Manchester Arena Inquiry

Day 52

January 18, 2021

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Monday, 18 January 2021

(10.00 am)

(Delay in proceedings)

(10.30 am)

MR GREANEY: Could I indicate that we are now live on BlueJeans and the YouTube feed will pick us up in 10 minutes.

(Pause)

SIR JOHN SAUNDERS: Just before you start, Mr Greaney, just let me say a few words.

For reasons that I have set out in my ruling, following the hearing last week, I have decided to attend this week's hearings remotely. The reasons for this, briefly, are that in consultation with the inquiry team I have decided it is not necessary for me to attend. I am therefore following government guidance that if it is not necessary for me to attend, I should not. In deciding whether it was necessary for me to attend, I have taken into account that I come within one of the vulnerable groups and I have not yet been vaccinated. If I were to get COVID, it may be that that would cause some delay at least to the inquiry, which I would not wish to risk.

Finally, it will give me an opportunity to experience attending a hearing remotely, which will give

me a better understanding of what the shortcomings, if any, of doing that are.

Mr Greaney, having said that, I would invite you to begin your opening. Obviously, you take breaks as and when you or the stenographers require it, and you make that decision.

MR GREANEY: Thank you very much. I have been informed that it is necessary to take a break about every hour and for about 15 minutes.

SIR JOHN SAUNDERS: Fine, thank you.

MR COOPER: Sir, may I just interject at this stage? Just some information that Mr Smith, Shane Smith, is having difficulty —— he's had numerous attempts to engage with this process. I wonder whether that could be perhaps addressed. I've just had a message to that effect. Sorry to interrupt.

MR GREANEY: I think Mr Cooper is not inviting us to pause but just to do what we can to assist his instructing solicitor.

MR COOPER: That is correct.

Opening by MR GREANEY

MR GREANEY: Sir, the oral hearing of the inquiry concluded for the Christmas break on 17 December. By that time, we had reached the conclusion of the evidence relating to the planning and preparation for the attack,

chapter 8, subject only to a small number of outstanding witnesses and issues to which we'll return in due course.

Our intention, as of that date, was to resume the hearing on 12 January with the evidence relating to chapter 9, which will involve an analysis of the events of the day of the attack and important evidence from survivors. Before that, however, on the evening of 4 January, the Prime Minister announced the third national lockdown. As a consequence, the public is required to stay at home and go out only when essential. Furthermore, primary and secondary schools are closed.

The following day, 5 January, a decision was made by the chairman that we should not resume on 12 January. That was for two reasons. First, it would not have been responsible to ask witnesses to travel into central Manchester in circumstances in which a risk assessment addressing the changed situation had not by that stage been prepared. The alternative of receiving evidence from chapter 9 witnesses, most of whom have experienced substantial trauma by reason of the arena attack, by video link seemed plainly not to be the right thing to do given the impact that was capable of having upon their experience of our process.

Second, time was needed to take advice from Public

Health England and other experts on whether it would be possible to resume in-person hearings safely in Manchester and, if so, when and under what conditions. Furthermore, once that advice was received, time was needed to speak with those representing the bereaved families and other core participants on the best way forward.

A public hearing, conducted via the video conferencing platform BlueJeans but broadcast publicly on YouTube, took place last Thursday, 14 January, in order that the chairman could hear submissions from the inquiry legal team and core participants on what should happen between now and the February half-term break. The chairman's ruling was published on the inquiry website on 15 January and it will suffice now to say the following about how we will proceed from this moment on.

This week, and indeed in a few moments, we will hear the opening to chapter 10, reminding those who are watching of the key concepts with which we will be concerned, events and issues. Chapter 10 concerns, of course, the emergency response.

Once that opening has concluded, either much later today or tomorrow morning, we will work through the sequence of events chart that deals with that response with Detective Inspector Russell, who will be familiar

to all. We will also play the key audio recordings from the night of the attack and we expect to conclude that exercise before lunchtime this Wednesday.

That in turn reflects the fact that we intend, for the time being at least, to sit no more than two and a half days each week. We are doing so in order to respect the increased childcare commitments of many participants in the inquiry in the current situation. A maximum of three members of the inquiry legal team, the witness and a member of RTS will be in the hearing room this week. Everyone else, including, sir, as you have indicated, the chairman, will attend remotely for good reason.

Next week, we will hear the closing submissions of core participants on chapter 7. That chapter, of course, concerned the security arrangements at the arena and the chairman has indicated that he intends to address that chapter in the first volume of his report, the whole of that phase. So Monday the 25th to Wednesday, 27 January, will be held virtually, so no one will be present in this hearing room.

In the following week, and the week after that, so 1 to 3 February and 8 to 10 February, we will return to chapter 10. That will involve the resumption of the form of in-person hearing that will occur this week.

Our aim during that period in the lead-up to the February half-term will be to call evidence that is not substantially controversial and discussions are underway with the core participants in relation to that evidence.

Then we will take, as we had always intended to take, a break from 15 February for the February half-term, but during that week, probably on Tuesday, 16 February, we will take stock at a further hearing of the sort that occurred last Thursday.

On that occasion we'll need to consider if and how we proceed from 22 February and, if we are to proceed, in what form and what evidence should be received. But those, as the chairman ruled, are decisions for then. But for now, we propose to make a start on the opening for chapter 10.

Before we do so, we can make clear that some of what we have to say will be distressing, as indeed will be the exercise of working through the sequence of events and audio. So it is important to refer to the fact that the hub is there to help everyone directly affected by the bombing. A document containing information about that was circulated last week and, moreover, is available on the inquiry website under the tab "support services".

Having made those remarks, we'll now commence the

opening for this chapter.

The evidence reveals many examples of those who were present in or entering the City Room in the period after the explosion conducting themselves with bravery, selflessness and kindness. Their decency and humanity stands in stark contrast to the truly wicked thing that Salman Abedi and Hashem Abedi did. During chapter 10 of the oral evidence hearings, we intend to acknowledge and pay tribute to each of those who helped to the extent that we are able to identify them. That we should do so is of obvious importance. But even more important to the public in general, to the bereaved families, to the core participants and to the inquiry is to learn the lessons of the emergency response that night.

So we will explore whether the emergency response really worked that night and, if it did not, whether that failure made any contribution to the extent of the dreadful loss of life that occurred. Where we identify things that went wrong we will probe why they went wrong and how they can be made to work in the future. And even where we identify things that did work, we will not simply accept that but instead will investigate whether they can be made to work better in the future.

We hope and, moreover, believe that all core participants share our hope that from this inquiry will

emerge real improvements in how emergencies, particularly those that arise out of terrorist attacks, are managed.

As for whether the emergency response worked on the night of 22 May, it is relevant to note that it did not take long at all for concerns to begin to emerge. Indeed, that very night, some of those on the ground were to experience and express frustration, even extreme frustration and anger at how events unfolded.

Nicholas Mottram was a GMFRS crew manager. He was working on the night of the bombing and, following the attack, was deployed to Philips Park Fire Station, a location a little under 3 miles to the east of the arena. And why the fire and rescue service deployed there is an issue we'll need to look closely at in the evidence.

The wife of Nicholas Mottram, Helen Mottram, was a paramedic and he spoke to her on a number of occasions in the aftermath of the bombing, learning that she was deploying to the scene of the attack. He spoke to his superiors and to other firefighters at Philips Park, explaining that paramedics were travelling to the arena, but he was directed to remain at the fire station for a period thereafter.

It is clear from the evidence of a number of those

at Philips Park that they experienced considerable disappointment and anger at not being deployed to the scene sooner in order to provide assistance. In particular, because that seemed to them to contrast with the response of other emergency services.

We expect to receive evidence that many firefighters still feel a deep sense of frustration that they were unable to play a role that they were both trained and willing to play in responding to the arena attack.

Furthermore, such feelings of frustration were not restricted to those within GMFRS that night. Many police officers who attended the City Room in the aftermath of the bombing wore video recording equipment, the product of which will be referred to as BWV or body-worn video. Much of the footage itself is graphic and distressing in the extreme and we do not consider that any such visual footage should be played publicly. Some of the audio from the BWV will, however, be played because it shows what happened at particular points in time and also because it reveals the thoughts of those who were there on the ground at the time.

Simply by way of example, at 23.02 hours, PC Hill, an officer in the City Room, is heard to say to a colleague, "We need paramedics like fucking yesterday".

At 23.08 hours, another officer, PC Kay walks over to a PC Ball and says, "There is nobody we can move, really, is there?" to which PC Ball replied, "Not really, no, they're all really badly injured. If we start moving people we need paramedics, basically".

Kam Hare was a sergeant in the GMP Tactical Aid Unit or TAU. His evidence fits this theme. He and his team travelled to the arena upon becoming aware of the attack and entered the City Room at about 22.50 hours. Police Sergeant Hare recalls shouting over the radio for paramedics to enter the City Room and emphasised to an advanced paramedic, Paddy Ennis, who was present in the room, that this needed to occur. And PS Hare became frustrated that this was not, as it seemed to him, being acted upon.

These are just examples from the many witnesses from whom the inquiry will hear but they serve to illustrate the concerns about the emergency response are not merely the result of detailed reflection in the months and years after 22 May, distant from the stress and emotion of the moment, but instead were being experienced and expressed as the response itself occurred.

Why the fire and rescue service did not attend promptly and why paramedics and other staff of NWAS did

not enter the City Room in significant numbers are just two of the questions we will need to examine in considering the emergency response overall. We should certainly not be taken to suggest that they are the only or necessarily even the most significant questions, although they are plainly questions of significance.

In July 2017, Andy Burnham, the Mayor of Manchester, then as now, appointed Lord Kerslake, the former head of the Home Civil Service, to head a panel to undertake an independent review of Greater Manchester's preparedness for and response to the arena attack and to advise the Mayor.

In its subsequent report, the panel identified things that went well but also things that did not. In a striking passage, the panel found, and we quote:

"GMFRS did not arrive at the scene and therefore played no meaningful role in the response to the attack for nearly 2 hours."

This compares with an average response time for the service of less than 6 minutes. The effect of this was that a valuable resource was not available to assist on the scene, particularly with the movement of those who were injured from the foyer to the casualty clearing station. The Fire Service was effectively outside the loop, having no presence at the rendezvous point

established by the police, little awareness of what was happening at the arena, and only a very limited and belated presence at strategic Gold Command.

It would be wrong, however, to think that the concerns of Lord Kerslake and his panel were restricted to the fire and rescue service. The panel also found that the response to the arena attack exposed the limitations in the service level agreement between GMFRS and North West Fire Control. The multiple duties that fell to both the GMP Gold Commander and GMP force duty officer, or FDO, were described as extremely wide-ranging and testing.

The FDO had been overburdened, causing significant difficulties for the GMFRS national inter-agency liaison officer, NILO, making contact with him. Furthermore, in the panel's view, GMP did not initially inform GMFRS or NWAS of the declaration of Operation Plato, and we'll explain that term shortly, and deployed (sic) the holding of the first strategic coordinating group, or SCG, resulting in a missed opportunity in the view of the panel to inform partner agencies that Operation Plato had been declared.

As for NWAS, Lord Kerslake's panel considered that other emergency responders did not understand that their primary role in the immediate response was scene

assessment and casualty management, not the treatment of casualties.

The process of this inquiry will of course pay respectful ——

SIR JOHN SAUNDERS: Mr Greaney, sorry, is it possible just to interrupt for a moment? You very kindly have given me a copy of what you're saying and you actually used an incorrect word. You talked about "deploying" the holding of the first strategic coordinating group when you in fact meant "delay to the holding".

MR GREANEY: I did indeed, sir:

"Delayed the holding of the first strategic holding group."

And as I was reading it out, sir, I think I spotted anther error, which I will also correct at this stage NILO, I think, does not stand for national inter—agency liaison officer but, from memory, I think stands for national interoperability liaison officer. But I'll make sure I've got that right by the time we turn to those events in more detail.

SIR JOHN SAUNDERS: I'm very sorry to interrupt you, I won't do it again, it just meant that the meaning might be misunderstood by people if they had the word deployed rather than delayed.

MR GREANEY: I'm very keen that if I make an error of that

sort that you should interrupt me or indeed that anyone who is able to does so. This needs to be as accurate and informative as possible.

As I was indicating, our process, the process of this inquiry, will pay respectful attention to the conclusions of the Kerslake Panel, but will not be bound by them. On the contrary, the inquiry will involve the closest independent scrutiny of the emergency response and the chairman will make his own mind up. It may be that he will conclude that the Kerslake Panel got it right or went too far, but he might also conclude that the panel did not go far enough in describing what went wrong. Whatever the conclusion is will be driven, of course, by the evidence.

As part of the inquiry's investigation, expert reports have been obtained from those with the necessary experience of how the Police Service, Ambulance Service and Fire and Rescue Service could reasonably have been expected to plan for and respond to a terrorist attack such as that which occurred at the Manchester Arena. In simple terms, the experts have been asked to provide their views on how the actual response on the night compares with what they consider should have occurred.

Their reports are very substantial. We summarised their conclusions during the course of the second and

third days of our opening statement in early September last year. We will touch upon them again today but will not rehearse them one by one. However, it is worth reminding ourselves that a number of key themes do emerge in a joint report prepared by the emergency services experts as a group.

In a moment we'll identify four of the themes they agree about, but we should not be taken as suggesting that those are the only areas of concern.

Before we get to those themes, it is helpful to say just a little about the historical context for the response of the emergency services in the aftermath of the arena attack. It appears to be the case that emergency management developed as a function of local arrangements based upon geographical areas shared by local government and the emergency services. Over time, smaller organisations, city police forces and Fire Service equivalents merged into larger organisations, covering wider areas, mirroring a similar reorganisation within local government.

Furthermore, from the mid—1990s, local police, fire and ambulance services started to develop what became known as a "major incident response" and that concept became embedded in some, but it seems not all, areas.

Moreover, even as between areas in which the concept

of a major incident response was recognised, in some quarters it was thought there was no or no sufficient consistency. That is not to say that multi—agency responses during this period were regarded as failures. As we understand it, some responses, on the contrary, were regarded as being successful.

However, the point is that there was or may have been an inadequate level of consistency across the country and across different emergency services in relation to how a major incident should be responded to.

The terrorist attacks on the United States of America on 11 September 2001 caused a reassessment within the United Kingdom of emergency management. As it happens, earlier that year, responsibility for civil protection had moved from the Home Office to the newly created Civil Contingencies Secretariat, the CCS, in the Cabinet Office. The CCS published a document entitled "Dealing with Disaster".

In the third edition of that document, dated June 2003, the CCS took into account events around the world, including 9/11. The document used the term "major emergency" and stated:

"Major emergencies have a variety of effects on society and the environment, thus they demand a combined

and coordinated response linking the expertise and resources of statutory organisations, emergency services, local authorities and Central Government, Health Service, armed forces, et cetera, private sector organisations, transport, utilities, et cetera, and voluntary agencies. Appropriate support has to be coordinated at local, regional or sometimes national level. The coordination of planning, training and exercising for an effective combined response to any type of emergency is fundamental [it was said] to the achievement of a successful outcome to all who may be involved in responding to a major emergency."

Thus the need for a coordinated emergency response to an emergency, including the need for such an event to be planned for, trained for and exercised for, had been long understood by 22 May 2017.

Indeed, the work of the CCS led to the introduction of the Civil Contingencies Act 2004, which established a clear set of roles and responsibilities for those involved in emergency preparation and response at a local level and we'll look shortly at the role of a body introduced by that Act, the Local Resilience Forum.

Before doing so, we'll turn, as we said we would, to those four themes identified jointly by the experts.

First, the experts consider that the emergency response to the Manchester Arena attack gives rise to significant concerns about the cooperation and coordination between the different emergency service agencies. The joint view of the experts is that there was an absence of joint agency tactical scene command, which had a profound effect on all agencies and resulted in what the experts called a JESIP failure, JESIP being a reference to the joint emergency services interoperability programme or principles, something we'll turn to in a few moments. That failure was, in the opinion of the experts, of command, not individual responders.

As we observed when first we opened this inquiry, that conclusion will no doubt generate particular public concern and will need to be examined closely during the oral evidence hearings. If it proves to be correct, we will need to explore whether changes have been made since the attack that are sufficient to ensure there is no repetition of the mistakes that were made. If such changes have not been made, or not sufficiently, the inquiry will need to be a driver for improvement, we suggest, in how the emergency services respond in a cooperative and coordinated way to a terrorist incident of the type with which we are concerned.

Second, in the view of the experts, the emergency services in Manchester had undertaken multi-agency training but the experts did not consider that the necessary lessons were learnt from that training. In particular, they criticise the failure of the emergency services to learn from Exercise Winchester Accord, a key counter-terrorism exercise that took place at the Trafford Centre just a year before the arena attack.

Third, in the view of the experts, more could have been done to generate an improved understanding in the control rooms of the emergency services and to promote the channelling of information as it was received. Control rooms, the experts consider, represent the first possible point of failure in any major incident so that they would benefit from what are described as "significant cycles of exercising".

Furthermore, the experts consider that coordination between control rooms was not adequate or effective on the night of the bombing.

The inquiry will need to explore what lessons can be learned from this and identify what should be done to avoid failure again if indeed failure is what occurred on 22 May.

Fourth, the experts consider that the declaration of Operation Plato, that is to say the declaration of an

incident involving what at the time of the attack was called a marauding terrorist firearms attack, an MTFA, but would now be known as a marauding terrorist attack, was not actively and accurately managed and, in the view of the experts, this too represents a failure.

Everyone listening and watching should understand that we, as counsel to the inquiry, are not expressing a view at this stage about whether these criticisms or concerns are well-founded, whether expressed by those on the ground on the night or by the experts. That, as with all evidential issues, will be a matter for determination by the chairman once he has heard all of the evidence that bears upon this chapter. Nonetheless, these are matters of obvious importance that we will need to confront head on once we embark upon the evidence in chapter 10.

Next, we'll set out the structure of what we propose to say about the emergency response in the balance of this opening statement. It will be in five broad parts.

In part 1 we will provide a brief introduction to some of the terms and concepts that will be used extensively in the course of the evidence in chapter 10, just as we did when we first made an opening statement in September, although we will develop what we have said and indeed some further terms will be explained.

The terms and concepts we'll seek to explain, at least in basic terms, are, first, what is meant by JESIP and what it should involve. Second, the levels of command that are expected to deploy in response to an incident such as the Manchester attack. Third, what is meant by a major incident. Fourth, what is meant by Operation Plato, which we've mentioned a number of times already, emphasising its importance. Fifth, the concept of primacy, that is to say whether GMP or BTP had principal responsibility for preparing for and responding to an attack at the arena and that, of course, is an issue that also received consideration in chapter 7, demonstrating that to some extent at any rate some of the chapters we're exploring are intertwined. Sixth, a term important for the Ambulance Service in particular and describing the use of an area is designated as having -- following an MTFA, that term being casualty clearing station. And seventh, an equally important and related term, casualty collection point, which describes a different area operated by the Ambulance Service, one closer to the seat of the attack itself.

We don't pretend that we'll be providing detailed or definitive definitions of terms such as JESIP at this stage because that, of course, will be for the evidence.

Instead, we're simply seeking at this stage to make what we say in the balance of this opening statement comprehensible and to assist once we start to hear from the witnesses.

In part 2 of what we have to say today, we'll deal with some general evidence about the role of the Greater Manchester Resilience Forum in planning for the response to a terrorist attack such as that carried out at the arena. We will explain what a Local Resilience Forum is and what it should do and we'll identify the issues that arise for the inquiry to consider in respect of the Greater Manchester Resilience Forum, which will often be referred to as GMRF.

In part 3 we will provide a very brief overview of the emergency response. Of course, we went through the events in some detail during the course of our initial opening statement. Furthermore, once this opening statement has concluded later today, we will begin, probably tomorrow, to work through the sequence of events with Detective Inspector Russell. As a result, we will do no more than provide a summary of what happened in the period between the explosion and 1 am on 23 May.

In part 4 we will deal with whether there is any basis for considering that a different emergency

response may have saved lives. Most of those who died suffered injuries in the bombing that were, on the expert evidence, unsurvivable even with current advanced medical treatment. However, we will be drawing attention to the fact that in two cases, a different response may, and we deliberately underline that word, may have led to a different outcome.

Those two cases are John Atkinson, to whom we referred expressly in September in our opening statement, and Saffie-Rose Roussos, who we didn't name at that time for reasons we explained.

Finally, in part 5 we'll identify some of the issues that we anticipate the chairman will wish to explore as he hears the evidence in chapter 10.

Having set out the structure we propose to adopt, we'll turn to deal with part 1, the terms that will be used extensively in the course of the evidence and indeed in the course of this opening statement.

First, JESIP. The Blue Light Interoperability Programme reported in April 2012. That programme had been run by the Association of Chief Police Officers, the Chief Fire Officers' Association and the Association of Ambulance Chief Executives, although with Home Office oversight.

The joint emergency services interoperability

programme, or JESIP, emerged out of the report of that programme. The aim of JESIP was to improve interoperability between the emergency services and it established to that end a set of apparently simple principles. We'll have on the screen a diagram that we have seen before, which is from the overview report of the policing experts, which sets out those principles. This is {INQ024271/54}.

So we can see what those principles are, if we can just enlarge the bottom half of the page or scroll it up, we can see the principles are: co-locate, that is to say co-locate with commanders as soon as practicably possible at a single safe and easily identified location near to the scene. A principle that we'll be looking at, I have no doubt, in detail during the evidence.

Communicate. That is to say, communicate clearly, using plain English.

Coordinate. That is to say, coordinate by agreeing the lead service and identify priorities, resources and capabilities for an effective response, including the timing of further meetings.

Jointly understand risk. So jointly understand risk by sharing information about the likelihood and potential impact of threats and hazards to agree potential control measures.

And shared situational awareness. In other words, shared situational awareness should be established by using what are known as METHANE and the joint decision model.

Thank you, we can take that from the screen.

Situational awareness, that term we've just used, is the idea that the emergency services should have a common understanding of the circumstances, immediate consequences and implications of the emergency they are concerned with, along with an appreciation of the available capabilities and priorities of those emergency services.

As we've just said, JESIP refers to METHANE. So could we have on the screen, please, another diagram which seeks to explain METHANE. Thank you very much indeed. We don't intend to descend into too much detail at this stage, but in short, so we all understand the evidence that we will receive in due course, METHANE stands for:

M. Major incident. Has a major incident or stand by been declared?

E. Exact location. What is the exact location or geographical area of the incident?

T. Type of incident. What kind of incident is it?

H. Hazards. What hazards or potential hazards can

be identified?

A. Access. What are the best routes for access and egress?

N. Number of casualties. How many casualties are there and what condition are they in?

E. Emergency services. Which and how many emergency responder assets and personnel are required or are already on scene?

We heard during the course of our opening statement in September the METHANE report provided by Sergeant Cawley of BTP to the BTP force duty officer, Inspector Dawson —— in fact, he may have been the FIM, and we'll hear it again once we start to work through the sequence of events documents.

The joint decision model, or JDM, referred to within JESIP in the context of situational awareness is designed to enable commanders to collate jointly all available information with a view to making decisions. Again, we can see a diagram designed to illustrate this on the scene. Thank you. {INQ024271/60}.

The central principle of that model is that people work together to save lives and reduce harm. The importance of that principle in the context of the Manchester Arena attack is obvious. The bombing cried out for an effective coordinated response. The JDM goes

on to describe a number of stages.

First, gathering information and intelligence. Second, assessing risk and developing a working strategy. Third, considering powers, policies and procedures. Fourth, identifying options and contingencies. And, fifth, taking action and reviewing what happened.

It is by reference to JESIP, METHANE and JDM that the inquiry will hear evidence about the response of the emergency services of Manchester on the night of the bombing. That then is a very brief indeed introduction to JESIP. We will learn, we have no doubt, much more about it during the course of the evidence itself.

Without seeking to make or invite any prejudgement, as we've indicated already, the evidence gathered by the inquiry suggests that the JESIP principles may not have been applied, at least not adequately, in the aftermath of the Manchester Arena attack, including within the various control rooms of the emergency services. The inquiry will need to consider whether that is so and, if it is, why that occurred and whether life was lost as a result of any failure.

As is beyond obvious, even the loss of a single life due to such a failure would be completely unacceptable. If there was a failure, whether causative of death or

not, the inquiry will need to identify what should be done in order to prevent such a failure in future.

The second term, command structure. JESIP also in fact deals with the command structure that emergency services would be expected to have in place when dealing with an emergency. In evidence, we will hear repeated references to Gold, Silver and Bronze Commanders. The public might readily, and indeed understandably think, that those descriptors designate seniority of rank with the Gold Commander being the more senior, but that is not so or not necessarily so. The level of command an emergency responder adopts during an incident does not necessarily convey their normal seniority or rank but instead demonstrates the level of command that they have for that scene. So those descriptors are role specific, not rank specific, and they can be assumed by any rank.

Frequently, as we shall see, the roles will be filled by officers who are immediately available and then, as more senior and/or experienced officers arrive at the scene, the earlier appointees will be substituted.

JESIP does not, at least as we understand it, use the terms Gold, Silver and Bronze Commander, but instead employs the following descriptions: first, the strategic commander. The strategic commander performs the role

that many, indeed most witnesses, describe as Gold. They have overall responsibility for their agency and its resources, they have responsibility for setting the strategic priorities for their agency and communicating that to the tactical commander.

The strategic commanders for the various agencies are expected to form part of a strategic coordination group known, as we have said, as an SCG, which we referred to earlier when we mentioned the concerns identified by Lord Kerslake. He, as we said, considered that there was a delay in convening the first meeting of the SCG following the Manchester attack.

The SCG is expected to be convened and to produce a specific strategic response strategy and record a strategy statement.

Sir, can I indicate my screen here in the hearing room went blank for a few moments. Could I check that you, sir, and others were able to follow what I was saying about the strategic commander? You were?

SIR JOHN SAUNDERS: Yes, I could, thank you.

MR GREANEY: Thank you very much, sir.

The second term used by JESIP is the tactical commander. The tactical commander performs the role that nearly all witnesses describe as Silver. In the view of the policing experts, the tactical commander is

likely to be the first senior officer to take command of an incident. Their role is to interpret strategic direction, develop a tactical plan and set priorities, coordinating activities and assets.

The policing experts also expressed the view that communications between emergency service tactical commanders, so the tactical commanders of the different emergency responders, is crucial and that they should be co-located at an agreed location so that they can maintain effective joint tactical command of the incident.

The policing experts' views about the role of GMP Silver are a matter of some controversy, as we understand it, but we'll get to that in the evidence.

JESIP certainly anticipates that the tactical commanders of all of the responder agencies should come together in order to form a tactical coordinating group, a TCG. The policing experts observe that the TCG can be established as a formal meeting, but will frequently assemble as a less formal gathering where quick decisions can be achieved by co-location and personal communication, sometimes known, they inform us, as a huddle or scrum.

Third and finally in terms of these descriptions, the operational commander. The operational commander

performs the role that most describe as Bronze. Their role is to execute the tactical plan, command the response of the agency of which they are part, and coordinate actions. They may be at the scene close by or in a command centre depending upon the nature of the emergency and the requirements of their role.

So as we start to hear from the witnesses, we'll understand that Gold means strategic, Silver means tactical and Bronze means operational.

Next, we'll also hear reference in the course of the evidence to the term "major incident". Indeed we've mentioned it already because the term is the M in METHANE. M indicates major incident.

JESIP defines a major incident as follows:

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

Declaring a major incident triggers a predetermined strategic and tactical response from each emergency service and other responder agencies or at any rate should do so. It takes time for operational structures, resources and protocols to be put in place. Declaring that a major incident is in progress as soon as possible means these arrangements can be put in place as quickly as possible.

The events at Manchester Arena on the night of 22 May 2017 undoubtedly, it seems to counsel to the inquiry, amounted to a major incident. Further, we do not understand any core participant to suggest that it was otherwise. In the course of the evidence, we will need to investigate which of the emergency services conducted a METHANE assessment and whether they declared a major incident, when they did so, and why. As part of that, we'll need to explore whether those emergency services that conducted a METHANE report shared it with their partners. Our current understanding is that BTP and NWAS each declared a major incident before 23.00 hours and GMP did so at about 1 am on 23 May. We do not understand that any organisation shared its METHANE report.

Next, and fourthly, Operation Plato. In November 2008, an Islamist terrorist organisation carried out a series of coordinated shooting and bombing attacks across Mumbai. The attacks lasted for 4 days and caused many deaths and injuries. In the aftermath of those events, the authorities within the United Kingdom conducted a major review of their planning, preparedness and response to what had occurred in Mumbai, namely what became known as a marauding terrorist firearms attack, often called an MTFA.

Operation Plato became the UK national identifier for the response to such an attack, an MTFA. The first edition of Operation Plato was published in 2012 and thereafter updated. An MTFA is obviously an extraordinary event, placing very significant demands upon the resources of the emergency services. It had been recognised for years prior to the Manchester Arena attack that the emergency services needed a well-briefed and rehearsed plan for dealing with such an event, with clarity of roles and responsibilities having been identified pursuant to plans.

By May 2017, it was well understood within the emergency services that the early identification of an MTFA and the rapid implementation of an appropriate joint response in accordance with JESIP principles was crucial to protecting the lives of both members of the public and responders. The answer given to the questions posed by an incident was that in the event of an MTFA, the local police force should declare Operation Plato, which would then generate a structured and coordinated multi-agency response.

It follows from that that once Operation Plato had been declared, that should be shared immediately with the control rooms of all other emergency services. A proper command structure should then be put in place

with different zones designated: hot, warm and cold, depending upon the threat in a particular area. A hot zone is a zone in which live terrorist activity is occurring, into which only suitably trained and equipped police officers should advance in order to prevent that terrorist activity. A warm zone is an area in which active terrorist activity has stopped but which cannot be guaranteed to be safe because, for example, an improvised explosive device, an IED, may be present, and into which multi-agency specialist teams, trained and equipped to operate within such an area, may be deployed to treat and/or evacuate casualties. A cold zone is an area where active terrorist activity has stopped and into which non-specialist responders may be deployed. These three designations of area will be of relevance to our analysis of the decisions of the emergency responders on 22 May.

On that date, the night of the attack, Operation Plato was declared by a GMP officer, Inspector Dale Sexton, who performed the role of force duty officer or FDO. He did so at 10.47 pm, so 16 minutes after the bomb had been detonated. The inquiry will need to consider whether that declaration was correct, whether it was communicated to other emergency services, and, if so, whether it was

communicated at the right time and whether it was maintained for an appropriate period of time. Only the police can cancel Operation Plato.

If the declaration of Operation Plato was incorrect or was maintained for too long, or not properly communicated by GMP to other emergency services, the inquiry will need to consider what difference that made and how such problems are to be prevented in the future.

Neil Basu is now an assistant commissioner with the Metropolitan Police Service and is currently the assistant commissioner for specialist operations, or ACSO, which includes command for the SO15 counter-terrorism command. He will give evidence to explain the structure for Counter-terrorism Policing within the UK to the extent not already explained by other witnesses. It is not necessary to describe that at this stage, but it's relevant to note that he will address a review that was undertaken of Operation Plato at a national level as a result of the events in Manchester.

Furthermore, as it happens, on 22 May, Neil Basu was a deputy assistant commissioner and the senior national coordinator for Counter-terrorism Policing as it was then known. That means that it was his job to assume national strategic command of the events in Manchester

and the investigative response to that attack. In evidence he will describe the steps he took on becoming aware that the Manchester Arena attack had occurred.

At the moment we plan to call Assistant Commissioner Basu in the week of 1 February, although we should make plain that he will not be dealing with the review that was undertaken and which we've just described at that stage of his evidence.

Next, we'll mention again the issue of primacy. We heard some evidence, of course, about this issue, which is undoubtedly an important one, during the course of chapter 7, but there is, if we can put it this way, some way still for us to go in relation to it.

We'll begin with a reminder of just the very basic facts. The freehold for the arena and City Room was owned by Network Rail. As a result, by reason of section 31 of the Railways and Transport Safety Act of 2003, the City Room was within the jurisdiction of BTP. In this context, the word "jurisdiction" means the parts of the country in which BTP officers have powers to operate as a constable. In other words, BTP, British Transport Police, had jurisdiction within the City Room.

Unlike BTP, Greater Manchester Police officers, as officers of what we now know is described as a Home Office force, are not similarly circumscribed in

terms of their jurisdiction. They have the powers of a constable generally, the consequence of all of that is that they had jurisdiction in the City Room as well as BTP. Accordingly, given that both BTP officers and GMP officers had jurisdiction to operate in the City Room, the question arises of which organisation should take the lead for the policing of that area.

As we've already observed, that question can neatly be described as the issue of primacy. On 22 May, the understanding between both organisations, as is agreed, as we understand it, by each of them was that BTP had primacy in relation to any property in which they have jurisdiction. So, because BTP had jurisdiction in the City Room, by this agreement primacy rested with BTP and, as such, BTP had responsibility for leading the policing of that critically important area.

It may be that there was an exception to this general rule, namely the response to terrorist incidents in relation to which GMP would have primacy. Whether there was such an exception, and if so whether in theory or in practice, and how it was expected to work in response to any given event will be matters for the inquiry to continue to investigate during chapter 10.

Counsel to the inquiry consider, as we've just stated, that the issue of primacy is an important one.

It is important because BTP's principal expertise is in the policing of the railways. Its jurisdiction in relation to the City Room and the arena is purely by dint of the fact that the freehold of the arena is owned by Network Rail. Ordinarily, such large scale public entertainment events —— and the arena was one of the largest such venues in Europe —— would be policed by the Home Office force, in this case GMP. And so there is a legitimate question about whether it was appropriate and/or whether it gave the best protection to the public that it was the police specialising in the railways that took the lead for all events that took place in the arena rather than GMP.

As we know from the exchange of correspondence between GMP and BTP, that we considered with ACC O'Callaghan of BTP when he gave evidence during chapter 7, those two police forces have been in discussion about the issue of primacy but no final agreement had been reached at that stage.

The inquiry will therefore need to investigate a number of matters related to the issue of primacy. These include: 1, the nature of the agreement which existed between the two forces and how it was defined, where it was documented, if anywhere, and where it appeared in plans, if anywhere. In this regard, as we

shall see and have seen, the fact that there had been a recent multi—agency exercise which included the City Room, namely Exercise Sherman, to which reference was made during chapter 7, may be a relevant consideration when it comes to whether there was a real opportunity to give this issue close consideration prior to the attack and, if so, whether either or both organisations seized that opportunity.

2. What the understanding of the issue of primacy was amongst the commanders of both BTP and GMP and amongst those officers who were on the ground. Regardless of what formal agreements may have existed between the two organisations, the understanding by those charged with planning for and responding to an incident such as that which occurred on 22 May is also a significant area for investigation.

In this regard, whether there was a confusion when describing primacy, such as by the use of the word "jurisdiction" when what is meant is primacy, will also fall for consideration by the inquiry because there are, for example, repeated assertions within the BTP radio traffic at an early stage of events on 22 May that BTP had "jurisdiction".

The inquiry will need to consider whether this had consequences on the night and, even if it did not,

whether things can be done better in the future, both at the arena and more generally throughout the country.

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

And, 4, whether the issue of primacy had any effect on the response of either BTP or GMP on the night.

During chapter 10 we will look forward, if that's the right way of putting it, to hearing from senior officers of GMP and BTP about what further progress, if any, they have made since that exchange of correspondence to which we've just referred. We make plain that flowing from all of this are likely, in our view, to be important lessons for the future, not only for Manchester Arena but also for other sites which give rise to the same or similar issues around the country.

Sir, I'm mindful that I have now been going for an hour, but if everyone will bear with me for another 5 minutes, I will just conclude this part of the opening statement.

So terms 6 and 7, casualty collection points and casualty clearing station. As we've said, these are related terms which describe different areas which are designated by the Ambulance Service as serving particular functions following the declaration of

Operation Plato.

An important JESIP document which bears directly on these terms, but is also important for other aspects of this inquiry, is "Responding to a Marauding Terrorist Firearms Attack and Terrorist Siege: Joint Operating Principles for the Emergency Services". This is commonly referred to as JOPs.

The version in force, so the version of JOPs in force at the time of the attack, was edition 3, which took effect from January 2016. As the title suggests, its focus is upon a marauding terrorist firearms attack. However, as the foreword makes clear, the principles can be used in situations beyond those involving the declaration of Operation Plato.

In the foreword, JOPs sets out its purpose in this way:

"The joint operating principles set out in this document have been developed by the Marauding Terrorist Firearms Joint Operational Working Group and will act as a significant enabler in the delivery of a consistent and integrated national emergency service response to an MTFA. This guidance should be used to inform existing major incident procedures and must be used in conjunction with local and national standard operating procedures. In non-terrorist attacks of a similar

nature, these principles may still deliver an effective response and consideration should be given to their use."

The JOPs glossary then goes on to define, amongst other terms, those terms casualty collection point and casualty clearing station. It does so in the following terms:

"Casualty collection point (CCP): a staging point that enables life-saving interventions to be undertaken before removal to the casualty clearing station.

"Casualty clearing station (CCS): an entity set up at the scene of an emergency by the Ambulance Service in liaison with the medical incident adviser to assess, triage and treat casualties and direct their onward removal."

The operational or, as we've said, Bronze Commander for the first part of the NWAS response was consultant paramedic Daniel or Dan Smith. In a statement provided in response to a request of the chairman, he states that:

"[He] wanted to create a casualty collection point at the bottom of the stairs where patients could be triaged and then moved into a casualty clearing station depending on how poorly they became."

He goes on to say that the CCS was intended to be

the entrance hall leading into the station concourse, however this proved to be too small, resulting in a spread further into the station.

The issue of the location of the CCP and the CCS has been considered by the ambulance experts, who observe that those terms, a further term, one that does not appear in JOPs, namely casualty clearing area, appear to them to have been used interchangeably at times on the night of the attack. The ambulance expert points to the risk of misunderstanding and confusion that such usage can lead to, and this is something, we suggest, for the inquiry to investigate.

Even more importantly for our investigation is the question of whether these areas were designated to appropriate locations. In particular, we will need to investigate whether the CCP, where paramedics could have provided emergency care, should have been located in the City Room or on the walkway. The ambulance experts assert that if there is any delay in evacuation, life-saving interventions can be undertaken in the CCP and they go on to offer the opinion that placing the CCP at the foot of the stairs was unnecessarily cumbersome and that the City Room itself should have been used as the CCP.

If they are right about this, it seems that the

effect would have been more triaging and treating paramedics in the City Room. Whether they are right, whether this would have been the effect and extent of any potential difference that would have made are all matters of very substantial importance for investigation in chapter 10.

Sir, that is the end of what we have to say about part 1 of chapter 10. We'll turn next, following a break -- may we have 20 minutes -- to deal with part 2, the role and responsibilities of the Greater Manchester Resilience Forum.

SIR JOHN SAUNDERS: Right. We will restart at 12 o'clock, which I think is 20 minutes. I assume that we can remain connected to BlueJeans and simply turn off our microphones and videos in the gap.

MR GREANEY: Yes, that's correct, sir.

SIR JOHN SAUNDERS: Okay. Thank you very much. 12 o'clock.

(11.38 am)

(A short break)

(12.00 pm)

MR GREANEY: Sir, I'm turning, as I indicated I would, to the role and responsibilities of the GMRF, the Greater Manchester Resilience Forum.

We've mentioned the Civil Contingencies Act already. Together with other measures, it provides a framework

for civil protection in the United Kingdom. That Act deals with emergencies. It contains a detailed definition of an emergency and, unsurprisingly, that definition includes a terrorist attack such as that which occurred at Manchester Arena on the night of 22 May.

The Act divides those who respond to an emergency into two categories, category 1 and category 2 responders. Category 1 responders are local authorities, emergency services and NHS bodies such as Ambulance Services, and various others of no relevance to the inquiry. They have the full set of civil protection duties.

By section 2 of the Act they are required, among other things, to assess the risk of an emergency occurring and to maintain plans for the purpose of ensuring that, if an emergency occurs, the responder is able to perform its functions "so far as necessary or desirable for the purpose of reducing, controlling or mitigating the emergency's effects".

Category 2 responders include railway operators. They have a lesser set of responsibilities than category 1 responders, principally requiring them to cooperate and share relevant information with category 1 and other category 2 responders.

The emergency services experts will provide a detailed explanation in due course of what emergency planning under the Act really means in their judgement. What we intend to do at this stage is to provide no more than a summary to aid understanding as we move into the evidence. It is, with everything we've said and will say in this opening statement, of course subject to the evidence.

The Civil Contingencies Act 2004 Contingency Planning Regulations 2005 require category 1 responders to cooperate with each other and with relevant category 2 responders in connection with the performance of the duties under section 2 of the Act to which we've just referred. Regulation 4 of the regulations mandates that one form that such cooperation must take is through a forum of all relevant category 1 and 2 responders, and such a forum is known as a Local Resilience Forum.

England has 42 Local Resilience Forums established in areas consistent with the boundaries of police forces. In Manchester, the LRF was known, as we've said, as the Greater Manchester Resilience Forum. Its members at the relevant time included GMP, BTP, NWAS and GMFRS, but not, as we understand the evidence, NWFC.

One of the issues the inquiry will need to investigate is whether GMRF discharged its statutory

responsibilities in the period leading up to the Manchester attack. The inquiry will also need to consider whether the level of engagement of members of GMRF was adequate, something on which the policing experts have expressed their views.

At the date of the attack, the chair of GMRF was Paul Argyle, the director of emergency response for GMFRS, so for the Fire and Rescue Service.

In a witness statement, Mr Argyle explains that the GMRF had a number of purposes. First, as a coordinating group for local responders engaged in preparedness for emergencies. Second, to enable the development of a consistent understanding of hazards and threats across the Greater Manchester area. Third, to reflect the fact that many emergency situations demand what Mr Argyle describes as "multi-agency working across all the partners", including the development of multi-agency LRF plans and the exercising of those plans.

Pausing for a moment, it might reasonably be thought that the Manchester Arena attack provides the perfect example of why multi-agency working and planning is of the utmost importance.

The fourth purpose of an LRF, explains Mr Argyle, is to liaise with government.

Mr Argyle goes on to explain that whilst an LRF does

not have an operational role in the event of an emergency, it should facilitate preparedness at a local level. To that end, GMRF had agreed terms of reference so as to "ensure that there is an appropriate level of preparedness to enable an effective multi-agency response to emergency incidents, which may have a significant impact on the communities of Greater Manchester".

The objectives of GMRF included, among other things, ensuring that appropriate multi-agency plans, procedures, training and exercises necessary to address identified or foreseeable local and wider area hazards are in place and outstanding gaps identified, and coordinating the individual approaches -- that word again, "coordinating" -- and responsibilities of each organisation to ensure that they complement each other and dovetail with partners' arrangements.

Once more, the importance of those stated objectives of the Local Resilience Forum in this area cannot be underestimated in the context of seeking to understand the emergency response to the Manchester Arena attack and in seeking to gauge whether it was adequate.

At the time of the Manchester Arena attack, GMRF had a number of multi-agency plans in place. We will need to investigate in chapter 10 whether those plans were

fit for purpose. GMRF also facilitated training and exercising events, some delivered by members of the resilience forum and some by external providers.

A number of these exercises concerned terrorist incidents. Exercise Winchester Accord took place, as we know, in May 2016. The exercise scenario was an MTFA at the Trafford Centre. It was a multi-agency response with the aim of testing and evaluating the response to a major terrorist attack.

The policing experts comment extensively upon this exercise in their report and express, moreover, serious concerns about whether the necessary lessons were learnt from it, and the other experts appear to share their concerns.

Subsequent exercises included Exercise Sherman in 2016 and Exercise Hawk River in March 2017. Both were multi-agency tabletop exercises focused upon an MTFA and participants included GMP, GMFRS and NWAS. We've already considered, of course, Exercise Sherman, which was of interest to the inquiry because it was based upon a terrorist attack in the City Room, the very thing, of course, that happened on 22 May.

In response to the report of Lord Kerslake and his panel, Kathy Oldham, the chief resilience officer for GMCA, wrote to the Mayor. In doing so, she emphasised

that regular meetings now take place to ensure that lessons have been learnt and that plans are in place to ensure that this is achieved. It will be necessary to consider whether the report of Ms Oldham represents much by way of concrete proposal. The current chair of GMRF is Nick Bailey, the assistant chief constable of Greater Manchester Police. He has provided the lessons learned statement on behalf of GMRF, the Local Resilience Forum.

In it, he observes, perhaps with a degree of understatement, the following:

"It was clear in the immediate aftermath of the attack that there had been some issues with multi-agency communication and the deployment of some agencies."

He goes on to describe the process of debriefing and reporting undertaken by the resilience forum with a view to ensuring that such issues did not recur. ACC Bailey expresses the view:

"GMRF has taken an extremely robust and methodical approach to identifying areas of learning and development from the multi-agency briefings and the Kerslake Report."

The inquiry will need to consider whether this is correct and in any event whether there are further lessons that should be learned about the operation of GMRF and indeed about LRFs more generally.

We are going to turn next to part 3 of our chapter 10 opening. As we indicated at the outset of what we've had to say today, this will involve a brief summary of the events in the period between the explosion and 1 am on 23 May, both on the ground and in control rooms. The purpose of what we intend to say is to provide a structure for the evidence once we start to hear it and an introduction to the evidence of Detective Inspector Russell.

We will not be dealing, at least not in detail at this stage, with the movements of each and every individual person who died, but may we emphasise that this is not because we consider those matters unimportant. On the contrary, they are of the utmost importance. However, those movements will generally be considered in chapter 12, whereas in chapter 10 we will maintain our focus upon the emergency services, when they arrived and what they did when they arrived, and on what difference any failures may have made.

Before we embark upon this part of our opening statement, it is important that we acknowledge publicly the pressure that those who responded to the attack, both members of the public and emergency responders, came under. It must, we acknowledge, have been enormous. Which of us who was not there and not

required to make critical decisions in the agony of the moment can understand what they felt like. This process, by which we mean the process of this inquiry, must understand that and will understand that, and our investigation must not be used to vilify those who did their best on the night, even if they made mistakes or could have done better.

Still, what we must do is to probe deeply, but always fairly, into the emergency response that night. If there were mistakes or failures, they will need to be revealed, not because our purpose is to criticise but instead so that the bereaved families may know the truth and also so that the real lessons may be learned and things be improved for the future.

We'll turn then to our summary. But again, before we do so, we recognise that even a summary of the events we are about to describe is capable of being distressing and we give that warning before we start.

In the seconds immediately after the explosion, PC Bullough and a group of BTP colleagues ran, together with a number of Travel Safe officers, towards the City Room, entering there no more than 2 minutes after the bomb had detonated. ETUK medics also made their way there.

At 22.34 hours, PC Corke entered the station and

made his way to the City Room. All will recall that he is the BTP officer with considerable experience of policing events at the arena but whose deployment there that night had unfortunately been delayed.

By 22.41 hours, 10 minutes after the explosion, three PCSOs, Browne, Renshaw and Morrey, eight PCs, Bullough, Corke, Trow, Campbell, Ayers, Bridgewater Edwards and Martin, all 11 of them BTP officers, had made their way to or very near to the City Room. As this period, the first 10 minutes after the explosion evidenced, a 12th officer, police Sergeant Wilcock, had just entered the arena complex.

Some of those who were captured responding in these first minutes were already within the Victoria Railway Station, others arrived from elsewhere. Those who arrived in vehicles brought first aid kits. Other such kits were fetched by those who were first into the City Room.

So far as other organisations are concerned, four ETUK medics reached the City Room within those first 10 minutes, with a fifth, Ken O'Connor, entering seconds later.

In relation to the staff of the station itself, one had brought first aid equipment to the City Room and two large NHS first aid bags had been brought out on to the

station concourse before being carried up to the City Room. That is what was occurring in those first 10 minutes.

In the next 10 minutes, so between 22.41 hours and 22.51 hours, a significant number of GMP officers arrived at Victoria Railway Station. These included four double-crewed patrol vehicles, two TAU or tactical aid unit carriers, and several armed response vehicles. Among those who arrived during that period were Inspector Michael Smith, who assumed the role of GMP Bronze, that is to say operational commander, along with at least 19 other unarmed officers and a minimum of ten firearms officers, including the operational firearms commander.

Before this period, that's to say the 10 minutes prior to 22.51 hours, was over, four firearms officers had passed through Victoria Railway Station and over the raised footbridge into the City Room, whilst another four had passed through the arena itself and the arena concourse in order to reach the City Room. Firearms officers had passed from one side of the City Room to the other and by the end of this period, fewer than 20 minutes after the explosion, had assumed defensive positions on both the raised footbridge entrance to the City Room and the arena concourse entrance to that area.

This, we emphasise, during the course of our summary, may be important when we consider whether Operation Plato should have been maintained for the period it was, assuming it was correct to call Plato in the first place, and in this regard we note that Operation Plato was only formally declared as this period we are just considering was drawing to a close. We hope that point is clear. The fact of the deployment of firearms officers during this early stage and the number of firearms officers and what they did must be relevant to our consideration of Plato.

To consider the CCTV evidence another way, approximately 15 minutes after the explosion the first armed officers are recorded as entering the City Room. The GMP Bronze Commander entered the City Room fewer than 3 minutes after that. And also arriving at the very end of this period was the first NWAS paramedic, Patrick Ennis. The number of ETUK medics operating in and around the City Room by 22.51 hours was six.

In the following 10 minutes, so in the period between 22.51 hours and 23.01 hours, additional members of the emergency services arrived. Patrick Ennis was, of course, already there and by 22.53 hours, or shortly afterwards, he had entered the City Room, made contact with the GMP Bronze Commander, Inspector Smith, and

spoken to a representative of ETUK. He then left the City Room having spent approximately 5 minutes there, just as another paramedic and a doctor were arriving.

By the conclusion of this period, and so 30 minutes after the explosion, there were a total of six NWAS paramedics at Victoria Station, including an advanced par, a senior paramedic, and a consultant paramedic, Dan Smith, who took up, as we have said, the role of Bronze Commander, along with an NWAS MERIT doctor, Michael Daley.

A further ambulance also arrived at the end of this period, but both of those within that vehicle got no closer to the City Room than Trinity Way because its occupants tended to and transported Saffie-Rose Roussos, who by then had been carried out of the City Room via the Trinity Way link tunnel.

Saffie is seen being carried out of the City Room via the Fifty Pence entrance at 22.57.08 and by 22.58.33, she had reached the end of the Trinity Way tunnel. As we are going to explain, on the basis of material which has been generated since we made our opening statement, survivability is an issue in the case of Saffie.

Additional, highly specialist firearms support in the form of three counter-terrorism specialist

firearms officers, or CTSFOs, had already arrived by the end of this period and entered the arena itself.

The subsequent 10 minutes, so those minutes between 23.01 and 23.11, take us to the point 40 minutes after the explosion had occurred. During that period, Patrick Ennis spoke in person to the NWAS Bronze Commander, Dan Smith, outside the City Room and then returned into that area. At least eight ambulances had by now attended Victoria Railway Station together with other NWAS employees in other vehicles. During this period, moreover, the NWAS Bronze Commander, consultant paramedic Smith, had established himself visibly as such and three off-duty doctors had briefly entered Victoria Railway Station.

However, the only deployment of a stretcher in the City Room had occurred and another injured person had been transported out of the City Room on a makeshift carrying platform. It is notable, we suggest, that by 23.11 hours, 40 minutes after the explosion, despite the presence of numerous members of NWAS staff within the station, Patrick Ennis was the only NWAS paramedic to have been within the City Room. Why that is so is plainly something that will need to be closely examined during the evidence in chapter 10.

On the policing side, more police officers had

entered the City Room during this period up to 23.11 hours and six more firearms officers were at the scene.

Turning to the period between 23.11 hours and 23.21 hours. At 23.14 hours members of the NWAS Hazardous Area Response Team, or HART, arrived at the station. That team had been established by NWAS in 2009 in response to the national terrorism level and, as the NWAS website explains, uses specialist equipment and skills to safely access and treat patients in difficult and hazardous conditions.

One of the issues the inquiry will want to consider is why such a specialist team, with obvious skills to bring to bear in the circumstances of the aftermath of the arena attack, did not arrive until 43 minutes after the explosion.

The members of HART who arrived were paramedics Lea Vaughan and Christopher Hargreaves. They made their way directly to the City Room. Once in the City Room, they spoke to Patrick Ennis and then started to move between casualties. Also during this period we're considering, at 23.17.40, and so more than 45 minutes after the explosion, the evacuation of John Atkinson from the City Room commenced as he was moved on a display board across the floor of the City Room

towards the raised footbridge.

The issue of John Atkinson's survivability is, as we said in September, and as we shall explain, a matter that will need to be investigated. During this period, GMP firearms officers were conducting a systemic sweep of the arena, again a matter that will be relevant to our consideration of Plato.

We turn then to the final 10 minutes of the hour after the explosion. At 23.23 hours, up on the raised footbridge, a metal barrier had been obtained to be slid under the display board used to move John Atkinson. By 23.24.25, John had been moved in this way to the area by the war memorial entrance where he was placed and tended to by an NWAS paramedic, Philip Keogh. He remained at this location for the next 24 minutes.

At 23.26.14, a party of police officers began to carry Georgina Callander out of the City Room on a makeshift stretcher taking her to Station Approach, where she was tended to by three paramedics.

As the hour after the explosion came to an end, both John Atkinson and Georgina Callander were carried out of the City Room. Whilst all of that was happening, three more paramedics walked into the station, and Lea Vaughan and Christopher Hargreaves and Patrick Ennis were still in that area in the City Room.

GMP Chief Inspector Dexter, the ground assigned tactical firearms commander, or GATFC, had also arrived during this period. That occurred at 23.24 hours and a minute later he entered the City Room.

What happened in the next 90 minutes, so between 23.31 hours and about 1 am on 23 May, we can summarise.

John Atkinson and Georgina Callander continued to receive treatment. At 23.47.50, chest compressions were started on John, who was still at that point in the area of the war memorial entrance. The chest compressions continued as he was wheeled towards an ambulance.

At 23.40.32 the final casualty was evacuated from the City Room on a makeshift stretcher comprised of cardboard and a crowd barrier.

Activity continued during those 90 minutes on the part of representatives of NWAS, GMP and BTP, with Chief Inspector Andrea Graham of BTP arriving and entering the City Room at just after midnight, where she approached Inspector Smith of GMP, the Bronze Commander.

Shortly after this, NWAS deputy director of operations, Stephen Hynes, had arrived and relieved Dan Smith of his role as NWAS operational commander.

And at 00.27 hours, Detective Chief Superintendent Worth, the GMP duty senior investigating officer, entered the station.

Then, at 00.37.08, a GMFRS fire engine arrived at Station Approach. A second GMFRS vehicle followed close behind. These were followed by two more fire engines seconds later.

At 00.37.37, a GMFRS national inter-agency liaison officer, as we indicated earlier, NILO, got out of his vehicle and spoke to Mr Hynes and Mr Dexter. As will be apparent from this chronology, GMFRS arrived at the arena 2 hours and 6 minutes after the explosion, and an important issue for the inquiry to investigate will be how that came to pass.

So in the period which covers the 90 minutes after the first hour, a number of important events occurred. These include the transportation of both Georgina and John from the scene to hospital prior to midnight, the removal of the last injured person from the City Room, meetings between commanders, a change of NWAS operational commander, the arrival of BTP Chief Inspector Graham shortly before midnight, the arrival of the GMP duty SIO at 00.27 and, at 00.37, the arrival on scene of GMFRS.

Obviously, what was happening on the ground represents only a part of the picture of what was occurring more generally. In the course of the evidence we will need to explore what was happening elsewhere,

away from the immediate scene, so far as the emergency response is concerned. When we first made our opening statement on these issues on 8 and 9 September last year, we descended into considerable detail about those events in control rooms and at GMP Headquarters. Now is not the occasion to do that again. All we will do now is identify the key personalities within each of the emergency services and the principal -- we emphasise principal -- decisions they took, as they seem to us to be.

As we have stated already, officers of BTP were the first into the City Room. They quickly made their supervision aware of what had happened. At 22.3219, PCSO Renshaw made a radio broadcast stating:

"We need more people at Victoria, we just had a loud bang."

And at 22.33.50, PC Bullough broadcast:

"It's definitely a bomb, people injured, at least 20 casualties."

At 22.32.54, there was a request for GMP to attend and at 22.34.04, PC Bullough made the first of a number of requests for ambulances.

At 22.35.00, PCSO Morrey asked for as many resources as possible.

BTP has two control rooms, one in Birmingham and one

in London. They are referred to as Force Control Room Birmingham, FCRB, and Force Control Room London, FCRL. The senior duty officer who was in command of both control rooms was based in London. On the night of the attack, the SDO was Chief Inspector Tony Lodge. Beneath the SDO in the command structure of BTP was the force incident manager, who at the time of the attack was Inspector Ben Dawson, and he was also in London at FCRL.

As the force incident manager, or FIM, it was Inspector Dawson's responsibility to take initial command of the incident as other roles in the command structure were populated. The BTP computer system records Inspector Dawson becoming aware of an unfolding incident at 22.33.52, so within 2 minutes or so of the explosion having occurred.

At 22.35.04, he made his first request for a METHANE report. Four minutes later he declared a major incident, the first of the emergency services to do so.

Inspector Dawson states that he considered declaring Operation Plato himself but decided not to do so as it seemed to him that this was a single person attack. At the time, as we've heard, BTP had no armed assets in the immediate Manchester area, so the inquiry will examine in those circumstances what a declaration of Operation Plato by Inspector Dawson would really have

meant in practice for BTP.

Still in London, Inspector Dawson continued to seek a METHANE report and at 22.58.13, the report of Sergeant Cawley that we heard in September and will hear again today or tomorrow commenced. As part of his report, PC Cawley stated:

"It's our jurisdiction, confirmed."

And it's obvious that this may be a reference to the issue of primacy.

As part of his METHANE report, at 23.01.37, Sergeant Cawley stated that there were at least 100 casualties. It appears to be the position that, contrary to the expected practice, BTP did not share its METHANE report with any other agencies.

Steps were taken by BTP to fill command roles. At 23.31.00, the command structure is recorded in the BTP incident log as being as follows: ACC Robin Smith was appointed the BTP Gold Commander. Shortly after 1 am in that role, and whilst travelling to Manchester from the south-east, ACC Smith spoke to the GMP Gold Commander, ACC Ford. During this conversation it was agreed between the two of them that GMP would lead the overall response to the incident.

By 4 am, ACC Smith had reached GMP Headquarters, just in time to attend the first strategic coordinating

group meeting, which took place at 4.15. It was at this meeting that ACC Smith first learned that GMP had declared Operation Plato. Why he did not learn this earlier, given that Operation Plato had been declared at 22.47 hours, is an obviously important issue for the inquiry to investigate.

During the first hour after the explosion, the role of BTP Silver Commander was performed by Inspector Dawson, the FIM. However, at 23.34 hours, he was relieved by Chief Superintendent Gregory. Shortly after midnight, Chief Superintendent Gregory attempted to contact GMP Silver. His records indicate that he was seeking to establish which force held primacy and exchange contact details. The BTP log indicates that he, that is to say Chief Superintendent Gregory, was informed that he would be called back. Chief Superintendent Gregory states that he tried at least one more time. However, and notwithstanding this, it appears that the BTP Silver Commander did not speak to the GMP Silver Commander throughout the course of the critical stage of the incident. Indeed, it was to take until nearly 1.20 the following morning for BTP systems even to record the name of the GMP Silver Commander.

It is also worth noting that Chief Superintendent Gregory, the BTP Silver, states he was never made aware

that GMP had declared Operation Plato. This is, we suggest, one example, albeit a highly significant one, with the potential ramification for the safety and well-being of BTP officers and/or those they were assisting of the inter-agency communication failure which is criticised by the policing experts and which the inquiry will inevitably investigate.

Chief Superintendent Gregory, BTP Silver, spoke to Superintendent Gordon of BTP at a time that will need to be investigated in the evidence and appointed him as Bronze Commander, notwithstanding that Superintendent Gordon was some distance away in Blackpool. The reasoning for this recorded in the Silver Commander's statement is as follows. He said:

"It was important to have senior command on the scene in order to have an accurate picture of what was happening on the ground and how the situation was developing."

This is a decision which will be the subject of careful scrutiny by the inquiry. The choice of Superintendent Gordon, as we shall see, led to there being no nominated BTP commander on the ground until after 1 am, despite the fact that BTP's internal contemporaneous records may record in the first hour that they regarded themselves as having primacy, that is

to say that they were taking the lead over GMP in terms of the policing response.

In the result, by the time Superintendent Gordon arrived at the scene, primacy had been formally agreed to rest with GMP in the conversation between ACC Smith and ACC Ford shortly after 1 am. The inquiry will need to investigate this and whether or not the absence of a BTP operational commander affected the adequacy and effectiveness of the emergency response. And one part of this will be to consider whether the decision to appoint Superintendent Gordon, as opposed to someone who was there or nearby, was the correct one.

As we explored during the course of the evidence in chapter 7, conduct of the BTP officers who were deployed to the station on 22 May is open to criticism in relation to the period before the explosion, although the question of whether they were instructed and supervised adequately during that period also arises.

Any fair and balanced assessment of the junior officers' conduct must, in any event, recognise that following the explosion, they acted selflessly and without apparent regard for the danger they themselves might be in and that they did so in order to seek to help those who needed it. Whether they, the junior officers of BTP, were provided during that period after

the explosion with the level of support they needed and whether there was the degree of coordination needed at command level within BTP more generally are issues for investigation.

As we have made clear, from an early stage the assistance of GMP was sought in response to the arena attack. The GMP command structure that was put in place in response appears to have been as follows: the role of force duty officer, or FDO, on the night of 22 May was undertaken by Inspector Dale Sexton. As the initial commander he automatically assumed both the Silver, so tactical, and Gold, so strategic, command roles until others took up those positions. The FDO is also the initial tactical firearms commander, or ITFC, in the event that firearms are deployed, as obviously they were, so Inspector Sexton also assumed the role of ITFC.

At 22.39 hours, the GMP Night Silver Commander, Superintendent Arif Nawaz, was notified of an explosion at the arena by Ian Randall, who occupied the role of force duty supervisor or FDS, the FDS being FDO's direct support.

At that point, Superintendent Nawaz became Silver Commander, so that's at 22.39. It is, as we have explained, the Silver Commander's role to activate emergency plans and formulate a tactical plan.

Superintendent Nawaz spoke to the FDO, Inspector Sexton, at 22.50, during which conversation he was told that 10 people had been killed by a terrorist and that Operation Plato had been declared. As we shall learn, Superintendent Nawaz did not know, at least as we understand the evidence, what Operation Plato was. If that's correct, we suggest it is surprising.

At 22.52, Superintendent Nawaz notified ACC Debbie Ford, who was the on-call duty strategic commander, of what was happening. At this point, ACC Ford assumed overall command for the incident in the role of Gold Commander. As it was a firearms incident, ACC Ford also became the strategic firearms commander, or SFC, as well. ACC Ford travelled and arrived at GMP Headquarters at 23.18.

At 22.45 hours, Chief Inspector Mark Dexter was notified by a colleague that Operation Plato had been declared in relation to the arena. This, it would appear, was a product of an informal prior arrangement he had with colleagues that he wanted to be notified of any serious event whatever the circumstances. He was not on duty at the time, but Chief Inspector Dexter decided to self-deploy to the scene and to assume the role of GATFC, which is ground assigned tactical firearms commander. This is one of two tactical command

firearms roles based, as the name would imply, at the scene. The other tactical firearms role, the tactical firearms commander, taking over from the FDO in their ITFC role, is based remotely.

The on-duty tactical firearms commander was Chief Inspector Rachel Buckle. She was notified around 22.45 hours. In the event she did not take over from Inspector Sexton as the TFC. The reason for this was that her superior, Superintendent Craig Thompson, a specialist tactical firearms commander, was notified by Chief Inspector Dexter and so he took this role, deploying to GMP Headquarters. And so it was that at 15 minutes past midnight, Inspector Sexton handed over the ITFC role to Superintendent Craig Thompson.

In terms of the operational, or Bronze Command, role, that role was taken up by Inspector Michael Smith for the unarmed officers, as we have explained, and PC Richardson as operational firearms commander or OFC.

PC Richardson arrived at the arena at 22.39, Inspector Smith arrived at 22.45. So within 15 minutes of the explosion, both were there.

At approximately midnight, Superintendent Nawaz was replaced as incident Silver Commander by Superintendent Chris Hill, who had become aware of the incident through social media whilst at home and who had been directed by

ACC Ford to take over the position. And why that occurred will need to be explored.

In the period that followed the attack, the command structure that we've just described operated from a number of locations, those locations being the operations communications branch, the OCB, from headquarters and, as we have indicated, from the scene.

The OCB, the operations communications branch, contained the operational control rooms, or OCRs, and this is where the FDO, Inspector Sexton, and the FTS, Ian Randall, a civilian employee, were based.

The FDO first became aware that something was occurring when a force wide incident number, often called a FWIN, appeared on his screen noting reports of an explosion at the arena. Although he thought this likely a hoax, he nonetheless ordered armed officers to the scene. We've seen already that such officers attended promptly.

PC Richardson, the OFC, radioed to make plain that he'd arrived outside the arena at 22.39.50. More and yet more calls started to come in to the OCRs and steps were taken by the FDO to agree a firearms tactic with other officers. In the result, an emergency search tactic was agreed upon and in the evidence we will explore what that actually meant as a matter of

practice.

In terms of the unarmed GMP response, 3 minutes after the first FWIN entry relating to the arena, Inspector Smith had contacted the OCB and nominated a rendezvous point, an RVP. An RVP is a critical part of a multi-agency response as it permits co-location of emergency services at or very near to a scene, and from this situational awareness can develop, risk assessment can be shared, and a coordinated response considered. In other words, establishing an effective RVP is a key part of JESIP.

The precise location of the RVP declared by Inspector Smith, the GMP Bronze, is something the inquiry will need to explore. His reference point was the cathedral, although what he said and what he meant may be open to interpretation. Whatever the precise location, what is clear is that this RVP was not used. Whether it should have been and whether this would have made a difference to the adequacy and effectiveness of the emergency response are matters to be explored by the inquiry.

In the course of what was to come, a number of RVPs were declared at different times and the overall approach to RVPs across the emergency service response is a matter of importance for investigation.

For now, we'll stay with Inspector Sexton, who at 22.46 activated his dictaphone. One of the first things the recording from that device captures is that 1 minute later, at 22.47, he declared Operation Plato. Once Plato had been declared, policy required that zones be applied and for the declaration to be communicated to other emergency services as a joint response is required under the JOPs, which were developed for this very scenario, as we have explained, and indeed the third joint operating principle of JOPs requires all other interested organisations be informed of the declaration of Operation Plato. This document and its implications will need to be the subject of detailed consideration in the course of the oral evidence hearings.

Once Operation Plato had been declared, the policing experts' view is that Inspector Sexton quickly became overwhelmed. This is something which, in their view, was entirely predictable given the training exercises which had gone before. Particular note should be taken of the outcome of Exercise Winchester Accord, which may be thought to have identified many of the issues that eventuated on the night of the attack, including the impact on the FDO. Inspector Sexton's own view is that it was necessary for him to prioritise his ITFC role, so his firearms role, in preference to the FDA as he lacked

capacity to address, as he describes them, the requirements of a major incident.

One of the key issues the inquiry will investigate in relation to both GMP but also in relation to the wider emergency service response is the extent to which Inspector Sexton becoming overwhelmed, if that is what happened, had an impact on the response. In his statement, Inspector Sexton says that he only became aware later, for example, that the GMFRS NILO had tried to contact him, but that contact had not occurred because he had been busy concentrating on managing the threat in his firearms commander duty. The inquiry will need to consider whether these are precisely the lessons that should have been learned from Exercise Winchester Accord.

So far as Inspector Sexton's approach to Operation Plato zoning is concerned, he says that he regarded the scene as a hot zone, which caused him to conclude that he should not send further unprotected personnel there. Indeed, he states that he considered that he was dealing with an area which was at very high risk of further attack. He goes on to say in his first statement that despite this he did not openly declare his view that the immediate vicinity was a hot zone to GMFRS or NWAS as he knew this would hinder the emergency

response. The hot zone, as defined by Operation Plato, as we explained earlier, is an area of live terrorist activity in which only armed police should operate.

Inspector Sexton also states that he did consider seeking to remove all unarmed personnel from this area, but he could not justify this to himself because of the need to treat and evacuate casualties. He describes having taken a calculated risk that the armed officers who were present would afford adequate protection in the event of a further firearms attack. But he knew that in taking this decision, he was going against national guidance.

Inspector Sexton states that his decision-making as set out included consideration of GMFRS. He knew that they were at Philips Park Fire Station, but he states that he was not minded to draw them in because he did not want to add to the risk. Clearly, these were all highly significant decisions in the context of what took place on 22 May and the inquiry will need to examine in detail Inspector Sexton's thought processes and, moreover, its consequences.

As the post-explosion events progressed, further reports about the arena and the surrounding area were coming in to Inspector Sexton. These included a report of a gunshot wound, a report of a second perpetrator,

a report of gunshots at Oldham Hospital, and a suspicious package at North Manchester General Hospital. It will be important not to judge decision-making with the benefit of hindsight but to look at what was known at the time, and in our view the importance of that cannot be overstated.

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

The impact of all of these matters will be considered by the inquiry in assessing the effectiveness and adequacy of the emergency response. May we say that many other issues in relation to Operation Plato arise, some of which we identified in our opening statement back in September, and they will all need to be investigated, even if we do not highlight them in what we have to say today.

But one such issue is worth mentioning at this stage. It's associated with the FDO and FDS roles that night. It relates to police support staff member David Myerscough. In circumstances that the inquiry

will explore, he came to be answering the FDO telephone line. He was manifestly not qualified to do so through no fault of his own. In his own words:

"I was in a situation which I wasn't trained for and lacked relevant experience for."

The inquiry will examine the extent of the impact of the role Mr Myerscough ended up playing on the performance of the OCB.

But to give just one example of a difficulty faced by Mr Myerscough, shortly before midnight he spoke to GMFRS Station Manager Andy Berry on the FDO line. The discussion was about forward control points. Mr Myerscough, after a substantial delay, came back with an RVP, which was dismissed by SM Berry. After further delay and obviously relaying what he had been told, Mr Myerscough offered another location, but that was also rejected by SM Berry. The conversation was plainly unsatisfactory and the very antithesis, we suggest, of promoting the joined-up approach which was required in the circumstances and which JESIP dictated.

In short then, the events at the OCB and the decisions of those working there and their actions will need to be the subject of close scrutiny during the course of chapter 10.

Sir, we're going to turn next to what was occurring

at the headquarters of GMP so this would be a convenient moment to break for lunch.

Could we resume, please, at 2 o'clock?

SIR JOHN SAUNDERS: Yes, certainly. Thank you very much. 2 o'clock.

(12.57 pm)

(Lunch adjournment)

(2.00 pm)

MR GREANEY: Sir, just before lunch I was continuing with part 3 of the opening statement and I had dealt with, in relation to GMP, the events in the operations communications branch, the OCB. Of course earlier today I dealt with events on the ground so far as GMP are concerned, which leaves over the question of what was happening at the headquarters of GMP in the period after the explosion. I'll turn to deal with that now.

The Silver Commander for the period covering the first hour and slightly beyond after the explosion was, as we have indicated, Superintendent Nawaz. He did not go to the scene but instead travelled to headquarters. The inquiry will need to examine that decision in some detail. This was, as we have said already, indisputably a major incident. As such, the GMP major incident plan should have been activated and the major incident plan directs that the tactical commander, Silver, attends the

scene. This is so for a number of reasons which the inquiry will explore and it will be important for the inquiry to consider whether or not the GMP Silver Commander going to headquarters rather than the scene improved or hampered the response of GMP and/or any other emergency service. This will include consideration of whether a tactical commander concerned exclusively with unarmed assets at the scene would have improved the emergency response.

Chief Inspector Dexter, who took up the tactical command on the ground for the firearms assets, has stated that he did not consider himself to be also in charge of the unarmed officers and this accords with the policing experts' view and also that of Inspector Sexton. However, GMP has suggested that this was Chief Inspector Dexter's role and that, as such, there was no need for an unarmed tactical commander at the scene.

Which perspective is correct, whether indeed both may be correct, and whether it made any difference to the adequacy and effectiveness of the emergency response are all matters for the inquiry to explore.

Following his initial contact with the FDS, Ian Randall, at 22.39, at 22.50 Superintendent Nawaz was called by Inspector Sexton, the FDO, who confirmed that

there was ten dead and that he had declared Operation Plato, as it was, as Inspector Sexton described it, a terrorist attack.

In a statement, Superintendent Nawaz states that he decided not to declare a major incident as Operation Plato was underway. However, he also states that at the time he had no knowledge of what Operation Plato was and had to ask Inspector Sexton. He states that he did not appreciate that Operation Plato addressed a specific type of terrorist attack.

By contrast, Inspector Sexton, who was responsible for the Operation Plato declaration, states that he expected the major incident protocols to be followed whilst he got on with managing the firearms side of the incident.

The inquiry will plainly need to investigate this mismatch of understanding, the extent to which it contributed to no major incident being declared by GMP until 1 am the following day, and whether the lack of an early declaration of a major incident by GMP with the actions which ought to flow from that had any effect on the adequacy and effectiveness of the emergency response of GMP and indeed viewed overall.

It appears that Superintendent Nawaz was the first to arrive in the Silver room at HQ. At 23.00 hours he

contacted FDS from that location. Superintendent Nawaz states that shortly after he arrived, others began to arrive. At 23.20, he briefed ACC Ford in person in her role as Gold Commander.

Superintendent Nawaz, as we explained earlier, was relieved of Silver Command at about midnight by Superintendent Hill and that appears to have occurred on the instruction of ACC Ford. He stayed on in support of Superintendent Hill rather than revert back to night Silver as this role was taken by Chief Superintendent Evans.

The policing experts are not only critical of the fact that Superintendent Nawaz did not attend the scene, they also criticise what they consider was a lack of real tactical decision-making by him during the period that he was Silver Commander. The inquiry will examine whether that criticism is justified and, if it is, whether it made any difference to the adequacy and effectiveness of the emergency response. This will necessarily involve consideration of the extent of Superintendent Nawaz's understanding of Operation Plato on the night, something which he states bore upon why it would have been irresponsible for him to make any unilateral decisions in relation to a plan.

The final GMP commander to further introduce at this

stage is ACC Debbie Ford, but we'll do so only briefly. She received notice of what had happened at 22.52 when she was awoken by Superintendent Nawaz's call. She explains that she was initially very shocked and found it difficult to comprehend what she was being told. She explains that her instruction to Superintendent Nawaz was to get more information from the FDO and to open up the Gold and Silver rooms.

She then devised a strategy, got dressed, made a number of calls, including to the chief constable and the head of North-west Counter-terrorism Unit, Chief Inspector Russ Jackson, and then she made her way to GMP Headquarters. She states that she was unable to get through to the FDO whilst travelling and, as we have explained, she was not the only one.

At 23.15, Superintendent Hill contacted ACC Ford, volunteering to be the Silver Commander, which offer she accepted.

At 23.20, she received her briefing from Superintendent Nawaz, from which point she remained at headquarters until the conclusion of the incident.

From that point, the point we've identified already, Superintendent Hill took over as Silver from Superintendent Nawaz. He, Superintendent Hill, then sought to activate the casualty bureau but encountered

difficulties because of the telephone system. In the event the casualty bureau was active by 1 am.

Shortly after 1 am, ACC Ford confirmed, as we explored earlier, that GMP had primacy in her conversation with ACC Smith of BTP.

At 01.29 hours, ACC Ford asked Detective Superintendent Chadwick to activate the Greater Manchester mass fatalities plan.

Finally, so far as our selective summary of the actions of ACC Ford is concerned, we note that it was not until some time after the period upon which we are focused, namely at 4.15 am, that the first strategic coordinating group meeting took place, which brought together for the first time the Gold leads of all of the emergency responders. Whether this should have occurred sooner and what effect that might have had, had it occurred, will need to be investigated.

We'll turn next to the NWAS command structure on the night. Neil Barnes was the NWAS Gold Commander on the night of the 22nd. He was also NWAS deputy director of quality. He was made aware of the bombing at 22.40. He mobilised later after the NWAS national NILO and tactical adviser, Steve Taylor, informed him of the need to go to GMP Headquarters and that is where he went.

Following his arrival at headquarters, he commenced

his decision log at 00.35. By this time, all patients had been evacuated from the City Room and all of the 22 deceased had been declared dead. So in those circumstances the inquiry will need to consider whether Neil Barnes made any real contribution to the emergency response.

Annemarie Rooney is the NWAS sector commander for central Manchester and also holds a role as a tactical commander. She was NWAS Silver Commander on the night of the bombing. She was informed of the bombing at 22.38 by the duty manager of the NWAS emergency operations centre, the EOC, and the name of the duty manager is Nicola Pratt.

In discussion with Nicola Pratt, Annemarie Rooney requested the attendance at the arena of HART. She also informed Nicola Pratt that the EOC needed to make reference to their Operation Plato cards because the information available at that stage indicated that a marauding terrorist firearms incident might be underway. However, she, that is to say Annemarie Rooney, was subsequently informed by Nicola Pratt that this was not an MTFA and that instead EOC staff were using the major incident action cards.

Annemarie Rooney travelled to GMP Headquarters, arriving there at 23.12. Having arrived there, she

describes being informed by Superintendent Nawaz and ACC Ford that what had occurred was not a shooting incident. However, at 00.18 hours, she was informed by GMP tactical commander Chris Hill that Operation Plato had been declared at 22.47, just over 90 minutes earlier. She was surprised and confused by this, as on more than one occasion she'd been told by GMP that there was no active shooter.

As we've made plain a number of times now, whether Operation Plato was correctly declared and, if so, whether it remained in place for too long are issues for the inquiry to consider. We will need to consider whether there was a clear understanding within the emergency services of what Operation Plato really meant and whether, on the night, it really applied.

Dan Smith is a consultant paramedic with NWAS and alongside that position held a role as a tactical commander. As we've explained already, he performed the role of Bronze Commander on the night of the bombing. He mobilised following a call at 22.41 from Annemarie Rooney and went to the scene. He set up a casualty clearing station as we have said, a CCS, on the station concourse, an area across the bridge from the City Room and down the stairs near the entrances from Station Approach. In his witness statement

Dan Smith explains that this was a deliberate decision because he considered that it would not have been safe to position the CCS nearer the City Room.

Dan Smith also spoke to Patrick Ennis, who, as we have observed already, was the first paramedic on the scene. Patrick Ennis told Mr Smith that there were many casualties and deceased in the City Room. However, the Bronze Commander, Dan Smith, did not enter that area itself and so, it would seem to follow, never made his own assessment of the position.

In his statement, Dan Smith recalls that at 23.00 hours the HART team arrived, although in fact it was about 15 minutes later. As we've made clear, this was the team that was trained and equipped to operate in a hazardous area. Mr Smith was advised that two members of that team had volunteered to enter the City Room. He said that whilst he could not guarantee their safety, he was, as he puts it, "fairly happy" that an MTFA was not underway and that the presence of "vast numbers of firearms officers" was sufficient to ensure safety.

Later, at 23.55, NWAS deputy director of operations Steve Hynes arrived and took over as Bronze Commander from Mr Smith. As will be obvious, this was at a late stage of events and the principal involvement of Mr Hynes was at 00.15 when he asked Chief Fire

Officer O'Reilly in a phone call for the attendance of 12 trauma-trained firefighters and a commander.

In the course of the evidence, the inquiry will need to examine the decision-making of Dan Smith and, if it concludes that mistakes were made, consider why that was, including whether he was adequately trained for the role he was required to perform that night.

Having identified the NWAS command structure on the night, we'll return to the chronology so far as NWAS command is concerned. We will not be dealing with every single time in that chronology, just those that seem to us as counsel to the inquiry to be of particular relevance.

Patrick Ennis, the NWAS advanced paramedic, must have arrived at the scene at about 22.46 because at that time he passed the following message to NWAS control:

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

at Victoria Station."

By this time, as we've observed, the EOC had spoken to Annemarie Rooney, tactical and Silver Commander, who had requested escalation to Gold Command and instructed the deployment of HART. The reality must be that control at this time knew full well that the incident was not restricted to six or eight casualties who were all walking wounded and, furthermore, Patrick Ennis was himself quickly to discover this was not the case and that the situation was in fact much, much worse.

At 22.49.53, Patrick Ennis is captured on Station Approach, approaching the war memorial entrance. He enters Victoria Railway Station 30 seconds later and was captured speaking on his radio as he did so. This was to be the first involvement of any officer of NWAS at the scene.

It's important to point out that as we currently understand the evidence, neither the attendance at the scene of Patrick Ennis nor his entry into the City Room were at the direction of an NWAS commander or as part of the implementation of a jointly agreed plan between the emergency services. Instead, it seems that Patrick Ennis had self-deployed having been made aware of the incident and had followed a police vehicle to the scene.

At 22.50.55, Patrick Ennis was recorded in conversation with a number of GMP officers on the station concourse. It was by now nearly 20 minutes after the explosion, there was only one paramedic at Victoria Railway Station, and he had not yet entered the City Room or treated a single casualty and indeed had attended voluntarily and not due to any instruction or direction. The inquiry will need, we suggest, to consider whether that represents a reasonable level of response by an ambulance service.

Between 22.51.38 and 22.52.59, Patrick Ennis made his way to the City Room via the raised footbridge. In the course of his journey he stopped briefly by some injured persons who were on the footbridge receiving treatment from others. Mr Ennis met up with GMP Inspector Smith at the raised footbridge entrance to the City Room. That occurred 22.53.01. Then, he entered the City Room.

When he gives evidence, we'll need to consider with Advanced Paramedic Ennis his actions once in that area. We will want to understand, among other matters, whether, as seems likely, he developed situational awareness that there was no marauding terrorist in the room, that there were dead, dying and injured people within the room in need of urgent medical attention,

that no stretchers were available, even though many of those injured could not walk, that there was a need for dressings and tourniquets to stem bleeding, that first aid and CPR efforts were taking place in the absence of paramedics and doctors, provided by security staff, members of the public and ETUK, who had limited supplies and, for the most part, no medical training, and that the police officers present in particular were asking in particular when the ambulances and paramedics would arrive in the room.

If, as we suggest it ought to have been, such situational awareness was developed by Advanced Paramedic Ennis, the inquiry will no doubt want to understand what was done in response.

At 22.59.57, Patrick Ennis is recorded leaving the City Room via the raised footbridge. At about this time, Dan Smith and NWAS doctor Michael Daley were arriving.

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

However, what is clear is that by 23.11, some 40 minutes after the explosion, Patrick Ennis was the only NWAS paramedic to have been into the City Room. As

we've observed already, the inquiry will need to consider whether that represents a reasonable level of response by an ambulance service.

As we explained this morning, at 23.14.04, NWAS HART paramedics, Lea Vaughan and Christopher Hargreaves, entered Victoria Railway Station. The CCTV indicates that they made their way directly to the City Room, where they arrived 1 minute later. As we have explained, the evidence indicates that they volunteered to enter that area. Once in the City Room, they spoke to Patrick Ennis and then started to move between casualties. Those two were the only HART paramedics to enter the City Room and the inquiry will need to consider why that is so, given that other HART paramedics were present in the station and they were, as we have now said a number of times, trained and equipped to enter a hazardous environment, even assuming that by 23.15 the City Room could properly have been described as such.

So only three NWAS paramedics ever entered the City Room during the critical period. An important issue for the inquiry to consider is why that was and whether it represents a reasonable response by NWAS to the attack on the arena. NWAS argues that it does, but if it does not, we will need to assess what went wrong

and what impact that had on the treatment of those who had been injured in the explosion.

NWFC and GMFRS obviously also formed a critically important part of the response that night by the emergency services. We will deal with their response in three phases: first, initial notification and response; second, multi-agency communication; third, the response from 22.50 hours. We can deal with the essential facts briefly.

First, initial notification and response. The first notification to NWFC of an incident at the arena came at 22.34, so 3 minutes after the detonation by Salman Abedi of his bomb. The NWFC control room operator -- we will refer to people in that role as CROs -- David Ellis was informed at that time of reports of an explosion in the foyer of the arena whilst talking to GMP about an incident that was unrelated. During the same call, GMP advised him that a bomb had exploded.

Later in the call, GMP told NWFC that injuries at the arena appeared to have been caused by shrapnel, that it was believed that there were between 30 and 40 casualties, but that was unconfirmed, and that they were still looking for a secondary device. It follows that NWFC had early notice that a shrapnel bomb appeared to have exploded in the foyer to the arena, in other

words within the City Room, resulting in multiple casualties.

At 22.37, NWFC CRO Joanne Haslam received a call from NWAS Control stating that a bomb had gone off at the arena. Between 22.43 and 22.46, during the same call, NWAS informed NWFC that there were reports of an active shooter, that there were potential gunshot injuries, and that there were approximately 60 casualties.

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

We've just said on the initial accounts because further statements of the relevant witnesses have been served on the inquiry by NWFC in which it is explained that NWFC staff did not in fact open or follow the bomb action card and it appears that there is independent support for that from the NWFC records.

As with all issues of fact, this will need to be explored in the evidence and a determination made on that basis. As we have said a number of times now, no one should jump to conclusions. A determination about the decision-making within the NWFC control room will need to be made on the basis of an assessment of the evidence that's actually given by the relevant witnesses and by reference to contemporaneous documentation.

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

In that call, SM Berry rejected the Cathedral Car Park RVP and suggested that the fire and rescue service would normally muster and added that, "The RVP should not be that close, we would not want central", to use his actual words.

SM Berry suggested Philips Park Fire Station, some 3 miles from the scene, and Michelle Gregson accepted that. Philips Park was not a multi-agency RVP and the reasons for the fire and rescue service locating there will need to be scrutinised along with NWFC's reasons for agreeing to that.

The recording of that call that we've just described will be played during the evidence of Inspector Russell. When it is played, it will be important to bear in mind that in his witness statement SM Berry states that he was concerned that the RVP at Cathedral Car Park was a predetermined RVP and would not be safe. He states:

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

However, given the timing of the call, the explosion had of course occurred nearly 10 minutes earlier. SM Berry suggests in his witness statement that NWFC had made the decision that GMFRS would not mobilise. An assessment of whether that is or is not correct will need to be made in the light of the call and in light of

all of the evidence.

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

As SM Berry was identifying Philips Park as the RVP for the fire and rescue service and commencing his journey, a number of calls were taking place. At 22.41, NWFC received a call from a member of the public who stated that there had been a bomb blast that had caused shrapnel injuries. The caller suggested that based on looking at the casualties, the blast may have been the result of "a dirty bomb of some description". While on the line to SM Berry, NWFC asked whether he wanted the information that had been received from this member of the public at that moment, to which SM Berry replied, "No".

At 22.42, NWFC received a call from GMP confirming that there had been an explosion at the arena. Two minutes later at 22.44, NWFC received a call from BTP, requesting confirmation of the number of Fire Service units being deployed to the arena. The NWFC CRO

confirmed that none had been deployed and stated they would call BTP back once they had further information.

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

At 22.48, SM Berry called NWFC and spoke to CRO Dean Casey. CRO Casey stated that they had received reports of a bomb exploding, 60 casualties, and reports of an active shooter. SM Berry stated that further GMFRS resources were going to rendezvous at Philips Park until, and again we quote his words, "We are instructed otherwise and we get some more information about this incident".

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

While SM Berry was on his way, NWFC received updates indicating that GMP officers and ambulances were travelling to the scene and that casualties were receiving treatment. In other words, NWFC received

information that some emergency services were deploying to the arena and the inquiry will plainly need to consider what impact this should have had on the decision-making of the fire and rescue service and NWFC. In other words, should they have thought: other emergency services are deploying to the scene, would it be sensible for the fire and rescue service to do the same? Whether that's a fair question will need to be answered once the evidence has been heard.

SM Berry arrived at Philips Park at approximately 23.41, an hour after first being informed of the incident, following delays caused, it would seem, by roadworks and traffic difficulties on the route.

Next, multi-agency communication and the fire and rescue service and NWFC. Although Cathedral Park had been the initial multi-agency RVP nominated by GMP at 22.37, the RVP was updated to Hunts Bank at approximately 22.54. The RVP was yet further updated by GMP to the Old Boddington's Brewery at approximately 23.30. The time at which NWFC and GMFRS were made aware of these RVP changes will need to be considered thoroughly given GMFRS's lengthy absence from any multi-agency RVP.

As we have explained already, BTP declared a major incident at 22.39. NWAS made a similarly timely

declaration and the GMP FDO declared Operation Plato at 22.47.

At 22.54, an NWAS officer at the scene provided METHANE information relating to scene, situational awareness, casualty numbers and the types of injuries sustained.

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

Evidence from GMFRS and NWFC staff indicates that this information, indeed this important information, was not communicated to the fire and rescue service and NWFC until significantly later. The time at which NWFC and GMFRS were made aware of this information and the reasons for any delay will require careful examination.

There was plainly, from an early stage, much information to provide to GMFRS and NWFC. The question is: when was it provided? If not promptly, as may be the case, then why not? These are issues, among others, that we will need to explore given that the procedures and indeed good sense required the emergency services to be working together to respond to the arena attack.

Next, the response of GMFRS and NWFC from 22.50 hours and onwards. At 22.52, NWFC notified Dean Nankivell, the GMFRS duty group manager, of the incident. He proceeded to the headquarters not of GMP but of GMFRS to begin setting up the command support room or CSR. Several other GMFRS senior officers also attended the CSR at the GMFRS headquarters, including the then Chief Fire Officer, CFO Peter O'Reilly.

At 23.35, Station Manager Mick Lawlor, who was off duty and at home, mobilised to GMP HQ to obtain situational awareness directly with GMP and to support the fire and rescue service deployment. SM Lawlor arrived at GMP Headquarters at 00.04. He obtained accurate operational information which he transmitted to the GMFRS NILO talk group.

Meanwhile, the team of GMFRS NILOs and responders who were still assembled at Philips Park RVP, a little under 3 miles from the arena, had already become aware that NWAS was using the Manchester central fire station as a holding area prior to deploying to the scene. Conversations were held between those at Philips Park and the CSR and it was eventual agreed they would travel to Manchester central station and co-locate with NWAS. They arrived at central station at approximately 00.13.

At approximately 00.12, just 1 minute earlier, the

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

As we observed earlier today, between 00.37 and 00.39, three fire engines and SM Berry arrived at the station. This was the first GMFRS deployment at the scene. That attendance was subsequently supplemented by the attendance of two further engines and another officer. GMFRS specialist resources were never deployed to the scene.

As is therefore obvious, fire engines did not arrive at the scene until more than 2 hours after the bomb had been detonated. This has been the subject of much public concern and indeed comment by Lord Kerslake.

The expert instructed by the inquiry considers that both GMFRS and NWFC were in a position on 22 May to provide an adequate and effective fire and rescue service response to the arena attack, but goes on to conclude that the overall fire and rescue service response, certainly within the first 2 hours of the incident, was "inadequate and ineffective". The inquiry

will need to consider whether that criticism is well-founded.

That is all we propose to say in outlining the facts so far as currently understood in part 3 of this opening statement. As we hope we have made clear, we have not sought to set out every single relevant fact and we acknowledge that there may be different opinions to be explored during the course of the evidence. But we hope that what we have said, both in September and moreover today, will at least provide a framework within which we can consider the evidence once we start to call it.

We are going to turn next to part 4, but again the screens in the hearing room have gone blank, so I'm going to pause to check that you are able to see and hear what is happening here.

SIR JOHN SAUNDERS: I'm sorry about that. I do, as you know, have the note of what you're saying. I shall be able to catch up on the very small amount I have lost. I have no idea when I lost contact, it may be something that I did, but anyway I have now regained contact.

MR GREANEY: Sir, if you lost touch with the hearing room, it may be that others also lost touch with the hearing room. We'll check whether that's the position. If that's so, it can't have been for very long and no doubt people can catch up on the transcript. But I can see

Mr Cooper would like to say something.

MR COOPER: Simply to say I certainly did not lose communication, so for my part it was seamless, but others may have had difficulty.

SIR JOHN SAUNDERS: I expect it was my fault, me doing something wrong, Mr Cooper, but I have no idea what it was, but it was not for long and I do have a script. I will certainly check up on any bit I have missed. I have noted every word.

MR GREANEY: Thank you very much.

For your benefit, everyone else will know we are turning now to deal with part 4, which involves the identification of issues in relation to what we have described and experts have described as survivability.

When we made our opening statement in early September, we explained that in chapters 11 and 12 of the oral evidence hearings expert evidence will be given by a group that we described as the blast wave experts. We've explained already why they are particularly experienced and able therefore to assist in this area of survivability.

In chapter 11 their evidence will be confined to giving an overview of the effect of a detonation in order to provide the context for the following chapter.

Chapter 12 will be concerned, as we said earlier

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

But their evidence, the blast wave experts, on that topic, has been supplemented now by other expert evidence in certain limited respects, but although limited, important respects.

As we have made plain already, the experience of each of the 22 murdered by the bomber and his brother must be the subject of the most close scrutiny in chapter 12. However, it is relevant to note at this stage, as we consider whether or not the emergency response was adequate, that issues of survivability do exist in relation to two of those who died, john Atkinson and Saffie-Rose Roussos.

Sir, before continuing, we pause to note that we are

going to deal next, in a little detail, with both John and Saffie, detail which is capable of being particularly distressing, we recognise, for their loved ones, and as such we'll give just a moment for people to prepare themselves or to walk away from their screen. If it helps, we estimate this next part of our opening statement will take about 5 minutes. Anyone wishing to step away will be able to return after that period.

(Pause)

First, sir, we'll deal with John Atkinson. John entered the City Room at 22.30.49. When the bomb went off, he was about 6 metres away. Immediately following the explosion, John managed to drag himself away in the direction of the Fifty Pence staircase. Fewer than 2 minutes after the explosion, John was being tended to by Ronald or Ron Blake. Mr Blake was at the arena to pick up his daughter. He stayed with John for just short of an hour until John started to receive treatment from paramedics. He applied a tourniquet to John's leg. A number of people interacted with John whilst he was in the City Room and during this period he was conscious and able to speak.

At approximately 23.17 hours, John was placed on to an advertising board and dragged by a number of people out of the City Room. The intention was to take him in

the lift but it proved to be unsuitable. As a result he spent a period of time on the raised footbridge whilst a metal crowd barrier was found and placed underneath the advertising board. John finally reached the war memorial entrance to Victoria Railway Station at 23.25.47, just under 10 minutes after he left the City Room. John was then treated by a number of paramedics.

At 23.34, his pulse was recorded as 62 beats per minute, but at 23.48 he suffered a cardiac arrest. At 23.59, the ambulance John was subsequently placed in departed for Manchester Royal infirmary, where he arrived 7 minutes later. Despite the efforts of those treating him, he was declared dead at 00.24.

Conducting the post-mortem examination, the pathologist, Dr Naomi Carter, found that John had sustained very severe leg injuries. He also had abdominal injuries. Dr Carter concludes that John's collapse from hypovolaemic shock, so cardiac arrest due to inadequate blood volume filling the circulation, would accord with a history of initial consciousness when first formally treated by NWAS, followed by a cardiac arrest.

In the course of her examination, Dr Carter identified that John had significant heart disease,

known medically as ischaemic heart disease. Dr Carter considers that this may have contributed to his death by making his heart more susceptible to failure and/or that it potentially reduced the chances of resuscitation. As such, she recorded it as a contributing factor in John's death.

The blast wave experts characterised John's injuries as being potentially survivable, subject to the extent to which his ischaemic heart disease may bear upon this question. The blast wave experts state that the impact of the heart disease is a matter outside of their expertise. By reason of the comments of Dr Carter and the fact that the blast wave experts consider the impact of John's heart disease as being outside their area of expertise, the inquiry instructed Dr Paul Rees.

Dr Rees is a consultant in cardiology, general internal medicine and pre-hospital emergency medicine. He has considered the circumstances of John's death by particular reference to what effect John's ischaemic heart condition may have had and his conclusions are stark.

On the balance of probabilities, Dr Rees considers that John's heart condition did not contribute to John's blood loss, to his cardiac arrest or to the inability successfully to resuscitate John. In short, Dr Rees'

opinion is that John's heart condition did not make any difference to whether or not John would have died and it follows therefore that the opinion of the blast wave experts remains that John's injuries were potentially survivable.

Second, Saffie-Rose Roussos. Saffie entered the City Room at 22.30.45 with her mother and sister. Saffie was standing about 5 metres from the explosion. About 4 minutes after the blast, Saffie was approached by Paul Reid, who was present at the arena with a view to selling posters after the concert had finished. Mr Reid was to stay with Saffie until she was taken to hospital in an ambulance. He was joined by a member of staff from SMG.

Approximately 10 minutes after the explosion, two medics of ETUK, Marianne Gibson and Elizabeth Woodcock, started to tend to Saffie. At 22.53.07 an off-duty nurse, Bethany Crook, began to help. Ms Crook's attempts to help those in the City Room were, it might properly be said, nothing short of heroic.

In Saffie's case she took charge of the situation and sought to assist Saffie with a number of police officers. A piece of advertising board was used as a makeshift stretcher and Saffie was carried through the Trinity Way link tunnel. A passing ambulance was

flagged down on Trinity Way and she was taken to hospital, leaving the area of the arena at 23.15.51 and arriving at hospital at approximately 23.25. Once at hospital, she received treatment, but it was to no avail and Saffie was declared dead at 23.40.

The post-mortem examination in Saffie's case was carried out by the pathologist, Professor Philip Lumb. He concluded that Saffie's death was caused by multiple injuries. In their first report, the blast wave experts characterised Saffie as being unlikely to survive her injuries, but they did not say that they were certainly unsurvivable. However, in an addendum report dated in March of last year prepared following the consideration of further material, the blast wave experts concluded that Saffie's injuries were unsurvivable with current advanced medical treatment.

Evidence has, however, been received recently by the inquiry from additional experts. That evidence has been received via the family of Saffie, although the inquiry legal team was consulted. The experts that we've just referred to are Dr Gareth Davies, consultant in emergency medicine and pre-hospital care, and Lieutenant Colonel Claire Park, a consultant in intensive care and pre-hospital care.

They observe Saffie sustained serious injuries to

her chest, abdomen and legs. She was, they observed tended to by members of the public, first-aiders, police and ambulance staff who recognised the seriousness of Saffie's injuries and cared for her with compassion and a clear desire to help save her life.

Ultimately, the experts conclude, blood loss from the injuries to Saffie's legs eventually led to her heart stopping and her death.

These experts, Dr Davies and Lieutenant Colonel Park, consider that the injuries in isolation or in combination, although severe, did not reach a threshold where they would be considered incompatible with life and so they consider that Saffie may have survived.

These experts and the blast wave experts will meet in order to identify areas of agreement and disagreement, if any, in order to assist the chairman when he hears evidence on this issue. Whilst it is plainly, in the view of counsel to the inquiry, important that core participants and the public should understand that survivability is a potential issue in the case of Saffie, we do not propose to say more at the moment because the core participants most directly affected, save for Saffie's family, have not yet had sight of the report and of course, as we have just said, the experts have yet to meet.

We have mentioned, may we say, these two cases not to increase the distress of anyone or to emphasise the awfulness of what happened, but instead to make clear that we are not investigating the emergency response on some theoretical basis, drawing it against some assumed list of points. Instead, we are considering how an emergency response may save lives and, if so, by what means that is to be achieved and whether it was in fact achieved on 22 May 2017.

So we turn finally in terms of this opening statement to part 5, the issues. As we have said already, on the material available there are issues which cut across all of the emergency services. The joint report from all three groups of emergency service experts identifies the areas in which they consider there are cross-emergency service areas of concern and criticism. Those include whether JESIP was sufficiently embedded within each service, whether the emergency plans for each service were well developed, whether the learning from Exercise Winchester Accord had been translated into real world improvements, whether Operation Plato was understood by all of those who needed to know what it meant, whether there was adequate focus on a multi as opposed to single agency response, particularly at a command level, whether there was an

adequate tactical level of command at the scene, whether a lack of co-location impacted adversely on the quality of the emergency response, whether the control rooms of each agency communicated adequately with each other, whether situational awareness was shared between services particularly in relation to Operation Plato, and whether there was an over-reliance on the force duty officer at GMP.

Each of these and inter-service issues will need to be considered in the course of chapter 10, both by reference to the overall response and in the case of each emergency service, and we will need to consider how their particular response contributed to the overall response.

Over and above these cross-emergency service issues we identify at this pre-evidence stage the following as matters for focus within the chapter 10 phase of this inquiry.

First, ETUK. Whilst not a Civil Contingencies Act responder, the first aiders arranged by SMG were amongst the first to arrive in the City Room. It will be necessary to understand how that organisation came to be providing that service and to examine whether or not those who staffed it, brave as undoubtedly they were when entering the City Room, had received an adequate

level of training in order to be able to contribute meaningfully to the work of the emergency services. And whilst we'll begin to consider this during chapter 10, we anticipate hearing from the majority of the first-aiders themselves during chapter 12.

Second, BTP and GMP. For present purposes, we take both policing services together. As we said when we made the opening statement in September and have repeated today, there are important issues for the inquiry to explore in relation to each surrounding primacy. As we have said, this is an issue in relation to which the inquiry has already generated a discourse between the two police services which had not previously existed and we will await an update.

The involvement with and commitment to the Local Resilience Forum by both GMP and BTP. Whether police officers responding to the incident were adequately equipped and/or trained in relation to the latter both in terms of their role within JESIP and in first aid.

Also, the adequacy of command, which is a topic encompassing whether GMP Silver should have gone to the scene through to whether or not BTP's command structure made any positive material contribution to the response at all.

Third, NWAS. As we've already said, there exists

a very important question about the location of the casualty collection point. Was the bottom of the staircase to the City Room the correct location or should it have been the City Room itself may be the critical question or a critical question when it comes to the life of at least one of those who died. Allied to this is the question about why so few paramedics entered the City Room at all, particularly given the difficulty in evacuating the most seriously injured, which undoubtedly existed.

Fourth, and finally, GMFRS and NWFC. As is now widely known, the single biggest question surrounding the fire service's response is why the on-scene attendance occurred as late as it did. Was this a failure in NWFC's procedures, an aberrant decision at a command level, a product of the unavailability of the GMP FDO, a combination of all three or some other reason? Connected to these is the question of whether the delay in attending by GMFRS made a material difference.

In short, we are determined to ask these questions in the course of the evidence in order to discover what GMFRS's role was and what it might have been.

That brings us to the end of our opening statement on chapter 10 and it remains only to say that the

inquiry continues to be, as the chairman has said, a search for the truth.

Sir, the next stage is for Inspector Russell to be called to take us through the sequence of events and to introduce the relevant audio recordings. We've been going for just an hour and in any event we would request a break before that starts. May we have a break for 20 minutes, please?

SIR JOHN SAUNDERS: Yes, certainly. Let's make it 3.25. So that's just over the time. Thank you.

MR GREANEY: Sir, may I indicate before we go to the holding screen that Mr de la Poer will be calling this next section of the evidence.

SIR JOHN SAUNDERS: Right. Thank you, Mr Greaney, for that extremely clear opening of what the issues are going to be in chapter 10. Thank you for that.

MR GREANEY: Thank you, sir.

(3.03 pm)

(A short break)

(3.25 pm)

SIR JOHN SAUNDERS: Mr de la Poer.

MR DE LA POER: Sir, can I begin by confirming that you can see and hear me, please.

SIR JOHN SAUNDERS: I can, yes, thank you.

MR DE LA POER: Thank you, sir. In terms of the shape of

the remainder of the day, with your agreement, sir, what I propose is that we go until about 4.30, which will follow the pattern that Mr Greaney has established of periods of hearing of about an hour.

SIR JOHN SAUNDERS: That's fine. You choose the time when we finish.

MR DE LA POER: Thank you very much indeed, sir.

Next I hope that you will be able to see, sir, that we have in the witness box Detective Inspector Mike Russell.

SIR JOHN SAUNDERS: Yes, I can. Thank you very much indeed, Mr Russell, for coming to the hearing.

A. You're welcome, sir.

MR DE LA POER: Can I please confirm with you, sir, that you are content, bearing in mind that the detective inspector has previously been sworn, there's no need to re-swear him now?

SIR JOHN SAUNDERS: Absolutely, thank you.

DETECTIVE INSPECTOR MIKE RUSSELL (recalled)

Questions from MR DE LA POER

MR DE LA POER: Thank you. Before I begin my questioning of the detective inspector, can I say this about the evidence that we are about to embark upon and which will continue tomorrow and into Wednesday. The sequence of events we are going to consider shows images after the

explosion. This will include images of parts of the City Room. Considerable care has been taken to apply redactions to anything which is overtly distressing. The aim has been to conceal any images of physical injuries and any image of any of those who lost their lives. Further, any image showing a person who appears to have been under the age of 18 has also been redacted to the extent required to avoid them being identified.

However, notwithstanding those efforts and the removal of what I've described as overtly distressing images, there can be no question but that seeing these images at that time has the capability to distress those watching.

Additionally, audio involving the emergency services will be played. This will include 999 calls, calls between emergency services, and calls between individuals within each service. We will interpose that audio into the sequence of events stills.

We are also going to play three short pieces of video towards the start of our progress through the sequence of events. All of those pieces of video were played during Mr Greaney's opening statement in September, but we will give a particular warning in relation to the playing of each of these.

It is important to stress in the judgement of the

inquiry legal team that the audio is capable of being highly distressing, notwithstanding efforts which have been made to avoid, where possible, the most distressing material. On behalf of the inquiry legal team, may I urge anyone watching to ensure that they are in an appropriate setting to receive this material and have considered, particularly in the circumstances of lockdown, what support structures are in place for them.

As I conclude what I'm saying now before turning to Inspector Russell, may I say one final thing and it is this: I make no apology for drawing attention again to the services of the NHS hub. They provide a service for anyone directly affected by the attack and details of how the hub can be contacted are on the inquiry website.

That said, detective inspector, we are going to begin our consideration together, please, of the sequence of events which has been prepared for the emergency response and identify that in the now standard way. {INQ035612/1}.

Before we look at our first image, can I just confirm three matters through you, please. Firstly, do you agree that what we have now is a starting point and there are still some names to be identified?

A. Yes, that's correct.

Q. Do you also agree that it is possible that corrections

will arise as we hear the evidence in chapter 10?

A. Yes.

Q. You having agreed with both of those, can I just say this to those listening: the inquiry legal team seeks the assistance and support of all core participants so as to ensure that by the end of chapter 10 there is as much certainty as possible.

Second point, please, inspector: is it correct that the times that are shown are as accurate as your team at Operation Manteline have been able to make them with the support, where appropriate, of other core participants?

A. Yes, they are.

Q. But to take one example, in relation to the dictaphone recordings we have, the start time is prone to a small degree of error?

A. That's correct.

Q. But nonetheless, the times that we have in the sequence of events represents the product of a lot of diligent and conscientious work?

A. Yes, they are.

Q. Included within that work there's one piece of work in particular I want to ask you about. When we began looking at the sequence of events during chapters 6 and 7 we were told on behalf of Operation Manteline that there was a concern in terms of calibration of cameras

within the station concourse.

A. That's right.

Q. Am I right in recalling that that calibration error was between 3 and 13 seconds?

A. Yes, that's right.

Q. Have steps been taken by your team to address that calibration error?

A. They have.

Q. And as a result, again relying upon those members of your team acting diligently as they have, have those timings been corrected in the document that we're about to look at?

A. Yes, they have.

Q. So this represents the most up—to—date thinking, having worked hard no doubt upon that particular issue?

A. Yes, that's right, sir.

Q. Thirdly and finally, do you agree that it is important when we consider all of this to bear in mind what is undoubtedly obvious, namely that the audio we are going to hear does not just occur in the second it starts?

A. No, that's correct.

Q. What I mean by that is this, that as we will discover, some of it goes on for many seconds and in some cases many minutes?

A. It does.

Q. And therefore there will be a degree of overlap in time between the various calls and what is shown as occurring subsequent to the start?
A. That's correct, yes.
Q. So whilst the audio has been interposed into the images, we should all have in mind that in fact time continues to move on, on the ground, as we listen to the audio?
A. Yes, that's right.
Q. Those preliminary matters dealt with, can I please invite page 2 of that INQ reference to be brought up on screen {INQ035612/2}. Can I please invite for us, as with all of these, just to crop it in to the maximum degree so we can still have all of the columns visible.
We begin with this one, please, Inspector Russell. The time here is 22.30.56.
A. Yes.
Q. So approximately 4 seconds before Salman Abedi detonated his device?
A. That's correct.
Q. Do we have here a view of the Victoria Station concourse platform side of the barriers?
A. Yes, that's right.
Q. And two individuals are identified, Philip Clegg and Niall Pentony?
A. That's correct.

Q. Were they both Travel Safe officers at the time?
A. Yes, they were.
Q. I think Mr Clegg has subsequently become a GMP officer?
A. That's correct.
Q. But at the time they were acting in a role providing security on the rail network, employed by Northern Rail?
A. Yes, I believe it was Arriva Trains.
Q. Thank you very much indeed. One thing to note about Mr Clegg, which will become particularly important when we come to chapter 12, did Mr Clegg have on him at the time, switched on, body-worn video?
A. Yes, he did.
Q. {INQ035612/3}. An image that we saw at the chapter 7 stage of the oral evidence hearings. Do we have the four BTP officers congregated at the war memorial entrance?
A. Yes, we do.
Q. The time showing is 22.31.00?
A. Yes.
Q. To identify those officers, PCSO Renshaw, PCSO Morrey, PCSO Brown and PC Bullough.
A. Yes. That's correct.
Q. So we are now going to play the first of our video footage. I will give the reference and can we please take it to the correct spot before it is played.

{INQ033797/1}. As that is being attended to and before it's brought up on screen, can I tell everybody what it is that we are about to watch. We are about to watch, as we saw in the opening, the dashcam footage from a car parked looking towards the arena and rail car park. That footage will capture the flash of the explosion. Having given everybody that explanation, can we please play it from 00:25 to 00:42.
Should we be looking in the top left-hand corner?
A. Yes, that's correct.
(Video played to the inquiry)
Q. Did we see there the flash?
A. We did, in the top left corner.
Q. So this footage then captures the moment of the explosion?
A. Yes, it does.
Q. Thank you very much indeed. We can take that down.
We are going to play the second of our three pieces of video footage, again seen during the opening. Can I explain to everybody what we're about to see so people can make their arrangements. We are going to see the mobile telephone footage taken from the arena which captures the sound of the explosion when it occurred, {INQ033795/1}.
(Video played to the inquiry)

Thank you very much. Was that mobile telephone footage which came into the possession of Greater Manchester Police as part of the Operation Manteline investigation?
A. Yes, it was.
Q. And that will be true, no doubt, of the first piece that we played as well?
A. That's absolutely right, yes.
Q. So having in those two ways captured the moment of the explosion, can we return, please, to {INQ035612/4}.
So we are about half a minute on from when we last saw these two Travel Safe officers. Is it the case that within seconds of the explosion, both these men began to move in the direction of the City Room?
A. Yes, that's right.
Q. We can see from the text that their route that they chose, as with others, was via the Fifty Pence staircase?
A. Yes, that's correct.
Q. {INQ035612/5}, please. A couple of seconds on from there, two of the four BTP officers at 22.31.37, PC Bullough and PCSO Morrey following those Travel Safe officers?
A. That's correct.
Q. {INQ035612/6}. Do we see the third of those BTP

officers, PCSO Lewis Brown, making his way to the station barriers again in the direction of the Fifty Pence entrance to the City Room?
A. Yes, we do.
Q. We heard from those two BTP officers and indeed PCSO Lewis Brown during chapter 7; is that right?
A. That's right.
Q. The fourth of those officers -- {INQ035612/7}, please -- PCSO Mark Renshaw, again clearly moving at pace in the direction of the City Room?
A. Yes, that's correct.
Q. Approximately 48 seconds after the detonation?
A. That's right.
Q. We are now going to hear the 999 call that we heard during Mr Greaney's opening statement back in September. It begins 4 seconds after the image that is on screen. {INQ019523/1}, please. So that everybody understands its duration, and as I have already warned people, its content is plainly capable of being highly distressing, particularly to the family of John Atkinson, with whom Mr Blake had positioned himself. Four minutes and 33 seconds is its duration. Before we play it, there are three speakers we're going to hear, is that right?
A. Yes, that's correct.
Q. Who are those three speakers, please?

A. Ronald Blake, who's the caller. You have the call handler, who it's unconfirmed at this time, but I understand it is Lisa Canavan from Greater Manchester Police, and then Philip Clegg will take over the call when Ronald Blake hands him the phone.
Q. So the second male voice we will hear is that of Mr Clegg, the Travel Safe officer?
A. That's correct.
Q. We will commence that 4-minute and 33-second call now, please.
(Audio played to the inquiry)
Inspector, that was the call of Ronald Blake?
A. Yes, it was.
Q. If we return, please, to our sequence of events, {INQ035612/9}. We can move straight to page 9 rather than moving through the images. Thank you very much indeed.
The top image shows PC Bullough, as marked in that white box?
A. Yes, it does.
Q. Making her way together with others towards the Fifty Pence entrance. Perhaps the bottom image is the best illustration of the way in which the audio and the video need to be understood. Do you agree that we can see in that image that Philip Clegg is still yet to make

it to the City Room?
A. That's correct.
Q. So we just need to bear that in mind as it is necessarily imperfect in terms of the way the images that we have and the audio interact?
A. That's correct.
Q. Next, we're going to go to {INQ035612/11} and again can I ask that we go directly to page 11. Thank you very much indeed.
Picking up the top image of the previous slide, do we see PC Bullough at 22.32.29 entering the Fifty Pence Piece, as it's sometimes known?
A. Yes, that's right.
Q. So that is the area which accesses the City Room via the Fifty Pence staircase?
A. That's right.
Q. It also provides access to the NCP car park?
A. It does.
Q. And through those red doors from which she is emerging is access to the railway station?
A. That's correct.
Q. As PC Bullough is entering the Fifty Pence Piece, we have our first 999 call to NWAS, is that correct?
A. Yes, it is.
Q. To the degree that it's been possible to establish it at

this stage, is the caller, the member of the public, a person who has been identified yet?
A. Not that I'm aware of.
Q. The person he is speaking to is a member of NWAS control?
A. That's correct.
Q. So that is, please, {INQ015293/1}, and again everyone will bear in mind that this is a call from a member of the public and so capable of being distressing to listen to. It's 2 minutes and 36 seconds long.
(Audio played to the inquiry)
Thank you very much.
We're going to hear, is this right, inspector, some internal radio transmissions within BTP?
A. Yes, that's correct.
Q. Is it fair to say, and I don't mean to cast criticism at anybody, that it is quite difficult to hear who is speaking and what they're saying?
A. It is, yes.
Q. Can you firstly confirm for us those people who are speaking in this clip?
A. At BTP Control, as I understand it, we have Greg Davidson and then the officers communicating with that person are Jessica Bullough, Mark Renshaw, Carl Roach, David Cawley, Stephen Corke, PC Conway and

David McMenemy.
Q. One of those voices, the female voice, will perhaps be the easiest to identify, namely PC Bullough?
A. Yes.
Q. But are we going to hear, and we'll play it through twice so people can listen to it, reports from PCSO Renshaw and PC Bullough in particular, reporting what is happening on the ground and other officers who are not present at that time responding, indicating that they are going to make their way there immediately?
A. That's correct.
Q. We won't bring it up now, but when we come to consider this further in the evidence, there will be a transcript which we can bring up on screen as well, but let's just play, please, for the first time this internal radio transmission footage from BTP. {INQ015877_C1/1}.
(Audio played to the inquiry)
Given that this is the first broadcast from the scene by the British Transport Police and bearing in mind the difficulty in catching everything, can I just ask that that is played one further time?
(Audio played to the inquiry)
Perhaps you can just help us with one piece of technical language, it may be very familiar to many, but in the course of that recording, inspector, we hear

Police Sergeant Cawley say this to officers at Victoria:
"Give me a sitrep as soon as you can."
Sitrep, please?
A. A situation report, an update.
Q. We're going to return now to the sequence of events, please, we're going to go to {INQ035612/12}, so directly to page 12, please.
Immediately following behind PC Bullough, did we have PCSO Renshaw, Philip Clegg, Reece McKay, PCSO Brown and Niall Pentony?
A. Yes, we did.
Q. And we can see that PCSO Renshaw at the time shown, 22.32.35, appears to have his right hand up towards his right shoulder?
A. Yes, he does.
Q. Is that a place that commonly police will carry a radio?
A. Yes, it is.
Q. And in fact, on the footage, and I'm sure you will accept it from me, inspector, at that precise moment within the audio footage, PCSO Renshaw can be heard saying, "Yeah, we need more assistance immediately".
A. That's right.
Q. At {INQ035612/13}, please, 22.32.44, following behind those officers, do we see PCSO Jon Paul Morrey?
A. Yes, we do.

Q. Whereas the others go up the Fifty Pence staircase, is it right that, before going to the City Room, PCSO Morrey goes into the NCP car park?
A. Yes, he does.
Q. Does his witness statement cover the fact that he offered assistance to some that he found there who were injured?
A. He did, that's right.
Q. Before we turn up the next image, can I just give this warning: we are about to see an image of the City Room now, albeit one which has been heavily redacted, but I give that warning as it's the first time that we'll be seeing such images. Hopefully once people know what to expect and the approach the inquiry legal team has taken, reassurance can be taken from it. But that warning in mind, can we go to {INQ035612/14}, please, which shows, 22.32.47, the top of the Fifty Pence staircase, is that correct?
A. Yes, it is.
Q. And the first of the emergency responders to enter the City Room, PC Bullough?
A. That's correct.
Q. Over the page, {INQ035612/15}, please, we see that Mr Clegg, who, as we have said, had on that body-worn footage, follows behind PC Bullough?

A. That's right.
Q. And 1 second later, {INQ035612/16}, do we see Mr Pentony and PCSO Renshaw have also gained the top of the staircase?
A. Yes, that's right.
Q. So we are now, can you confirm, just to root us in the timeline, because it's sometimes easy to lose sight of that with all the timings, fewer than 2 minutes post-explosion?
A. That's right.
Q. And those that were stationed down on the concourse, many of them have made it into the City Room?
A. That's correct.
Q. Just a couple of seconds later, {INQ035612/17}, do we also see the arrival of PCSO Lewis Brown and Mr McKay?
A. That's correct.
Q. Could we now please go directly to {INQ035612/19}. We're going to see a different camera angle. This is an image from within the concourse that surrounds the arena bowl; is that correct?
A. That's right, yes.
Q. And identified at 22.33.38 is a woman by the name of Liz Woodcock?
A. That's correct.
Q. Can you confirm that she was one of the first-aiders

employed by Emergency Training UK?
A. Yes.
Q. Were they the first−aiders contracted by SMG to provide first aid support to the event that night?
A. That's correct.
Q. We'll come back to them in the course of these images. The next image we're going to look at is {INQ035612/20}. It's been entirely redacted, but there is still value in bringing up this slide because it will tell us the time particular people have been identified as doing important things within their response. In this case, can you confirm that what the image shows is PCSO Mark Renshaw and Lewis Brown both leaving the City Room to go down the staircase?
A. Yes.
Q. And that they are followed by Travel Safe officer McKay?
A. That's correct.
Q. Is that because, as we shall discover, they went to seek out first aid equipment?
A. That's exactly right, sir.
Q. Thank you. {INQ035612/21} next, please. A new view from the CCTV system, this one showing Station Approach; is that right?
A. Yes, outside the front of the train station.
Q. Picked out in that white box is a BTP patrol vehicle?

A. Yes, that's correct.
Q. And has it pulled up essentially outside the war memorial entrance?
A. Yes.
Q. So we can see that that BTP vehicle response arrived at 22.34.05?
A. Yes.
Q. So just over 3 minutes after the detonation?
A. Yes, that's correct.
Q. Back to the City Room at {INQ035612/22}, again an entirely redacted image, but can you confirm please that what the CCTV depicts is that at 22.34.35, the first of the ETUK medics, Liz Woodcock, entered the City Room?
A. Yes, that's right.
Q. Next, please, {INQ035612/23}. Help us with this slide, please.
A. This is PC Stephen Corke's arrival into the station.
Q. Is he the officer who we know from the other evidence in chapter 7, who had been allocated to attend the concert, is this the time he first arrives that night?
A. Yes, sir.
Q. And we heard his voice, didn't we, in that BTP audio, indicating that he was on his way in response to these first transmissions?
A. That's correct.

Q. {INQ035612/24}, please, 22.34.43. Do we pick up again with those two PCSOs who had left the City Room, who are now making their way towards the station entrance?
A. Yes, that's right.
Q. At about that time, {INQ035612/25}, do we see another officer who's arrived, PC Matthew Martin of the British Transport Police?
A. Yes, that's correct.
Q. Do we know from the evidence that he was paired at the time that the call for a response was made with PC Corke?
A. As I understand it, yes, sir.
Q. So those two arriving in the vehicle that we saw?
A. Yes.
Q. With PC Corke going directly into the station entrance, whereas PC Martin stopped to offer assistance to casualties outside?
A. Yes.
Q. A new camera angle for today's purpose, {INQ035612/26}, please. Is this an image from win the Trinity Way link tunnel?
A. That's correct.
Q. Do we see two BTP officers travelling at pace, PC Thomas Campbell and PC Danielle Ayres?
A. That's correct.

Q. Over the page, {INQ035612/27}, is their arrive into the Fifty Pence Piece picked up in this image?
A. Yes, it is.
Q. Next, please, {INQ035612/28}. What we can see in this image is a very large number of people on the pavement and street outside the arena; is that right?
A. Yes, this is on Trinity Way, sir.
Q. So two exits from the arena area, firstly the link tunnel?
A. That's right.
Q. And that emerges, is this right, by the roller entrance?
A. That's right.
Q. Picked out at the bottom of the image, another BTP officer who's responded to the request, PC Simon Trow?
A. That's correct.
Q. At {INQ035612/29}, we're going to return to Station Approach. Do we see further BTP patrol vehicles arriving at 22.35.21?
A. Yes, that's right.
Q. Again, if we just remind ourselves where we are in the chronology. This is fewer than 5 minutes post−explosion?
A. That's correct.
Q. As we approach that 5−minute mark, we're now going to play the third and final piece of video footage. It's

just 4 seconds long. Can you confirm, please, inspector, that so far as your team have been able to ascertain, there is no timestamp on this footage?
A. No.
Q. No doubt a product of the way in which it ultimately found its way into your team's hands. So this is very much an estimated time by your team?
A. Yes, it is.
Q. So it is prone to a degree of error, but your team estimates that it was filmed approximately 5 minutes after the detonation?
A. That's correct, and that's based on who was present in the City Room at that time and what is happening.
Q. So it's 4 seconds long. Can I please ask for {INQ033798/1}.
(Video played to the inquiry)
Can you identify for us where approximately that was filmed?
A. I think that was on Hunts Bank actually, wasn't it?
Q. Yes.
A. Sorry, I do apologise.
Q. Not at all. So on the Hunts Bank or in the Hunts Bank area?
A. Yes.
Q. It captures the sounds of sirens of attending emergency

response vehicles, police vehicles, and we also see some of those who have emerged from the arena area?
A. That's correct.
Q. Returning to what is taking place inside, can we go, please, to {INQ035612/30}. There we have an image of PC Campbell of the British Transport Police, who we earlier saw running together with PC Ayres up the Trinity Way link tunnel?
A. That's right.
Q. And shortly behind him, at {INQ035612/31}, do we see PC Ayres and pick up again with the Travel Safe officer Reece McKay, who we saw earlier, leave the City Room?
A. Yes, we do.
Q. We are now going to pause in the sequence of events to listen to two pieces of radio traffic. The first, can you confirm who we will be hearing from?
A. Yes. From GMP Control, we have Dianne Bowden, we have Inspector Mike Smith and Robert Rudkin(?).
Q. In terms of Inspector Smith, is that the same Inspector Smith who assumed the role of Bronze Commander on behalf of GMP?
A. Yes, it is.
Q. So the timing of this, 22.35.11 is when it starts, and the reference is {INQ018644_C1/1}, 2 minutes and 8 seconds.

(Audio played to the inquiry)
So without going into the detail of it, do we hear discussion about an RVP?
A. Yes, we do.
Q. Which I'm sure you can confirm is an acronym for rendezvous point?
A. Yes, it is.
Q. And in the course of that transmission, Inspector Smith provides an RVP?
A. He does.
Q. While much of that conversation is going on, is there concurrently another call, this time between GMP control and North West Fire Control?
A. Yes, that's right.
Q. So the timing of this is 22.35.15 as a start time, so a start time just 4 seconds after the clip that we just listened to.
A. That's correct.
Q. This is 2 minutes and 25 seconds long. Can you confirm who, so far as being able to be ascertained, participates in this conversation?
A. Yes. As we understand it, it's David Ellis from North West Fire Control and from Greater Manchester Police it's Lisa Brooks.
Q. And the reference is {INQ04331_C1/1}.

(Audio played to the inquiry)
Again, would I be right in thinking, Inspector Russell, that much of the content of the information relayed by the GMP Control to North West Fire Control appears to have been derived from Mr Blake's call?
A. It will be, but it's likely that it's from the force wide identification number as well and updates going on there from other callers, but undoubtedly it would be Mr Blake's call that's included in that.
Q. Thank you. We're going to return to our sequence of events, {INQ035612/32}, a view of Station Approach. We pick up PCSO Renshaw. We've tracked him from the City Room, where he went originally, through the station and he is now outside by a police vehicle. Is that in furtherance of his quest to find first aid equipment?
A. Yes, it is.
Q. Back to the City Room and Mr McKay and the two BTP officers with him, {INQ035612/33}, please. Do we see that those two officers enter the City Room for the first time at 22.35.34?
A. Yes, that's correct.
Q. {INQ035612/34}, please. Do we see PC Trow, who we'd previously seen towards the bottom of that image, now making his way, 22.35.40, into the Trinity roller

entrance?
A. That's correct.
Q. {INQ035612/35}. We're back to PCSO Renshaw and PCSO Brown; is that right?
A. Yes, it is.
Q. They have now equipped themselves with a number of green boxes containing first aid equipment?
A. That's correct.
Q. There's a note to this in red. Can you help with us that, please, in terms of what your team has managed to ascertain?
A. Yes. The investigation officer, Vincent Gibbon, has noted that the train station staff have handed first aid kits to the officers as well.
Q. Not necessarily all of those kits came from the BTP vehicle?
A. No.
Q. But the assistance of the platform staff was also procured?
A. Yes.
Q. {INQ035612/36}, please. We can see two more BTP officers here. It's just over 5 minutes post-explosion. PC Jane Bridgewater and PC Dale Edwards; is that correct?
A. Yes, it is.

Q. The red bag in PC Edwards' hand?
A. Again, we believe it to be first aid equipment.
Q. {INQ035612/37}, do we see PC Corke again?
A. Yes, we do.
Q. In his case we know he's arrived in that vehicle with PC Martin, he has made his way directly into the station, and does he then at this point, 22.36.04, begin to ascend the staircase towards the City Room?
A. Yes, he does.
Q. Seconds behind him, at {INQ035612/38}, do we see, 22.36.10, those two PCs from BTP who entered the station seconds previously?
A. Correct.
Q. We're going to go back to the arena concourse now and ETUK, {INQ035612/39}, please. It is the second of the ETUK staff identified to date. Is this Mr Ian Parry?
A. Yes, it is.
Q. And is he, as you understand it, the principal of ETUK?
A. That's correct, sir, yes.
Q. I've used that word in a non-technical sense. It is of course a limited company, but he is, as far as your investigation has been able to establish, the senior person within that organisation?
A. Yes, he is.
Q. We can see in this image, 22.36.15, Mr Parry making his

way towards the City Room?
A. Yes, that's right.
Q. As he was doing so, if we go back to GMP and what is going on internally, at exactly that time, 22.36.16, did there begin a conversation between two members of GMP?
A. Yes, there was.
Q. Can you identify for us who those two people are?
A. The force duty officer, Mr Dale Sexton, and Paul Lawton, who's a firearms officer, who was a tactical adviser on the night.
Q. So are we going to hear a discussion between them about firearms deployment?
A. Yes, we are.
Q. This is a call lasting 47 seconds. It's identified by {INQ018855_C1}.

(Audio played to the inquiry)

I'm not going to ask you to give expert evidence about firearms, but did we hear there mentioned from Mr Lawton the phrase "emergency search"?
A. Yes, we did.
Q. And in due course we will receive evidence about what that means and what it was that he was intending to convey to the FDO.

We will return now to the scene. Whilst that call is taking please between those officers, {INQ035612/40},

please. Do we see another BTP officer, PC Carl Roach, entering the railway station?
A. Yes, we do.
Q. We remind ourselves that he is one of the officers heard on that first BTP broadcast, indicating that he would respond immediately to the request for support.
A. Yes, that's correct.
Q. And he has in his hand a large red bag?
A. He does.
Q. And does your investigation understand that to be a first aid kit bag?
A. That's correct.
Q. Over the page, {INQ035612/41}, is he tracked on the CCTV going directly from the entrance to the staircase leading up to the City Room?
A. Yes, he is.
Q. A new camera perspective for this presentation, {INQ035612/42}. We had tracked them into the railway station, but do we see a little ahead of PC Roach those three officers we've previously mentioned, PC Corke, PC Bridgewater and PC Edwards?
A. That's right, yes.
Q. And the time, can you confirm, is 22.36.28?
A. Yes, that's right.
Q. {INQ035612/43}, just 3 seconds later as those officers

are making their way up the staircase on to the raised footbridge, do we see Mr Parry of ETUK entering the City Room?
A. Yes, we do.
Q. 22.36.31?
A. That's correct, yes.
Q. Back to PC Roach and those other officers at {INQ035612/44}, do we see again they continue to make good progress through the station, carrying the bags that they've previously been shown to have, on their way to the City Room?
A. That's right, yes.
Q. We're going to go directly, please, to {INQ035612/46}, and back to the arena concourse. Here are we picking up PC Trow?
A. Yes, we are.
Q. We'd previously seen him at the Trinity Way roller?
A. That's right.
Q. And he's plainly made his way directly from Trinity Way up on to the arena concourse?
A. That's correct, yes.
Q. {INQ035612/47}, please, 22.36.58. We see identified BTP officer PC Matthew Martin. We had previously seen PC Martin, is this right, tending to casualties outside the entrance?

A. That's correct.
Q. He having arrived with PC Corke?
A. That's correct, yes.
Q. {INQ035612/48}. We are back to PCSO Renshaw and PCSO Lewis Brown entering the City Room with those green boxes or bags that they had containing first aid equipment?
A. Yes, that's right.
Q. We'll pause to remind ourselves that those two PCSOs were initially at the war memorial entrance. They went straight up to the City Room, is that right?
A. Yes, it is.
Q. Then they went all the way back down, where they collected first aid equipment from both the BTP patrol car and members of the rail staff?
A. That's right.
Q. This is their second time of going back into the City Room?
A. Yes, it is.
Q. We are not going to show {INQ035612/49}, I repeat not going to show {INQ035612/49}, but can you please just summarise for us and confirm we are not going to show —— thank you —— that what we see in the images on {INQ035612/49} are those police officers from BTP who had gone up carrying the first aid equipment, pausing to

offer assistance on the raised footbridge to people who were injured there?
A. That's right, PC Corke, PC Bridgewater and PC Edwards and they all stop with the first aid equipment to start dishing it out to help people.
Q. We can go directly to {INQ035612/50}, where we complete our tracking of PC Trow from Trinity Way up to the City Room, which he enters at 22.37.36?
A. That's correct.
Q. We can go back to the raised footbridge at {INQ035612/51}, please. We've seen PC Carl Roach come into the station carrying a bag, making his way up to the raised footbridge. Do we see in this image —— and we're still fewer than 7 minutes post explosion —— he now has his hands empty and is making his way back to the station concourse?
A. That's correct.
Q. Meantime, coming in the opposite direction in the lower image, do we see PC Martin make his way up on to the raised footbridge?
A. Yes, that's correct.
Q. We're going to look at {INQ035612/52} now, please. The third of our ETUK medics so far. Is this Mr Ken O'Connor?
A. Yes, it is.

Q. Is this captured within the arena area?
A. Yes, it is.
Q. Is he seen carrying a bag containing what has been concluded to be first aid equipment to the City Room?
A. Yes, that's right.
Q. I think with the chairman's leave, given the hour, we'll look at just one more. {INQ035612/54}, please, for us to go directly to. Perhaps it is helpful to just complete what PC Roach was seeking to do. Does this capture Mr Roach, having left the footbridge by the war memorial entrance, in discussion with people from Northern Rail?
A. Yes, that's right.
Q. Again, just signposting something which will become perhaps much more important in chapter 12, but do we see there identified a member of Northern staff, Mr Owen Sanderson?
A. Yes, that's right.
Q. Is Mr Sanderson, together with another person, responsible for some footage from within the City Room that has been extremely helpful to GMP in their identification of what occurred to those that lost their lives?
A. That's correct, yes.
Q. And that footage was provided by way of a mobile phone

that was surrendered to GMP?
A. That's correct.
Q. So to conclude this slide, we can see that PC Roach is speaking to them and then, as it records, he goes out on to Station Approach?
A. Yes, that's right.
MR DE LA POER: Sir, I'm entirely in your hands. We've done an hour together and I readily recognise that this is heavy going and extremely detailed. I submit that now might be a good time to break for the day.
SIR JOHN SAUNDERS: I think that's a good idea. Thank you very much, Mr de la Poer, and thank you to the witness.
Can I say also thank you to all the technical staff. As far as I am concerned, everything has worked extremely well. I hope it has for everybody else. If not, no doubt they will let Mr Suter know so that we can try and do something about it. And we're due to start at 10 o'clock tomorrow, is that correct?
MR DE LA POER: Yes, sir. Can I just indicate, because I know that they will want to know that their messages have been received, that we have had some feedback from some core participants about issues in terms of buffering and audio and we are in contact with the technical people who help us with all of this to ensure that that is eliminated if at all possible, but it seems

that there is a good line of dialogue and I hope that, if this is the right phrase, people have had a satisfactory technological experience with accessing the information. Yes, sir, to answer your question, 10 o'clock.
SIR JOHN SAUNDERS: Yes. So certainly some of the audio is not always that easy to hear, but I suspect that's the nature of the audio rather than anything else.
MR DE LA POER: That is certainly right and sometimes it will stutter and that shouldn't be taken to be a reflection of our technology but rather the technology that was used at the time and which came under increasing pressure.
SIR JOHN SAUNDERS: Right. Thank you very much, everybody. 10 o'clock tomorrow. Thank you.
(4.30 pm)
(The inquiry adjourned until 10.00 am on Tuesday, 19 January 2021)

I N D E X