Manchester Arena Inquiry

Day 13

September 30, 2020

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(9.30 am)

SIR JOHN SAUNDERS: Mr Greaney.

MR GREANEY: Good morning, sir. First today we'll hear from Ms Blackwell on behalf of NHS England.

SIR JOHN SAUNDERS: Ms Blackwell, good morning.

Opening statement by MS BLACKWELL

MS BLACKWELL: Sir, this is the opening statement on behalf of NHS England. I'm instructed and greatly assisted by Gerard Hanratty and Helen Simm of Browne Jacobson Solicitors.

The devastating events that unfolded on 22 May 2017 caused unimaginable suffering to the bereaved families and friends of those who tragically died in the bombing as well as the survivors. NHS England would like to express its deep and profound sorrow to all of those affected by these events. The appalling consequences rippled outwards from the time of the bombing and continue to be felt today.

No one listening to the commemorative hearings delivered to this inquiry over the course of the past 2 weeks could have failed to have been emotionally moved by them. It has been an honour to get to know more about those who died through the generous sharing of memories by their loved ones.

NHS England understands that the bereaved, the survivors and others affected from within and outside of the Greater Manchester community must be provided with the clearest understanding of what happened on the night of 22 May 2017, of the background to the bombing and what lessons have been and can be learned to reduce the risk of such tragedy being repeated.

This opening statement is made in response to your request, sir, of 20 January of this year and in accordance with that request this statement is aimed at the informed listener and is composed of plain and direct language. It addresses each applicable term of reference so far as NHS England's responsibility is concerned.

I would like to begin with an explanation of the organisation that is NHS England in an effort to assist all core participants to understand the framework within which it functions and its connection to other relevant agencies.

NHS England oversees the budgeting, planning, delivery and day-to-day operation of the commissioning side of the National Health Service in England, as set out in the Health and Social Care Act 2012. Funding is allocated by NHS England to clinical commissioning groups who in turn distribute funding to NHS trusts and

foundation trusts as well as community healthcare and primary healthcare providers for the provision of healthcare services specific to their local area.

In addition to commissioning responsibilities, NHS England is a category 1 responder under the Civil Contingencies Act 2004, the Contingencies Act, and has accountability under the NHS Act 2006, as amended, to the Secretary of State for Health and social care.

The NHS Act requires NHS England to ensure that the clinical commissioning group and each service provider is properly prepared for dealing with a relevant emergency; that is an emergency which may affect either organisation.

The generic emergency preparedness resilience and response, EPRR, role and responsibilities of NHS England include leading the planning for, responding to and recovery of the NHS in the event of an emergency. NHS England developed the EPRR framework 2015, the EPRR framework, to provide a structure within which all NHS-funded organisations could meet the requirements of the Civil Contingencies Act and the NHS Act as well as the NHS standard contract. This also includes organisations which are not designated under the Civil Contingencies Act, such as mental health trusts.

The EPRR framework sets out strategic national

guidance to be followed by, amongst others, NHS trusts and foundation trusts as well as providers of NHS-funded services. It should be noted, sir, that as from 1 April 2019, NHS England and NHS Improvement have been working together as a single organisation to better support the NHS to deliver improved care for patients. Whilst the two organisations are still separate statutory bodies, they now have a single executive leadership team and a single operating model enabling a whole-system approach to implementing the long-term plan.

NHS England is represented on each local health resilience partnership and local resilience forum to ensure integration of plans across the regions which deliver a unified NHS response. Under the Greater Manchester Accountability agreement NHS England's functions in relation to EPRR in Greater Manchester are discharged through the Greater Manchester Health and Social Care Partnership, the partnership.

Joint planning for health incidents takes place through the local health resilience partnership which supports the health sector's contribution to multi-agency planning through the local resilience forum. The Greater Manchester Resilience Forum, as you

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

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

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

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

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

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

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

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

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

It was one of a series of exercises funded by the

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

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

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

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

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

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

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

To test decision-making and recording and finally to

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

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

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

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

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

given the opportunity to provide questions based upon the contents of those reports. One such question asked of the ambulance experts by the families focused upon Socrates. They asked:

"Is there positive learning from the benefits of Operation Socrates, particularly in terms of the desired frequency of training exercises of this kind?"

In response to this question, the ambulance experts agreed that this positive learning should be encouraged and stated that:

"It would be beneficial to the NHS to consider the benefits from ensuring that such exercises are completed regularly with the appropriate frequency."

This is being done. Exercise Socrates 2 took place on 18 September 2018. The scenario was a marauding terrorist attack, similar to that of the original exercise. The overall purpose was to support the further development of response plans, planning the Greater Manchester Trauma Network, and the ability of constituent organisations to cope with a mass casualty incident.

Through testing casualty dispersal, reporting and communication tools, command structures and coordination of the response, lessons were identified to further improve the response to a mass casualty incident.

Socrates 2 was also an opportunity to add to the national learning from the other trauma network exercises and further explore outcomes from the previous Socrates exercise and the arena attack.

This time, the planning groups sought to include additional aspects such as resources, including specialist equipment and blood, the role of the hospital ambulance liaison officers, HALOs, and increasing hospital capacity.

In November 2017, the NHS had introduced the concept of operations for the management of mass casualties to define a framework of response in which NHS England may direct NHS resources in the event of a mass casualty incident. This states that:

"During a major incident, as defined in the NHS England EPRR framework, which results in mass casualties, organisations will be expected to deliver emergency care to those affected. In addition, it may be necessary for services to consider enhanced care or the expansion of these functions beyond normal service provision to deal with the surge in patients. All organisations are expected to ensure that they maintain appropriate safeguarding measures at all times, especially for incidents involving children or persons of interest."

So an additional aim of Socrates 2 was to orientate staff to this concept of operations and that was done. This exercise was evaluated in the same ways as previously done and was also well-received.

Exercise Socrates 3 was held on 27 March 2019 to explore the practicalities of the ongoing acute hospital care phase and provision of psycho-social support following a mass casualties incident.

This time, the exercise participants were presented with a similar scenario involving a marauding terrorist attack. The objectives focused on learning from the previous exercises and recommendations from the Kerslake Review, which, as you know, sir, was published following the Manchester Arena attack.

The planning group also wanted to include aspects such as accelerated discharge procedures for acute hospitals and identify areas for improvement relating to self-presenters and psychological reports for casualties. The opportunity to include these aspects had not arisen during the previous two exercises.

Socrates 3 was well-received by participants, who engaged fully with the scenario and subsequent discussions, and the participants noted that this was a useful exercise to allow discussion and promote further learning around the ongoing response to a mass

casualty incident.

Going forwards, these exercises will be arranged regularly and with appropriate frequency.

The immediate and operational response to the detonation of the explosive device, terms of reference 3(iii) and 5(iii), and the inter-agency liaison communication and decision-making, term of reference 5(iv).

On-call personnel are available at every moment of the day and night to ensure that NHS England can effectively discharge its duties as a category 1 responder under the Civil Contingencies Act. The role of the First On-call is to establish the nature of the alert and ensure that the most appropriate and effective management is established as early as practicable. The role of the Second On-call is take effective action to manage a critical and/or major incident either singularly or in conjunction with the clinical commissioning groups or multi-agency partners as appropriate.

On 22 May 2017, the First On-call was Ben Squires, held of primary care operations, and the Second On-call was Colin Kelsey, head of urgent and emergency care transition and EPRR at that time.

Both had an extremely strong record of training and

exercising prior to the Manchester Arena attack. The immediate focus on the night was to establish the context and situational awareness of the incident and ensure that the NHS responders had the necessary resources and support to operate safely and effectively. This was done, in close collaboration with NWAS and multi-agency partners at the GMP Headquarters.

At 23.10 hours the partnership team was alerted to the explosion at the Manchester Arena by NWAS and a major incident was declared at 23.13 hours. Colin Kelsey assumed the strategic commander role and attended the NWAS Regional Operations Coordination Centre to liaise with their strategic command.

On arrival, he confirmed the activation of all Greater Manchester acute hospitals' emergency departments and agreed the use of the Greater Manchester framework for patient dispersal in a mass casualty event. He later attended the Greater Manchester Police Force Headquarters to represent the NHS in the multi-agency response.

The partnership command team worked closely with NWAS and the hospital emergency departments to coordinate the NHS throughout the night, which included liaison with other partners such as Transport for Greater Manchester, the Greater Manchester Fire and

Rescue Service and the Royal Oldham mortuary.

Although a major incident standby was declared at 05.10 hours on 23 May, Colin Kelsey remained at Greater Manchester Police headquarters for several hours, arranging for Greater Manchester providers to receive supportive calls and visits from VIPs.

Relevant policies, systems and practices, term of reference 5(ii), including inter-agency liaison, term of reference 5(iv), and the impact of any inadequacies, term of reference 5(v).

As you know, sir, command and control within the emergency services is exercised through a three-tier system categorised as the Gold/Silver/Bronze hierarchy of command. This follows the Cabinet Office guidance, "Concept of Operations", which refers to these three tiers as: strategic, Gold; tactical, Silver; and operational, Bronze. A commander is said to have a span of control commensurate with their particular tier of command or functional role.

NHS England represents the NHS at the strategic level and attends the strategic coordinating group whose role is to set strategic direction, coordinate responder agencies and prioritise resources and, as a category 1 responder, NWAS also attends such meetings.

It is the role of the Tactical Coordination Group to

interpret strategic guidance, develop tactical plans and coordinate activities and assets. The hospital trusts, for example, as well as NWAS occupy the tactical tier.

Operational responders execute the tactical plan, command a single service response and coordinate actions. The clinicians within the hospital trusts and paramedics occupy the operational tier.

Prior to the Manchester attack there were several multi-agency plans in place involving NHS England acting through the partnership. These covered all relevant policies, systems and practices relating to an attack of the kind that took place at the Manchester Arena. These included the identification of locations and procedures for establishing and operating a suitable environment for managing such mass casualty emergencies.

And following the Manchester Arena attack, there were a series of debriefs. In addition to the single agency debriefs, there were several multi-agency debriefing sessions in accordance with the mass casualties plan in order to encourage openness and promote learning.

NHS England also facilitated clinical reviews, the aim of which was to promote discussion between NHS colleagues about the clinical response to the attack and the management of patients in an open environment to

promote learning and development. Particular expertise was shared in relation to blood-borne viruses and the treatment of blast injuries.

The final Greater Manchester multi-agency debrief report of December 2018 makes clear that responders felt that overall preparedness was good. Further, that the thorough risk assessments led by the partnership had enabled the impacts to be fully understood, the correct capabilities to be put in place, and the response of the combined agencies on the night and in the days which followed to be comprehensive and very effective.

Survivability, including whether any inadequacies in the emergency response contributed to individual deaths and/or whether any of the deaths could have been prevented, term of reference 7(iii).

Of the 22 who died, three individuals were pronounced dead at hospital. John Atkinson and Georgina Callander were both taken by ambulance to the Manchester Royal infirmary. Saffie-Rose Roussos was taken by ambulance to the Royal Manchester Children's Hospital. This was in accordance with the arrangements which had been planned for within the Greater Manchester framework for patient dispersal in a mass casualty event.

Of these three, only John Atkinson's injuries are

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

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

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

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

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

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

SIR JOHN SAUNDERS: Thank you, Ms Blackwell.

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

SIR JOHN SAUNDERS: Thank you.

Mr Warnock.

Opening statement by MR WARNOCK

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

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

SIR JOHN SAUNDERS: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sir, as has already been said, there are obvious

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

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

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

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

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

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

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

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

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

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

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

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

as had happened during Winchester Accord.

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

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

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

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

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

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

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

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

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

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

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

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

duty NILO until 22.40.

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

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

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

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

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

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

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

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

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

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

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

Mr Berry will give evidence that he was concerned

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

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

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

Based on what Mr Berry knew, we submit his decision

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

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

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

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

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

effect on behalf of the families.

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

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

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

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

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

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

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

I should make clear it was not the Chief Fire Officer's role to command the incident, but, as Mr Hall says, his intervention had the positive outcome of actually getting fire personnel to the scene.

Since the attack, measures have been taken to ensure an effective command structure in the event of a similar attack, including the mobilisation of an assistant principal officer, which is an area manager or above, to take incident command at the RVP. It is anticipated that this should avoid a similar situation where no one is in charge of an incident of this nature arising again.

Term of reference 5(iv), the inter-agency liaison communication and decision-making between relevant emergency services and with others, including their adequacy and compliance with relevant planning, preparation, policies, systems and practices.

GMCA has said from the outset of this process that it will take responsibility for its own failings and it does not seek to blame others for its own shortcomings. GMFRS acknowledges and accepts that but for the mistakes it made, Fire Service personnel would have attended the arena sooner. GMCA also recognises that on this dreadful night, no emergency responder or the organisation they worked for wanted to do anything other

than the best for those who were the victims of this callous act.

We do not underestimate the immense pressure that police and ambulance responders at the arena were working under, and we recognise their fortitude and bravery. We also recognise the danger of hindsight when later analysing decisions that were made in the agony of the moment.

It cannot be ignored, however, that inter-agency communication has long been recognised as a potential area of weakness when the emergency services are dealing with the particular challenges of a mass casualty terrorist incident. In the context where emergency services are supposed to work together, it is inevitable that inadequate joint working by other agencies, particularly where they have a wider effect on the response of others, must be considered too. That's necessary if lessons are to be learned.

The errors on the part of other agencies that GMCA identifies in this section are errors which the other agencies also identify and accept. We consider here their impact on GMFRS.

None of the initial mobilisation decisions made by NWFC or GMFRS would have mattered had the other emergency services shared their situational awareness,

as was the expectation and responsibility under JESIP. Had the force duty officer spoken with Mr Berry and confirmed the RVP or given him an FCP, GMFRS would have been able to co-locate with the other agency incident commanders and make joined-up decisions in full knowledge of what was occurring at the scene.

Several individuals in the other agencies' key command roles go as far as to state that they held the view that the attendance of the GMFRS was not needed, notably the force duty officer, the GMP tactical firearms commander, and the NWAS operational commander. That information was not shared with GMFRS at any level, preventing GMFRS from challenging the view and reminding the other agencies of both its specialist resources and its general rescue and casualty management capability.

It is significant, however, that the failure in communication and information sharing within GMP was not limited to the FDO and GMFRS received virtually no contact from GMP at all prior to its arrival at the arena. Similarly, there were failures in communication with NWAS who were also obviously aware that GMFRS were not at the scene.

Importantly, crucial developments were not communicated to GMFRS as they should have been by the control rooms or commanding officers of other agencies,

in particular a declaration of a major incident by the British Transport Police at 22.39, the declaration of Operation Plato by the force duty officer at 22.47, which should have been shared immediately with NWAS and GMFRS, along with a METHANE report which GMP never issued, a METHANE report issued from the scene by NWAS at 22.54, and the METHANE report from the scene by the British Transport Police at 22.58.

The experts have highlighted the importance of the fact that these matters were not shared on an inter-agency basis in their reports, and GMCA agrees with Mr Hall that communication of these would have had, and I quote:

"... an almost instant and significant effect on the response from GMFRS and NWFC."

In addition, GMP did not declare a major incident or issue any METHANE report, a failure described as a "serious omission" by the policing experts. It is no exaggeration, sir, to say that the inter-agency liaison, communication and decision-making on the part of all the responding agencies fell very far short of what was expected under the JESIP principles and the multi-agency training prior to the event, and GMFRS regrets the part that its own shortcomings played in that overall failure.

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

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

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

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

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

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

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

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

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

Finally, GMFRS has invested in additional stretchers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GMCA recognises that all of those who attended the

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

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

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

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

improvements to practice which may be identified.

SIR JOHN SAUNDERS: Thank you, Mr Warnock.

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

SIR JOHN SAUNDERS: Thank you.

(10.51 am)

(A short break)

(11.20 am)

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

SIR JOHN SAUNDERS: Thank you, Mr Smith.

Opening statement by MR SMITH

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

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

portraits and the memories and sentiments that have been expressed. It is important to North West Fire Control that its approach to the evidence in the inquiry is undertaken with all of those who have been so deeply affected in mind.

The company's aim is to consider how it can best serve to assist the inquiry and also to manage the interests of the company in the light of all the evidence that is to be received. In doing so, North West Fire Control will, as you will hear, acknowledge the failures for which it has been responsible.

However, it will also be necessary for North West Fire Control to respond to criticisms that have been made concerning the actions taken by the control room staff on the night of the attack. It is Fire Control's hope that the families will recognise and understand that this course is in no way intended to diminish the importance of their evidence or the prominence that their interests have in the inquiry process.

North West Fire Control's written opening statement cannot be delivered orally in its entirety in the timescale allotted by the inquiry; we wish to emphasise that we make no complaint about this. The expectation is that the inquiry requires focus and must operate

efficiently. Of necessity, therefore, much of the detail that has been set out in the uploaded written opening statement will necessarily need to be reduced in oral presentation.

MR GREANEY: Mr Smith, I am very sorry to interrupt you, but you'll understand and accept that I wouldn't do so unless necessary. I'm told that there is a problem at Spinningfields. I'm very sorry to report that again. It's obviously important that those who are there --

SIR JOHN SAUNDERS: Mr Smith, I am very sorry about this, we'll have to sort a technical problem out. We will come back as quickly as we can. We will also find out how much hasn't been heard of what you've already said so you can go back over it again if you'd be so kind.

MR GREANEY: In fact in the time I have been on my feet, the problem has been resolved. What I don't know is how much of Mr Smith's... I'm told about 3 minutes has been missed and what I suggest therefore, if Mr Smith is content with this, is he simply starts again.

SIR JOHN SAUNDERS: Are you happy to do that, Mr Smith?

MR SMITH: Of course.

SIR JOHN SAUNDERS: Thank you so much.

MR SMITH: North West Fire Control is represented, of course, as you know, sir, by myself and Ms Gilmour, and we are instructed by Mr Stephen Graham and

Mr Tristan Meears-White of Ward Hadaway of Newcastle-upon-Tyne and Manchester.

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Some important factual material has been allocated to two appendices to the written opening statement for this reason. Appendix 1 is an important detailed analysis of calls into and out of the control room during the period in question. The company's written opening statement and a brief supplemental statement will, we understand, be uploaded to the inquiry website in due course and will be available to be studied in detail.

It therefore seems essential to us that we should concentrate at this stage only upon the principal aspects of North West Fire Control's written opening statement in order to meet that expectation.

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

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

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

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

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

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

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

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

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

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

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

It is of particular importance to emphasise that

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

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

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

Once an incident type has been selected by the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

action plan, an implementation phase and a marauding terrorist firearms attack stand-down phase.

As far as the standby phase is concerned, this action plan required North West Fire Control, if a call was not received from GMP, to inform the duty NILO to obtain the address of the incident and to seek advice.

After the attack at Manchester Arena, Greater Manchester Fire and Rescue Service produced revised action plans, some of which have been further updated and amended. The first of these was an action plan headed "Bomb -- general", and that action plan required Fire Control, in the event that an explosion had occurred, to change the incident type to "BG3115 -- explosion".

The second revised action plan was the Fire Service's incident type action plan "BG3115 -- explosion". This action plan now required Fire Control in the event that a bomb had exploded, and following the requirement in the new action plan "Bomb -- general", to send a Technical Rescue Unit, pumps and a station manager to the scene and inform the duty NILO. There were a number of other additional or revised action plans provided relating to Operation Plato.

I would like to turn to the practical effect of the changes and the inferences to be drawn from them. The

result of these changes is that the revised action plan for an incident type involving a bomb which has exploded requires Fire Control to mobilise to the scene and removes the requirement of North West Fire Control to obtain instructions from the duty NILO before mobilising.

This, submits North West Fire Control, represents a significant change in the response required of Fire Control in the event of a bomb having exploded and which North West Fire Control contend was clearly not the situation at the time of the incident.

In this context, the inquiry may wish to explore the reasons why it was deemed necessary for the Fire Service to revise their action plan after the incident in the light of the fact that it has been contended, and we'll deal with this in detail in due course, that Fire Control should have followed the action plan for explosion.

The inquiry may wish to consider that if the route which should have been followed was clearly expressed in the existing plans, there would have been no requirement to amend them.

North West Fire Control contend that in the light of the information received into the control room on the night, that a bomb had exploded, the action plan then

current for an explosion was not the appropriate action plan to be followed. The most appropriate action plan, in the absence of a METHANE message or communicated declaration of Operation Plato, was that for "Bomb -- general".

The actions required to be taken in the form in which they were expressed in the action plans current at the time of the incident were, we submit, not clear and unambiguous in their terms.

The inquiry may wish to examine the wording of each one of these action plans in more detail as the evidence progresses. It is of significance that an action plan for an exploded bomb had never been supplied to North West Fire Control by the Fire Service and therefore no such plan had been loaded on to Fire Control's computer-aided despatch system.

The Operation Plato action plan all required Fire Control to contact and take advice from the duty NILO as the first action, as did the "Bomb -- general" action. This is the course that was followed.

In evidence supplied to the inquiry in writing so far, General Manager John Fletcher of the Fire Service has observed that no particular criticism is directed to North West Fire Control in relation to their decision. He points out that:

"They deliver a service that we ask them to deliver, which is based on call handlers following a series of action plans for multiple incident types, which can be confusing."

His suggestion that the Fire Service had more experienced call handlers who had a greater familiarity with the Fire Service's own procedures and the geography of Greater Manchester is misplaced.

The duty team leaders who made the decision to inform the duty NILO on the night were both experienced in control room procedures. One of them, Michelle Gregson, had worked for Lancashire Fire and Rescue service from 2004, and the other, Lisa Owen, was a call handler at Greater Manchester Fire and Rescue Service from 2010.

Of particular significance in this context is a draft MTFA mobilisation emergency response guidance dated 27 February 2017, which Greater Manchester Fire and Rescue Service had prepared and circulated prior to the incident. The purpose of the document is expressed to be one of giving guidance for the actions required by officers undertaking various roles to support a marauding terrorist firearms attack. The document was expressly relevant to North West Fire Control's operatives as well as NILOs and others.

The document recognised the:

"... rapidly changing and unique features of this type of attack require a more dynamic and collaborative approach to that adopted in standard major incident planning ..."

Significantly, its terms, if implemented, would have required North West Fire Control, on notification, to obtain as much information as possible and to inform the duty NILO as a priority and obtain specific operational instructions from the duty NILO. This was consistent with the predetermined action plans in place at the time for both "Bomb -- general" and Operation Plato standby and implementation phases.

In one moment, I'm going to come to deal with the response by the control room to the emergency calls, but before I do so I'd like to deal with some apparently inconsistent evidence relating to the response by the control room, of which you, sir, are aware and which has already been uploaded to the portal.

Before we deal with the control room's response to the emergency calls, it is necessary to point out that there is some potential for confusion arising from references in the Kerslake Report and in witness accounts provided by North West Fire Control's employees in relation to the descriptions of the physical action

taken by the control room staff after an incident log had been commenced that night at 22.38.48, and the explosion action plan had been accessed by the control room operator, Mr David Ellis.

Contrary to what is said in some of the material and evidence that has been gathered, the control room operators at North West Fire Control did not open the action plan for "Bomb -- general". Only the action plan for explosion was opened, and this was at 22.38.51.

No other action plan was opened until 00.58.12, when the control room opened the action plan for Operation Plato stand by phase as the data establishes. It is not disputed that the action plan for an explosion was not followed after it had been opened and that the control room staff considered that the action plan for an explosion was not applicable to the nature of the incident based on the information that was coming into the control room.

In particular, as has been made clear, the explosion action plan would have required North West Fire Control to mobilise resources to the incident, which was something that was not done. Instead, the team leaders in the control room took the first action that would have been required of them had they followed the "Bomb -- general" action plan, which was to inform the duty

NILO before mobilising and to await guidance before proceeding further.

The scope for confusion in the evidence relates to the issue of whether the control room staff either opened or followed the action plan for "Bomb -- general" and what is meant by those terms in the various documents and statements in which they've been referenced.

Of course, sir, you will determine the facts, but the evidence of a duty team leader Michelle Gregson and Lisa Owen, and the duty operations officer, Janine Carden, is to the effect that in the light of the information coming into the control room, the team leaders decided that the duty NILO should be informed and that resources would not be mobilising other than under his instruction. This action corresponds with the first action that would have been required of North West Fire Control under the "Bomb -- general" action plan, which was current at that time and with which the control room team leaders were familiar.

Whether the control room staff actually followed the "Bomb -- general" action plan in the sense that they followed the sequence of events set out in the plan is a matter which may have to be explored in more detail in evidence. Some of the control room staff have, as you

know, sir, recently provided further statements to reflect what they will say is a more accurate account of this important aspect of the events, the investigation into which, it is submitted, falls squarely within the inquiry's terms of reference 3(iii) and 5(iii).

In addition, the witness Janine Carden, the operations manager who arrived in the control room at 11.05 that night in response to being notified of the incident, has provided further information and an additional statement is to be taken from her by the inquiry team.

Sir, I turn to the response by the control room under terms of reference 3(iii) and 5(iii). The control room received two initial calls from the emergency services, which provided the basic information necessary to permit Fire Control's control room staff to make a decision in relation to mobilisation of tenders and personnel. The first of these calls was, as you've heard, from Greater Manchester Police. It was initially unconnected with the attack at Manchester Arena. The call commenced at 22.32 and in the course of that call, at 22.34.44, Greater Manchester Police asked North West Fire Control:

"Have you been told about an explosion in the city centre?"

The control room operator, David Ellis, said that they had not. He closed down the unconnected incident which had initiated the call, leaving the telephone line with the police open.

At 22.35.15 the police then informed Mr Ellis that they had just been told that there had been an explosion in the foyer area of the Manchester Arena and, at 22.35.50, that a bomb had exploded at the arena. Almost immediately, some details of casualties were relayed to Fire Control by Greater Manchester Police.

At 22.37.20, the police informed Fire Control that it was believed that there were 30 or 40 casualties but that that was unconfirmed.

At 22.38.51, the control room operator David Ellis opened the explosion action plan and, at 22.39.20, told the police, after consulting with Lisa Owen, one of the duty team leaders, that North West Fire Control was going to inform the duty NILO before mobilising. This telephone call was eventually closed down at the request of Greater Manchester Police at 23.01.12.

The second of these calls came in to Fire Control's control room at 22.37 from the Ambulance Service. It was taken by Fire Control's control room operator Joanne Haslam and the call informed North West Fire Control -- these were the words:

"... the bomb has gone off, by the way."

North West Fire Control passed to the Ambulance Service at 22.38.58 the information concerning the number of casualties that had been provided to them by Greater Manchester Police. During this call, Joanne Haslam made a number of requests for further information from the Ambulance Service including, at 22.42.13, a request for any further information to the fire crews.

At 22.43.11, the Ambulance Service reported to North West Fire Control that they were receiving reports of people being shot:

"There is a [report] of a shooter ... a shooter going on as well."

At 22.44.29, a caller reported that there were 60 casualties.

At 22.45.14, a caller reported:

"I have just been informed that there's an active shooter."

At 22.46.23, Fire Control sought and received from the Ambulance Service confirmation for the purposes of recording details on the incident log that they had had reports of a bomb that had exploded, that there were 60 casualties, and there was an active shooter. It is apparent from the transcript that Joanne Haslam

continued to provide information to the Ambulance Service. This took the form of road closure details, details of a rendezvous point provided by Greater Manchester Police outside the cathedral.

At 22.48.28, the Ambulance Service enquired whether there was any further information and Fire Control was able to report that they did have further information that had just been put on the log of shrapnel wounds. This call was closed down at 22.49.28.

According to the brief statement provided by Joanne Haslam to Greater Manchester Fire and Rescue Service for use by Greater Manchester Police at the time of the initial investigation, at a point approximately 47 seconds into the call received from the Ambulance Service, she informed the team leaders, Michelle Gregson and Lisa Owen, that North West Fire Control had just received a call from the police and that David Ellis had created an incident log. She provided them with the remainder of the information which had come from the Ambulance Service.

It's important to appreciate also that within the time parameters of these two calls, North West Fire Control made its first call to the duty NILO, Station Manager Berry, at 22.40 hours. That call was made by Michelle Gregson.

At 22.40.10, Fire Control, through her, reported the fact to Mr Berry that there had been an explosion at the Manchester Evening News Arena, and I'm going to quote from the transcript:

"... it's already detonated ... the police that we've got on the line are saying it is a bomb... there's been 30 casualties reported so far ... the rendezvous point at the moment is the car park area outside the cathedral ... I've just phoned you while we're still on to the police. Would it be all right for you to get in touch with them? Obviously we are not mobilising at the moment... can you just speak to them and we'll hang fire ..."

At 22.41.58, Michelle Gregson, the line remaining open, informed Station Manager Berry that they had just got a member of the public on the telephone and they were just getting some more information in and she said to Station Manager Berry, "But I don't know if you want that at the moment." Station Manager Berry indicated that he did not and he then gave the following instructions to North West Fire Control. These were his words:

"Just give me four pumps to standby or rendezvous at Philips Park for now. I'll speak to the Force Duty Officer."

At 22.44, Rochelle Fallon, control room operator,

left a voicemail on Station Manager Berry's mobile telephone making him aware of reports that people had been shot. The member of the public to whom Michelle Gregson was referring was Mr Hosken. His call was received by the control room operator Dean Casey at 22.41. He reported that there had been a big blast and that there were people with shrapnel in the neck and back. At 22.42.25, Mr Hosken asserted that:

"Looking at the people, I would suggest it's a dirty bomb of some description."

A NILO, as I've already indicated, has a degree of security clearance, which North West Fire Control's operators and team leaders do not have. NILOs are security cleared, trained and qualified managers who can advise and support other agencies on the Fire and Rescue Service capability to reduce risks and safely resolve incidents. They can be provided with restricted and sensitive information. There would, we submit, be no expectation from the team leaders and duty operations manager at Fire Control that communications between the duty NILO and the force duty officer would necessarily be shared with Fire Control or passed over the Airwave radio.

It follows from the above that within less than 4 minutes of the information coming into the control

room that a bomb had exploded, the two team leaders made the decision that before North West Fire Control would mobilise, the duty NILO was to be informed. When he was informed, Station Manager Berry gave a clear instruction that four pumps were to standby or rendezvous at Philips Park and he used these words, "for now".

He indicated, as you've heard, he would speak to the force duty officer. This was a clear instruction from the duty NILO to Fire Control. And from that point onwards, Fire Control complied with the duty NILO's requirements and with instructions from other senior officers at Greater Manchester Fire and Rescue Service.

Four tenders were mobilised to Philips Park Fire Station. Both Michelle Gregson and Lisa Owen were of the opinion that Station Manager Berry's instructions constituted the action that they would also expect in these circumstances.

At 22.44, Lisa Owen contacted the duty operations manager for NWFC, Janine Carden, and informed her that North West Fire Control had not mobilised to the incident scene and that Station Manager Berry required four appliances to muster at Philips Park and that he had not authorised anyone to proceed to the incident.

At 23.05, Janine Carden arrived at the control room. Her statement and the statements provided by

Michelle Gregson and Lisa Owen, we submit, establish very clearly that, having regard to the information coming into the control room, this incident appeared to be an MTFA incident and that the action plan for Operation Plato's implementation phase would have required Fire Control to take the steps that it had taken.

The data available from the control room establishes what action was taken in the control room and the times and this will be of significance to the inquiry when considering the issue of the potential for confusion in relation to the steps taken with the predetermined action plans described in some of the witness statements that have been provided by North West Fire Control personnel.

Sir, I turn to terms of reference and 5(iii) in particular, the adequacy of the control room's response.

The evidence relating to the qualifications and experience of the control room staff who were on duty at the time of the incident establishes that they were possessed of the necessary expertise and training to equip them to make the correct decisions in the light of a demanding and fast-moving situation. They were properly trained for this type of emergency.

Janine Carden, the operations manager, was the

day-to-day specific point of contact with Greater Manchester Fire and Rescue. She had already demonstrated her capability in the course of what are known as MTFA audits and training for precisely such an event. This is evidenced by the fact that in early February of 2016, Greater Manchester Fire and Rescue Service hosted a visit arranged by the Chief Fire Officers' Association, the purpose of which was to determine the level of preparedness of the fire and rescue service for an MTFA incident.

By an email of 12 February 2016, the Fire and Rescue Service, through both group manager John Fletcher and Assistant Chief Fire Officer Dave Keelan, expressed their admiration for Janine Carden's contribution to that exercise. These are the relevant words of that email:

"I believe Dave Keelan will be emailing you later on the same subject. I just wanted to pass on my appreciation for the efforts of Janine yesterday with the assurance visit. From the feedback given by the auditors, she gave a stellar performance with her level of knowledge, not just around the mobilising but also the wider MTFA incident implications."

Janine Carden had informed the head of North West Fire Control, in a series of emails

associated with this, that the staff should all have her knowledge already.

Therefore, and it follows from the above, acting on the initiative of its team leaders, Michelle Gregson and Lisa Owen, North West Fire Control took the decision to inform the duty NILO and not to mobilise to the scene but instead to await further instructions from the Fire and Rescue Service. This decision was endorsed by Janine Carden, the duty operations manager, when she arrived at North West Fire Control and was briefed by the team leaders in relation to the information received into the control room and the actions that they had taken. These decisions were consistent with the initial requirement that would have been imposed on Fire Control by the Fire and Rescue Service's predetermined action plan for a "Bomb -- general" on Fire Control's computer-aided despatch system, which, had it been followed, would have required North West Fire Control's personnel to have taken the steps that they actually took, namely:

"To inform the duty NILO, request guidance on actions to be carried out before proceeding further -- bomb general."

These decisions were also consistent with the information coming into the control room.

North West Fire Control contend that this decision was the correct one to take. This will, of course, be a matter for the inquiry to determine and that will be done in the light of the evidence, but for the time being North West Fire Control takes issue with the proposition that has been advanced by some witnesses and by the independent fire expert, Mr Hall, that North West Fire Control should have mobilised tenders and personnel to the scene and should have followed the explosion action plan on their system.

That proposition, advanced as it is by Mr Hall at paragraphs 45 to 47 of his addendum report, and by the Chief Fire Officer, Peter O'Reilly, who was duty principal officer at the time, in paragraph 114 of his statement, is, North West Fire Control submit, entirely misconceived.

This may seem to be an ambitious submission by North West Fire Control, involving, as it does, serious challenge to the opinion of an experienced senior fire officer and to that of an independent expert in fire control, but it is our duty to give clear notice that the stance adopted by these witnesses in this respect will be submitted, on North West Fire Control's behalf, to be unsustainable and unrealistic.

It is also important to add that, in Mr Hall's

addendum report, Mr Hall states that:

"A decision to choose one action plan over another is down to the individual assessment made at the time by the operator and/or the duty team leader."

And that:

"North West Fire Control operators would be best placed to provide a rationale for why that decision was taken based on any training they had received."

These comments in particular, we submit, require close examination in the course of evidence by the inquiry.

The reason why Fire Control contends that this proposition is entirely misconceived is that, given the nature of the incident and the risk to Fire Service personnel of a potential deployment to an MTFA hot zone, the team leaders were conscious, as a result of their training, that Fire Service personnel could be placed at risk of fatality or serious injury as a result of being mobilised to the scene without further information concerning the seriousness of the threat and the risk.

Fire Control did not have that information and was in no position to determine the appropriateness or otherwise of deploying pumps and personnel to the scene of an exploded bomb. They knew an incident of this nature and casualties on this scale required the

mobilising displayed by the Fire Service. The "Bomb -- general" Operation Plato action plan required the duty NILO to be contacted as a first step and that in the absence of instructions to do so, North West Fire Control should not mobilise to the scene.

Within less than 4 minutes of the receipt of the information that a bomb had exploded at the arena, the duty NILO had been appraised of the situation, including the number of casualties and the police rendezvous point.

Shortly thereafter, reports were received from both the police and the Ambulance Service of a possible shooting as well and of an active shooter and it would have been obvious that North West Fire Control would expect that the situation would result in the transmission of a METHANE message by one or more of the emergency services and that Operation Plato could be expected to be declared by the police.

In fact, if multi-agency communications worked as they should have done in accordance with JESIP principles, North West Fire Control would have been informed that Operation Plato had been declared while both of the initial calls from the police and the Ambulance Service were in progress and the lines remained open.

That information could have been conveyed to Station Manager Berry, who was unable to contact the force duty officer. In such circumstances, Fire Service personnel could not under any circumstances be mobilised directly to the incident. Janine Carden's statement to the inquiry demonstrates the reasons for the decision and I will, if I may, quote from part of her statement:

"The incident appeared to be an MTFA incident and the actions for this would require us to inform the duty NILO and to await further instruction. At the time of this incident, the action plan for the Operation Plato implementation phase required of us those steps. The agreed process was clear: that we were not to mobilise any resources until confirmation from the NILO had been received, confirming which resources were required and where they were to be mobilised."

After Station Manager Berry was contacted and provided GMFRS's instructions to Fire Control, Fire Control took all steps required of them by the Fire Service and this is established by the real evidence available from the recording of calls coming into and out of the control room.

Appendix 1 to the written opening statement consists of analysis of calls into and out of the control room from the time at which information that a bomb had

exploded at the arena was received by Fire Control, 22.35.50, until the point at which pumps and personnel were mobilised to the scene, 00.25.02.

It's necessary to point out that Station Manager Berry has considerable experience in the management of MTFA situations. After the arena attack, he took on responsibility for the MTFA lead following the departure of Neil Gaskell to the Home Office on secondment. He was responsible for training and implementation of the new joint operating principles. His training and experience is incorporated in his statement and other documents.

North West Fire Control contend that he could have been in no doubt that his advice was being sought by Fire Control when the team leader Michelle Gregson spoke to him at 22.40, and he was told that Fire Control was not mobilising at the moment.

The inquiry may wish to explore in evidence with Station Manager Berry the accuracy of a claim that he has made in paragraph 52 of his witness statement that normally Fire Control would follow their action plan and that would mean sending the resources specified in the predetermined attendance listed on that action card straight to the address of the incident. He should be aware that there are several action cards. His

assertion that it is not the role of the NILO to determine what initial resources are sent because they are already determined by the action card requires detailed scrutiny since that is precisely the role of the NILO in respect of the action cards which were on the computer-aided despatch system for use in respect of bombs and MTFAs, as already explained.

Likewise, his statement that he wished he had challenged what he was being told by Fire Control is inconsistent with his experience and position. The inquiry may wish to consider in this context his acknowledgement in his written evidence that on the basis of what he had been told:

"This was a terrorist incident."

And that:

"From the outset my thought process was that this was a terrorist attack."

The inquiry may also wish to consider whether what has been said in paragraphs 65 and 70 of Station Manager Berry's statement is an attempt by him to dilute his responsibility for the obligation to communicate the necessary decisions in relation to mobilisation, including any command structure, to North West Fire Control's control room.

The former Chief Fire Officer, Peter O'Reilly,

arrived at Greater Manchester Fire and Rescue Service headquarters shortly before midnight. Mr O'Reilly has provided evidence to the inquiry that in the course of a meeting held with the Mayor of Greater Manchester on 24 May 2017, when the passage of time between the initial call and the deployment of the first fire tender to the scene was discussed, the initial information GMFRS had received led to the decision not to deploy to the scene but to use Philips Park as a muster point.

He explained that the information that the Fire Service had been given was that there was an explosion and an active shooter, and he records in his evidence that he informed the Mayor of Greater Manchester of the following:

"We discussed that if this information had been accurate and we had deployed directly to the scene, there was a risk that firefighters could have been shot or involved in a secondary explosive attack ... I told the mayor that as a firefighter it would kill me if I found out that we could have saved more people by getting there quicker but I also knew that the Fire Brigades' Union and the Health and Safety Executive would have had me in the dock if firefighters had been sent directly to the scene and had been killed by a terrorist."

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

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

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

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

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

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

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

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

in the light of this material.

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

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

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

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

followed after the two team leaders were consulted.

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

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

point at Hunts Bank at 22.54.

Seven, from the point at which instructions were received from Station Manager Berry, North West Fire Control acted entirely in accordance with the instructions provided to them by Greater Manchester Fire and Rescue Service. These instructions were provided by the NILOs, Berry, Meakin and Levy, and from the duty group manager, Dean Nankivell, who established himself in the command support room at Fire Service Headquarters at 11.30 pm. The Assistant Chief Fire Officer and the Chief Fire Officer, Peter O'Reilly, joined him there shortly thereafter.

Eight, the instructions given to North West Fire Control included a requirement to mobilise pumps, Technical Rescue Unit and MTFA capability to Philips Park Fire Station.

Nine, as the transcripts will show, North West Fire Control was specifically instructed not to mobilise to the scene. They acted in accordance with those instructions. Once later instructed to mobilise to the scene, Fire Control again acted in accordance with their instructions.

Ten, throughout the period embraced by the first call to North West Fire Control by Greater Manchester Police until the mobilisation of pumps and personnel to

the scene, Fire Control was not provided with sufficient information to permit them to have shared situational awareness and, in particular, Fire Control received only three direct calls providing them with information. These were from Greater Manchester Police, the Ambulance Service and one member of the public. There was one call from British Transport Police, which was not such as to provide them with any relevant information.

Eleven, North West Fire Control was not informed that Operation Plato had been declared at 22.47 and did not receive any METHANE message informing them that a major incident had been declared.

Importantly, conclusion 12, the North West Fire Control control room failed to actively elicit sufficient information from any of the emergency services, whether that was by way of enquiring whether Operation Plato had been declared or whether any emergency responder had sent any METHANE message or otherwise. They had failed to elicit sufficient information from any of the emergency services to permit them to share that situational awareness with Greater Manchester Fire and Rescue Service, and we immediately acknowledge that failure on behalf of North West Fire Control.

Sir, I come to the final part of our oral opening statement, which deals with failures in communication, terms of reference part 5(iv), 5(v) and 7(iii).

North West Fire Control monitored the GMP channel from approximately 23.34 at the suggestion of General Manager John Fletcher. They were reasonably entitled to conclude that the other emergency responders would be using it to share information. This channel was not used to convey any significant information between the emergency service responders. The only transmission made on the talk group was at 1 minute after midnight when Greater Manchester Police conducted a radio check to see whether any of the other emergency services were monitoring the channel.

North West Fire Control was the only emergency service to respond and confirm that the talk group was being monitored. The inquiry will be alive therefore to the criticism that in these circumstances, and in the knowledge that this was a major incident in which a METHANE message and declaration of Operation Plato could be expected, North West Fire Control was not more proactive in seeking out relevant information in order that the Fire Service could have situational awareness.

The Kerslake Panel report concluded that North West Fire Control's control room was placed in an

information vacuum that they were not used to. Because Fire Control did not actively seek further information, the report concluded that they were dependent upon the limited information coming into the control room from other responders. Although Fire Control was in contact with GMFRS senior staff, as the analysis of the calls in appendix 1 of the written opening statement demonstrates, the evidence available to the inquiry shows that the Fire Service and Fire Control did not have situational awareness, with the result that relevant information could not be passed to and from Fire Control and the Fire Service.

The Kerslake Panel report concluded that it was insufficient for North West Fire Control to be merely monitoring the Airwave channel. Operators should have been actively using the channel to draw METHANE information from other responders. The company accepts that criticism, as carefully set out in the Kerslake Panel report.

The available evidence leads to the conclusion North West Fire Control's control room did not enquire of other responder agencies whether a METHANE message had been passed or whether any of them were aware of the declaration of Operation Plato. The first enquiry by the NILOs in relation to Operation Plato came at 00.15

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

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

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

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

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

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

The evidence provided by the head of Fire Control,

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

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

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

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

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

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

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

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

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

place.

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

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

Thank you, sir.

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

(12.54 pm)

(Lunch adjournment)

(2.10 pm)

SIR JOHN SAUNDERS: Mr Greaney.

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

SIR JOHN SAUNDERS: Thank you.

Mr Browne.

Opening statement by MR BROWNE

MR BROWNE: I appear with Andrew Hartley, who is to my right. He is general counsel of the University of Salford and the director of legal and compliance.

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

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

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

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

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

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

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

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

further work or study.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

monitor the behaviour of its students.

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

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

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

This is commonly known as the Prevent duty.

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

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

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

system and does not require the higher education sector to play a direct part in crime prevention.

The other elements of the CONTEST strategy are: Pursue, that is the police and security service's role to stop terrorist attacks by detecting, prosecuting and otherwise disrupting those who plot to carry out attacks against the UK; Protect, which is to strengthen protection against a terrorist attack in the UK primarily through the work of police, border security and those engaged in the transport system, national infrastructure and public places; and, finally, Prepare, reflecting the role of local and Central Government and the emergency services to mitigate the impact of a terrorist attack, thereby increasing the UK's resilience.

Prevent is the only element of CONTEST that applies to higher education.

The role of the police and security services in CONTEST, including the Prevent element, is pivotal and crucial as is reflected in the National Policing Counter-terrorism Strategy and as detailed in the statement of Shaun Hipgrave of 27 January this year, paragraphs 9 to 12 and 20. Universities are not in a position to act as law enforcement agencies, rather the approach of universities to Prevent is centred on

protecting the welfare of individuals, it is on identifying individuals, in this case students, perceived as having a vulnerability and who may therefore need support and advice to help steer them away from a route that could lead to radicalisation and other extreme behaviour.

The term "due regard", as used in the 2015 Act, does not impose a positive obligation on authorities like universities to prevent persons from endorsing terrorism or from committing terrorist acts, neither does it require universities to conduct surveillance on their students. Rather, due regard means that the authorities should place an appropriate amount of weight on the need to prevent people being drawn into terrorism when they consider all the other factors relevant to how they carry out their usual functions.

For a university to be assessed to be having due regard to the Prevent facility it must have proper policies and processes in place which respond to the statutory guidance and it must be able to demonstrate that it is actively implementing these policies.

Safeguarding is a key principle underpinning policy and practice because Prevent is primarily seen as a welfare issue. If Prevent is to be effective then it is necessary, indeed fundamental, that there is

properly integrated multi-agency working.

A key part of the Prevent strategy is Channel. This is the route by which an organisation will refer an individual, with their consent, to a multi-agency panel. Through this panel, support and assistance is provided to the individual to help steer them from a path that could otherwise lead into criminality and even terrorism.

It will seek to identify those at risk of being drawn into terrorism, assess what that vulnerability might be, and then provide appropriate targeted support for those referred to them. To be effective, this requires that there is a positive and constructive multi-agency working between the police, local authorities, social and health services, the justice system and, where appropriate, universities.

This can then take the form of case planning with levels of intervention designed to meet the need in the individual case. It is important to note that Prevent is only relevant where it can be used to steer a vulnerable individual down a path away from radicalisation. If that person has already been radicalised, then it is not an issue for Prevent; rather, it becomes a matter for law enforcement under the Pursue element of CONTEST.

It is of course a matter for this inquiry to determine if a Prevent referral should or could have been made in respect of Salman Abedi and others and, if so, what was the appropriate time to have made such a referral. However, an important question is also whether a Prevent referral could ever have been the right course if the radicalisation of Salman Abedi and Hashem Abedi had been so deep-rooted that a referral could or would not have made a difference.

Turning then to the university's approach to Prevent. Until 2018, the Higher Education Funding Council for England, known as HEFCE, was the regulator of higher education in England and Wales. Under the 2015 Act, between 2015 and 1 April 2018, HEFCE had the responsibility for monitoring implementation of the Prevent duty by universities.

In line with HEFCE guidance, most universities, including Salford, identified the risks pertinent to their own context and developed appropriate tailored responses. As I have already explained, Prevent is primarily seen as a welfare issue since, as stated, the university's duty is to seek to identify vulnerable people and help prevent them from being radicalised.

In practical terms, the identification of vulnerable students has been embedded into the university's Ask Us

well-being team, the university's single channel for handling all student welfare and support issues.

On receiving a referral, the well-being team will triage the matter and direct it to the most appropriate area of management, differentiating a student's needs, welfare issues and/or other vulnerabilities towards teams more able to deal with the issue.

In this way, should the well-being team identify a vulnerability that a student is at risk of radicalisation, a referral will be made for consideration as to whether or not a Channel referral is appropriate. The university understood its Prevent duty clearly and were concerns to be raised that an individual was at danger of radicalisation it would seriously consider making a Channel referral. HEFCE and its successor regulator, the Office for Students, has consistently assessed the university as having due regard for the Prevent duty.

Turning to state agencies. Under the terms of the Security Service Act 1989, MI5 has a statutory responsibility to ensure the protection of national security from a number of threats including terrorism. MI5 is responsible in the UK for the collection, assessment, dissemination and exploitation of intelligence from its own sources or other sources on

its behalf. It has the lead role over national security intelligence in the UK and in countering threats to UK interests overseas.

In addition, the police play a significant role in the disruption of terrorist activities and networks. In his witness statement provided to you, Mr Chairman, dated 15 July 2019, DCS Dominic Scally deals with certain important matters concerning Salman Abedi's movements and what was known by the security services about him: at paragraphs 100 to 104, what was known about Salman Abedi by NWCTU and MI5 from December 2010 up to 2017; at paragraphs 105 to 108, details of his prison visits; at paragraphs 109 to 111, details of his trip to Istanbul in May 2016; and at paragraphs 112 to 114, the fact that Salman Abedi was closed as a subject of interest by MI5 during July 2014.

Within SIO Barraclough's witness statement, at paragraphs 226, 228, and 313 to 314, he references Salman Abedi's repeated trips between the UK and Libya.

The university were wholly unaware of any of the matters concerning Salman Abedi as set out by DCS Scally and/or DCS Barraclough. Similarly, those matters set out in the witness statement of security service Witness X at paragraphs 83 to 114 concerning MI5's knowledge of Salman Abedi as an open/closed subject of

interest, his contacts and travel abroad were matters wholly unknown to the university.

In particular, the university did not know, since this information was not shared with it, that from mid-2015 onwards MI5 received information on Salman Abedi on several occasions, which included conflicting information as to his espousal of pro-ISIL views. Similarly, the university did not know since this information was not shared with it, details of Salman Abedi's family and/or history and/or if it were the case the radicalising influences his father or brothers had upon him. If it was the case that it was known to the police and/or security services that Salman Abedi had links to a serious crime group in South Manchester, that too was information unknown to the university. It is, we observe, plain that the university was in no position to have considered that Salman Abedi might have been radicalised as he was and/or to take any steps to make a Prevent referral.

Turning then to the university's independent review if I may, please. This was established in August 2017 and continued to meet until February 2018. The review panel made certain findings based upon the evidence it had seen. For present purposes they can be summarised in this way.

In his second year Salman Abedi began to disengage from studies during autumn 2016. By the beginning of 2017, and in particular at the time of his examination on 13 January 2017, he appeared fundamentally disengaged with his course. In the examination sat on 13 January 2017, he made no attempt to answer any of the questions on the paper. He left the examination room at the earliest permitted time, and received a 0% mark for that paper.

There was clear evidence, had the strands been taken together, that Salman Abedi had fundamentally disengaged from his course by the beginning of 2017. The review panel considered what, if anything, was known by the university about Salman Abedi and what, if any, action it could or should reasonably have taken in the light of that knowledge.

In dealing with this question, there were certain important matters to which the panel drew attention. There are six.

Firstly, at no stage did GMP, via CTU or otherwise, notify the university that Salman Abedi was a person of interest to them.

Secondly, at no stage did the university have any information or evidence whatsoever to suggest Salman Abedi was or might be at risk of being drawn into

terrorism.

Thirdly, from the evidence the panel saw and read, the consistent theme was that the university did not have students who presented with extreme political and/or religious views and opinions.

Fourthly, as would be expected, there appeared to be good and harmonious relations between staff and students. Student welfare was at the heart of the Prevent agenda. The Faith Centre and the chaplains who work there did and continue to do good, important work. Inclusivity to all faiths was and remains a key part of the message they deliver.

HEFCE was satisfied by the university and its self-assessment in its 2016 Prevent duty report that the university had had due regard to its Prevent duty. However, notwithstanding all of the above, the panel were satisfied that having regard to the extent of Salman Abedi's disengagement, particularly from the point in time of 13 January 2017 onwards, there was a missed opportunity by the business school staff to communicate to Salman Abedi's personal tutor and/or the student progression administrator and/or student support services as to the extent of his lack of engagement.

Had that taken place, then the panel would further have expected that contact would or should have been

made, or at least attempted, with Salman Abedi to address the possible reasons for this lack of engagement. However, what the panel could not say was what, if any, difference this would have made to how Salman Abedi engaged at the university thereafter. In particular, the panel stated that it could not know whether, had effective contact been made with him, Salman Abedi would have proffered a plausible, or any, explanation for his disengagement, performance, or what that explanation might have been. To make any suggestions in this regard would, in the panel's view, have been speculative.

The most it could say was that there was a missed opportunity for university staff to attempt intervention in order to consider the reasons for his academic disengagement and what, if any, support and, if needed, welfare services could then have been offered. In the light of what we now know from Hashem Abedi's trial, it seems, at best, unlikely that Salman Abedi would have responded to any such attempt.

Even had a decision been made to invoke the provisions of the attendance policy and a point was reached where Salman Abedi's registration was cancelled, the panel found it could not possibly be known within that time frame what might then have taken place and it

could not be known what Salman Abedi's reaction to that would have been. Had the university terminated his studies for non-participation he might have sought to appeal that decision. If so, it could not be known what the outcome of any such appeal would have been.

Therefore the panel stated it had no evidence to enable it to say that, even had the attendance policy cancellation of registration provisions been invoked, Salman Abedi would have not remained a student at the university on 22 May 2017.

In its February 2018 report with recommendations, the review panel issued recommendations to the university largely around the further strengthening of its already established systems of student safeguarding, support and welfare. All those recommendations have been accepted and implemented by the university and are referred to in its lessons learned statement filed with the inquiry on 5 June this year.

With regard to the inquest and the public inquiry, the university has consistently sought to engage positively and constructively with them, seeking interested person core participant status at an early stage. It has co-operated with the inquiry in an open and transparent manner. It disclosed the reports, statements and other documents it had collected as part

of its independent review in a complete and non-selective manner, as was acknowledged by the inquiry in its update note of 4 October 2019.

Sir, in conclusion of this opening statement, the shock and sadness suffered by the entire community as a result of Salman Abedi's hideous actions endures at the university today. It continues to put the welfare of its students at its centre, with further developments being introduced each year. It also continues to positively discharge its Prevent obligations and play an active role regionally in this field.

It is, we respectfully observe, clear that at the time of the tragedy the university had no information or material, nor had it received any communication to suggest that Salman Abedi had been radicalised or was being drawn into terrorism. Had the university had any information or material to this effect, or any information that Salman Abedi was likely to commit the heinous attack which he did, it undoubtedly would have acted on it.

SIR JOHN SAUNDERS: Thank you, Mr Browne.

MR GREANEY: Sir, finally so far as chapter 5 is concerned, we'll hear the opening statement of the Secretary of State for the Home Department delivered by

Ms McGahey.

Opening statement by MS McGAHEY

MS McGAHEY: Sir, I represent the Home Secretary and I make this statement on behalf of the Home Office and MI5. Other government departments who are not core participants have, through the Home Secretary's legal team, submitted witness statements and documents to the inquiry.

On behalf of all of these departments and all the members of this legal team, may I offer our sympathies to the families and friends of those who lost their lives. The desperate sadness of the pen portraits has brought home to everyone the overwhelming grief that these families have had to bear.

The horrific attack on the arena has also caused immense suffering to others who were in the City Room that night, to those who were injured and to those who now care for and support those who survived and those who are bereaved. There may be nothing that will make their suffering any less, but if there is anything, it may be the knowledge that changes have been made since May 2017 and that those changes will save other lives and the vital work of this inquiry is to understand not just what happened but why and how it happened and to ensure we all learn all that we possibly can from this

tragedy. The Home Secretary and all of the government departments involved are wholly committed to supporting the inquiry in these aims.

In these submissions I will address first issues relating specifically to MI5 and then, in the second part, issues relating to the Home Office more widely.

In respect of MI5, as everyone will understand, it is not possible to give a detailed account on every point because to do so would jeopardise national security, but every effort has been made to address each issue meaningfully.

In a speech delivered in October 2017, the then director-general set out MI5's approach to the terrorist attacks that had occurred earlier that year. He said:

"Throughout our history, MI5 has been all about innovating to meet the changing threat and the shifting technological environment. We review every major operation and learn from our successes and when an attack happens we are determined, using the harsh light of hindsight, to squeeze out every last drop of learning that we can to be the very best we can be now and in the future."

That approach has been the basis of the response of MI5 to the numerous reviews and investigations into the attacks perpetrated in 2017. The internal reviews that

were conducted by MI5 and Counter-terrorism Policing after the 2017 attacks in Manchester and London, overseen by Lord Anderson, were rigorously and intensely self-critical. The final reports were the products of months of work compiling all the relevant material and painstakingly analysing all facts and the systems engaged.

Everybody engaged in the reviews was driven by a genuine desire to understand what had happened and ensure that lessons were learned in the hope that lessons from all of the attacks would give the UK intelligence community and their police counterparts the best possible chance of preventing future attacks.

However, everybody understands that these reviews are not a substitute for the work of this inquiry, which, with the advantage of its oversight of the whole picture, will look again closely at the matters considered by the reviews.

The Government recognises that the inquiry provides an important opportunity to learn from this tragic event. We need to do everything possible to improve the ability of all those concerned with the safety of the public to protect the people of this country and to protect our way of life.

For this reason and to ensure that, to the greatest

extent possible, the bereaved families are able to gain a full understanding of the circumstances in which those they loved lost their lives, MI5 has provided complete cooperation to the inquiry, including unfettered access to all the relevant material that it holds. The chairman and counsel to the inquiry have acknowledged that cooperation on a number of occasions during the course of this investigation and MI5 is grateful to you for that, sir.

But it wants to give these reassurances directly to the bereaved families and all of those affected by this terrible attack. Firstly, material has been withheld from disclosure to core participants only where that has been necessary in order to protect national security. We cannot disclose information when that disclosure could damage the ability of the security agencies to prevent another attack.

Secondly, the inquiry has been given full and unrestricted access to all the material that has been withheld from disclosure to core participants and arrangements have been made to ensure that the inquiry has been able to undertake a rigorous and critical examination of all of that material.

Thirdly, the conversion of the original inquests into a statutory inquiry means that it will be possible

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

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

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

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

The families and the public are asked to put their

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Also in 2015, MI5 received information that

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

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

On three subsequent occasions, Abedi was identified as a second-level contact of a subject of interest. Firstly in April 2016. That subject of interest was under investigation on the basis that he provided financial support to a member of ISIL in Syria.

Secondly, in January 2017. The subject of interest

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Salman Abedi's travel and his associations with other subjects of interest were reasonable and understandable when judged in the light of the information available at the time.

Further information, as I have said, was then received in the months prior to the attack. As for these two occasions in the months before the attack when information was received which can now be seen as relevant to the attack, MI5 has of course given very careful consideration as to whether different decisions could or should have been taken in response to this information and whether any different decisions might have led to detection of the attack planning. As the inquiry will know, these matters will be subject to detailed analysis in the course of the closed hearings.

Sir, you'll reach your conclusions on these questions when you have heard the evidence and we do not seek to pre-empt your analysis. Lord Anderson in the conclusion to his report observed that:

"MI5 and Counter-terrorism Policing got a great deal right. Particularly in the case of Manchester they could have succeeded had the cards fallen differently."

The fact that Lord Anderson considered that the cards might have fallen differently plainly calls for the most rigorous scrutiny of what was known, what might

have been done differently, and what impact such action might have had.

In the light of its internal review, MI5's assessment is that the decision not to re-open Salman Abedi as a subject of interest on the basis of the information obtained in the months before the attack was a finely balanced one, but it was understandable in all the circumstances.

However, MI5 also considers that there were certain aspects of the information that came to its attention in the months before the attack which could have been handled differently and, if they had been, that different handling might have helped the investigative team in their decision-making.

However, the extent to which the different handling of that information might have affected the team's subsequent decision-making is highly uncertain. It is also the case that the opportunities for detecting Salman Abedi's attack planning would have been very limited indeed.

Two learning points identified in the Manchester post-attack review related to the process for reviewing closed subjects of interest and the analysis as to whether they merit further investigation. On 3 March 2017, Salman Abedi hit a priority indicator

under a process code named Clematis on the basis of information that had been received in mid-2016. As I have explained, subjects of interest are closed when they no longer meet the threshold for investigation, essentially when it's assessed that they not or are no longer engaged in activities of national security concern.

However, further intelligence received in respect of a closed subject of interest may cause that closed SOI to be re-opened, and in addition, MI5 operates the Clematis process to identify closed SOIs who are potentially worthy of further investigation. Clematis is designed to identify emerging and residual threats by identifying specific indicators to highlight closed SOIs for potential further investigation.

Closed SOIs who hit specific triggers were at the time then referred to separate process codenamed Daffodil to consider the use the limited investigative tools to look at that individual further.

This indicator triggered in respect of Salman Abedi did not relate to any intelligence connected to the attack. It was triaged and MI5 assessed that he met the threshold for further investigation under Clematis.

Further checks were then conducted, which led the Clematis team to assess that he was overseas, probably

in Libya. On 8 May 2017, the Clematis team assessed that he should be referred to Daffodil for further low-level investigative enquiries to identify whether he had re-engaged in Islamist extremist activity. The meeting to consider the potential referral to Daffodil was scheduled for 31 May 2017.

The fact that the Clematis process had identified Salman Abedi as an individual who potentially merited further investigation at the time of the attack does show that the system itself was working. MI5 does, though, acknowledge that the trigger for the Clematis assessment was information that had been received many months before Salman Abedi was identified for further consideration on 3 March 2017 and that this indicates a potential area for improvement.

The specific reasons for the delay cannot be explained in public because of the damage that doing so would cause to national security, but it is right to say that part of the explanation lies in the significant challenges posed by the very large cohort of closed subjects of interest for MI5 and counter-terrorism police.

There is not, and nor should there be, a standard inflexible approach to dealing with information received about closed SOIs. Actions taken need to be

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

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

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

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

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

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

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

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

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

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

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

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

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

against a dark and shifting canvas.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

challenge of terrorism. Secondly, to safeguard and support those most at risk of radicalisation through early intervention, identifying them, and offering support. And thirdly, to enable those who have already engaged in terrorism to disengage and rehabilitate.

Section 26 of the Counter-terrorism and Security Act 2015 places a duty on specified authorities, such as the police, local authorities and prison governors, to have due regard to the need to prevent people from being drawn into terrorism. This is known as the Prevent duty.

The second element of CONTEST is Pursue, which also aims to reduce the terrorism threats we face by detecting, prosecuting and disrupting those who plot to carry out attacks against the UK or UK interests overseas. The deployment of investigative and disruptive counter-terrorism and immigration powers and the prosecution regime form part of the Pursue strategy.

The third element, Protect, is a multi-layered strategy that aims to reduce the UK's vulnerabilities to terrorist attack. Its key objectives are to detect and deal with suspected terrorists and harmful materials at the border, to reduce the risk to and improve the resilience of global aviation, other transport sectors and critical national infrastructure most at risk to

terror attacks, to reduce the vulnerability of crowded places, specific vulnerable groups and high-profile individuals, and to detect and prevent terrorist access to and use of materials, knowledge and information that could be used to conduct attacks.

The fourth, Prepare, aims to mitigate the impact of a terrorist incident if it occurs. Its objectives are to deliver a coordinated multi-agency response to all types of terrorist attack, to ensure that the UK has a full range of options to respond to current and future threats, and to minimise the impact of terrorist attacks on people, services and communities.

The topics that I address in these submissions all sit under one of these strands and all ultimately are the responsibility of the Home Office. In practice, this means that the Home Office sets policy objectives and, in some cases, provides directional guidance on the implementation of those policies, although the actual operational work is done by others.

In these submissions I will seek to explain the Home Office's role in developing the policies and strategies that are relevant to this inquiry and I will seek to set out any strategic issues that have been identified as a result of the circumstances of this attack.

The Channel programme is part of the Prevent strategy and it is a voluntary programme that aims to ensure that targeted support is provided to people who have been identified as being vulnerable to being drawn into terrorism. It operates by way of panels run at a local level by local authorities and police and are required to have regard to statutory guidance issued in 2015 in exercising their functions known as the Channel guidance. If an individual consents to be and is accepted into the support programme via Channel, then Prevent interventions would be available to support that person.

The potential intervention activities are wide-ranging, and can include anything from education and housing support to mentors, to cognitive and behavioural support. The intervention activities that are offered in any given case would be determined by the panel's assessment at the time about the level of risk and vulnerability, and by what is available locally.

Manchester is, and was in 2017, a priority area for Prevent-related activity which means that it received and receives additional Home Office funding. The local activities of Prevent are delivered by local authorities who have the awareness and understanding of the risks of radicalisation in their areas. These authorities work

with key agencies such as the police and specifically counter-terrorism units. The activities of the Prevent team all look to raise awareness in the community of the risk and help people to identify concerns and understand how and where to seek support.

The vast majority of these activities engage a wide range of communities and groups and, as such, would not be considered to be individually targeted Prevent interventions. The Prevent work available to target specific individual or family members is the channel programme.

Neither Salman Abedi nor any member of his immediate family was ever the subject of a referral to Prevent. As a result, there was no opportunity for Salman Abedi's threat, or that of any of his immediate family members, to be managed through the Channel programme. It's not possible to say whether referring Salman Abedi to Prevent might have made a difference, or indeed whether he would have been eligible for interventions. However, the London and the Manchester attacks have highlighted the scale of the challenge of detecting individuals who may be inspired to commit terrorist attacks in the UK and the pace at which plots can move to acts of violence. This knowledge places a renewed importance on improving our understanding of individuals who are

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

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

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

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

extremism.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

adequacy of those arrangements.

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

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

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

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

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

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

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

develop action plans of mitigating activity.

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

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

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

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

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

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

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

attractive targets for terrorists and that strategic changes were required.

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

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

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

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

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

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

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

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

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

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

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

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

I turn now to the question of emergency response.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARP works with subject matter experts from the emergency services to provide tools and products, such as guidance documents and videos, that enable them to embed the joint doctrine and the JOPs into their local services.

In the JOPs, Operation Plato is defined as the agreed national identifier for the response to a no-notice marauding terrorist firearms attack. Only the police can declare an Operation Plato and activate the multi-agency response. The JOPs state:

"Information on a suspected marauding terrorist firearms attack should be shared amongst emergency service control rooms immediately. The police are responsible for formally declaring that a marauding terrorist firearms attacks is occurring and that the response, Operation Plato, will be used."

Changes have been made since 2017. The London and the Manchester attacks in that year demonstrated that JESIP had become a critical element of the emergency response to a major incident, but that further work was needed to refine and improve it.

After the attack both the JOPs and the police single-service guidance were revised. This work was coordinated by the Home Office and involved multi-agency and cross-government input. The changes took into

account all of the learning from the 2017 attacks, including that provided by the Kerslake Report.

The changes that have been made including, firstly, that Operation Plato is now the identifier for an ongoing marauding terrorist attack rather than a marauding terrorist firearms attack reflecting the broad range of the nature of recent attacks and the JOPs have been retitled to reflect the change.

Secondly, the importance of the underlying JESIP principles have been reinforced.

Thirdly, updated scripts have been added to assist with the use of zoning when it's needed.

Fourthly, greater emphasis has been placed on the importance of joint working, swift risk assessment, and situational awareness.

Fifthly, the layout and the content of the JOPs has been simplified.

At the time of the attacks, JESIP was overseen by the ARP team in OSCT but in April 2019 direct oversight moved to the emergency services.

I will turn now to prison visits. The Joint Extremism Unit, known as JEXU, is a joint Prison Service and Home Office unit which was established in April 2017 to be the strategic centre for all counter-terrorism work in prisons. The inquiry requested information

about any visits made by Salman Abedi to prisons before the attack. These enquiries were coordinated by JEXU and involved searches across national databases as well as targeted requests of prison establishments.

On 26 February 2015 and 18 January 2017, Salman Abedi visited a convicted terrorist offender. On both occasions he visited with others. A further visit booked for 16 March 2017 did not take place.

Every prisoner in the UK is placed in one of four categories, A to D. The category reflects the level of security necessary to hold that prisoner, with category A being the highest. The purpose of categorisation is to help manage the threat posed by each offender. Three main factors are considered during the categorisations process: their risk of escape, their risk to the public if they were to escape, and their risk to the security of the prison. The categorisation of offender will determine the level of security necessary to manage them.

The offender visited by Salman Abedi was a category B prisoner. Because of this, that prisoner was not subject to the approved visitor scheme which operates for category A prisoners. Offenders who are on that scheme can receive visitors only from a pre-approved list authorised by the prison governor.

For prisoners in categories B to D there is no routine vetting of visitors, other than for prisoners where there are child safeguarding or harassment concerns.

There are approximately 80,000 prisoners in England and Wales and there is a finite capacity of the police to vet proposed visitors. However, resources are deployed where necessary to manage the risks posed by the most high-risk offenders, including convicted terrorist offenders. Additionally, any infringement on a prisoner's or a visitor's right to respect for a private and family life must be justified as being necessary and proportionate in the circumstances. Such an infringement might arise in the event of delays to the scheduling of visits pending completion of potentially lengthy security checks.

Nonetheless, the operational improvement review recognised that work was ongoing to see how the scheme could be used more effectively by the time of the report of Parliament's Intelligence and Security Committee, OSCT and explained that JEXU and the Prison Service were exploring the feasibility of extending the approved visitor scheme. This intention was supported by the ISC.

The Prison and Probation Service have now undertaken a comprehensive review of the way in which

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

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

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

them when they happen.

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

Thank you, sir.

SIR JOHN SAUNDERS: Thank you, Ms McGahey.

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

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

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

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

Mr Greaney.

Housekeeping

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

SIR JOHN SAUNDERS: Thank you.

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

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

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

virtually .

We, the inquiry legal team, advocated the second approach for a number of reasons:

(1). None of those diagnosed have been into this hearing room, and the public parts of the court building into which they had been have been deep cleaned.

(2). The inquiry has updated its risk assessment in light of developments.

(3). And importantly, the measures in place to protect those attending the inquiry hearing spaces are currently , it seems to us, working well . We are sitting at different times from other court hearings to minimise queueing times; longer breaks are being taken; hand sanitisers are available throughout the hearing space; face masks are being worn in public areas; capacity is reduced in each venue; perspex is being used to separate seating areas; and social distancing is being maintained.

(4). There has been no positive case in this building for nearly 2 weeks now.

(5). The view from HMCTS, working closely with public health practitioners , is that it is currently safe for this court building to be open and, of course, we will continue to work closely with HMCTS.

The inquiry's note of 28 September sought any

submissions from core participants by the end of yesterday . All of the family teams replied , as did a number of other core participants , but it's not necessary for us to delve into the detail of those submissions and that is for the simple reason that there is a consensus, or at any rate a broad consensus. It is agreed that you should adopt what we have described as the second approach, namely carry on as we have been doing with a flexible approach to seating in this room.

However, all consider that the situation should be kept under close review and we agree with that.

Furthermore, we agree also that there should continue to be close liaison , as has occurred, between the inquiry legal team and the core participants about this issue and indeed about many other issues.

We have now said twice that there needs to be a flexible approach to seating in this room and it is important that we should acknowledge and acknowledge publicly that those who have shown flexibility are the bereaved families , who have agreed to watch the proceedings, either from the annex or remotely, and we thank them for that approach.

There is , however, some good news, or at least good news looming on the horizon. As we've said , Friday will mark the two-week point from the last positive COVID-19

case in this building . As a result , and subject to no further cases in the meantime, we hope to invite a limited number of family members back into this hearing room, if they wish to come, of course, from Monday.

Sir , we don't propose to invite oral submissions on these COVID issues, at this stage at any rate , given the consensus which has emerged, but if any core participant wishes to make any point they should feel free to do so at the hearing which is listed tomorrow to address a number of issues .

Sir , subject to those remarks, that's as far as we can take it today.

SIR JOHN SAUNDERS: Thank you.

MR GREANEY: May I indicate what the programme is for tomorrow. Tomorrow morning, Mr de la Poer will call Chief Inspector Sam Pickering to introduce certain materials which will be of relevance during chapter 7, security arrangements at the arena . Mr de la Poer anticipates that that process will take about 90 minutes. After that , and after a break , and therefore at about 11.30, we'll address a number of outstanding issues of procedure and law.

Sir , having introduced tomorrow, we would now invite you to rise and we'll resume at 9.30 tomorrow.

SIR JOHN SAUNDERS: Thank you.

(4.03 pm)

(The inquiry adjourned until 9.30 am on Thursday, 1 October 2020)

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