 4 out of 5, which means that transmission of the
6 disease is high or rising exponentially. New national
7 restrictions have been brought in and local restrictions
8 remain in Greater Manchester. Furthermore, four people
9 who have been into this building have tested positive
10 for COVID-19.

11 Against that background, the inquiry legal team
12 considered it sensible to review how the inquiry's oral
13 evidence hearings are being conducted and, in
14 particular, we considered that it was relevant to ask
15 whether it was safe and appropriate to continue to hold
16 physical hearings in the Magistrates' Court.

17 To that end, on Monday this week the inquiry legal
18 team circulated a note to all core participants.
19 In that note, four possibilities were raised. First,
20 that we should adjourn this hearing indefinitely.
21 Second, that we could continue to conduct physical
22 hearings, as we have done to date, with a flexible
23 approach to seating in this hearing room. Third, to
24 adjourn for a period of two weeks. Fourth, to continue
25 with the hearing, but to do so, wholly or partially,

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1 virtually .
 2 We, the inquiry legal team, advocated the second
 3 approach for a number of reasons:
 4 (1). None of those diagnosed have been into this
 5 hearing room, and the public parts of the court building
 6 into which they had been have been deep cleaned.
 7 (2). The inquiry has updated its risk assessment in
 8 light of developments.
 9 (3). And importantly, the measures in place to
 10 protect those attending the inquiry hearing spaces are
 11 currently , it seems to us, working well . We are sitting
 12 at different times from other court hearings to minimise
 13 queueing times; longer breaks are being taken; hand
 14 sanitisers are available throughout the hearing space;
 15 face masks are being worn in public areas; capacity is
 16 reduced in each venue; perspex is being used to separate
 17 seating areas; and social distancing is being
 18 maintained.
 19 (4). There has been no positive case in this
 20 building for nearly 2 weeks now.
 21 (5). The view from HMCTS, working closely with
 22 public health practitioners , is that it is currently
 23 safe for this court building to be open and, of course,
 24 we will continue to work closely with HMCTS.
 25 The inquiry's note of 28 September sought any

1 submissions from core participants by the end of
 2 yesterday . All of the family teams replied , as did
 3 a number of other core participants , but it's not
 4 necessary for us to delve into the detail of those
 5 submissions and that is for the simple reason that there
 6 is a consensus, or at any rate a broad consensus . It is
 7 agreed that you should adopt what we have described as
 8 the second approach, namely carry on as we have been
 9 doing with a flexible approach to seating in this room.
 10 However, all consider that the situation should be
 11 kept under close review and we agree with that .
 12 Furthermore, we agree also that there should
 13 continue to be close liaison , as has occurred, between
 14 the inquiry legal team and the core participants about
 15 this issue and indeed about many other issues .
 16 We have now said twice that there needs to be
 17 a flexible approach to seating in this room and it is
 18 important that we should acknowledge and acknowledge
 19 publicly that those who have shown flexibility are the
 20 bereaved families , who have agreed to watch the
 21 proceedings, either from the annex or remotely, and we
 22 thank them for that approach.
 23 There is , however, some good news, or at least good
 24 news looming on the horizon . As we've said , Friday will
 25 mark the two-week point from the last positive COVID-19

1 case in this building . As a result , and subject to no
 2 further cases in the meantime, we hope to invite
 3 a limited number of family members back into this
 4 hearing room, if they wish to come, of course, from
 5 Monday.
 6 Sir , we don't propose to invite oral submissions on
 7 these COVID issues, at this stage at any rate, given the
 8 consensus which has emerged, but if any core participant
 9 wishes to make any point they should feel free to do so
 10 at the hearing which is listed tomorrow to address
 11 a number of issues .
 12 Sir , subject to those remarks, that's as far as we
 13 can take it today.
 14 SIR JOHN SAUNDERS: Thank you.
 15 MR GREANEY: May I indicate what the programme is for
 16 tomorrow. Tomorrow morning, Mr de la Poer will call
 17 Chief Inspector Sam Pickering to introduce certain
 18 materials which will be of relevance during chapter 7,
 19 security arrangements at the arena . Mr de la Poer
 20 anticipates that that process will take about
 21 90 minutes. After that, and after a break, and
 22 therefore at about 11.30, we'll address a number of
 23 outstanding issues of procedure and law.
 24 Sir , having introduced tomorrow, we would now invite
 25 you to rise and we'll resume at 9.30 tomorrow.

1 SIR JOHN SAUNDERS: Thank you.
 2 (4.03 pm)
 3 (The inquiry adjourned until 9.30 am
 4 on Thursday, 1 October 2020)
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1 I N D E X

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3 Opening statement by MS BLACKWELL1

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5 Opening statement by MR WARNOCK18

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7 Opening statement by MR SMITH48

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9 Opening statement by MR BROWNE98

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11 Opening statement by MS McGAHEY117

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