

OPUS2

Manchester Arena Inquiry

Day 52

January 18, 2021

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1 Monday, 18 January 2021
2 (10.00 am)
3 (Delay in proceedings)

4 (10.30 am)
5 MR GREANEY: Could I indicate that we are now live on
6 BlueJeans and the YouTube feed will pick us up in
7 10 minutes.

8 (Pause)
9 SIR JOHN SAUNDERS: Just before you start, Mr Greaney, just
10 let me say a few words.

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

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

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

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

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

10 SIR JOHN SAUNDERS: Fine, thank you.

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

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

20 MR COOPER: That is correct.

21 Opening by MR GREANEY

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

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

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

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

25 Second, time was needed to take advice from Public

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

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

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

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

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1 to all . We will also play the key audio recordings from
 2 the night of the attack and we expect to conclude that
 3 exercise before lunchtime this Wednesday.
 4 That in turn reflects the fact that we intend, for
 5 the time being at least , to sit no more than two and
 6 a half days each week. We are doing so in order to
 7 respect the increased childcare commitments of many
 8 participants in the inquiry in the current situation .
 9 A maximum of three members of the inquiry legal team,
 10 the witness and a member of RTS will be in the hearing
 11 room this week. Everyone else, including, sir , as
 12 you have indicated, the chairman, will attend remotely
 13 for good reason.
 14 Next week, we will hear the closing submissions of
 15 core participants on chapter 7. That chapter,
 16 of course, concerned the security arrangements at the
 17 arena and the chairman has indicated that he intends to
 18 address that chapter in the first volume of his report,
 19 the whole of that phase. So Monday the 25th to
 20 Wednesday, 27 January, will be held virtually , so no one
 21 will be present in this hearing room.
 22 In the following week, and the week after that, so 1
 23 to 3 February and 8 to 10 February, we will return to
 24 chapter 10. That will involve the resumption of the
 25 form of in-person hearing that will occur this week.

1 Our aim during that period in the lead-up to the
 2 February half-term will be to call evidence that is not
 3 substantially controversial and discussions are underway
 4 with the core participants in relation to that evidence.
 5 Then we will take, as we had always intended to
 6 take, a break from 15 February for the February
 7 half-term, but during that week, probably on Tuesday,
 8 16 February, we will take stock at a further hearing of
 9 the sort that occurred last Thursday.
 10 On that occasion we'll need to consider if and how
 11 we proceed from 22 February and, if we are to proceed,
 12 in what form and what evidence should be received. But
 13 those, as the chairman ruled, are decisions for then.
 14 But for now, we propose to make a start on the opening
 15 for chapter 10.
 16 Before we do so, we can make clear that some of what
 17 we have to say will be distressing , as indeed will be
 18 the exercise of working through the sequence of events
 19 and audio. So it is important to refer to the fact that
 20 the hub is there to help everyone directly affected by
 21 the bombing. A document containing information about
 22 that was circulated last week and, moreover, is
 23 available on the inquiry website under the tab "support
 24 services".
 25 Having made those remarks, we'll now commence the

1 opening for this chapter.
 2 The evidence reveals many examples of those who were
 3 present in or entering the City Room in the period after
 4 the explosion conducting themselves with bravery,
 5 selflessness and kindness. Their decency and humanity
 6 stands in stark contrast to the truly wicked thing that
 7 Salman Abedi and Hashem Abedi did. During chapter 10 of
 8 the oral evidence hearings, we intend to acknowledge and
 9 pay tribute to each of those who helped to the extent
 10 that we are able to identify them. That we should do so
 11 is of obvious importance. But even more important to
 12 the public in general, to the bereaved families, to the
 13 core participants and to the inquiry is to learn the
 14 lessons of the emergency response that night.
 15 So we will explore whether the emergency response
 16 really worked that night and, if it did not, whether
 17 that failure made any contribution to the extent of the
 18 dreadful loss of life that occurred. Where we identify
 19 things that went wrong we will probe why they went wrong
 20 and how they can be made to work in the future. And
 21 even where we identify things that did work, we will not
 22 simply accept that but instead will investigate whether
 23 they can be made to work better in the future.
 24 We hope and, moreover, believe that all core
 25 participants share our hope that from this inquiry will

1 emerge real improvements in how emergencies,
 2 particularly those that arise out of terrorist attacks,
 3 are managed.
 4 As for whether the emergency response worked on the
 5 night of 22 May, it is relevant to note that it did not
 6 take long at all for concerns to begin to emerge.
 7 Indeed, that very night, some of those on the ground
 8 were to experience and express frustration , even extreme
 9 frustration and anger at how events unfolded.
 10 Nicholas Mottram was a GMFRS crew manager. He was
 11 working on the night of the bombing and, following the
 12 attack, was deployed to Philips Park Fire Station,
 13 a location a little under 3 miles to the east of the
 14 arena. And why the fire and rescue service deployed
 15 there is an issue we'll need to look closely at in the
 16 evidence.
 17 The wife of Nicholas Mottram, Helen Mottram, was
 18 a paramedic and he spoke to her on a number of occasions
 19 in the aftermath of the bombing, learning that she was
 20 deploying to the scene of the attack. He spoke to his
 21 superiors and to other firefighters at Philips Park,
 22 explaining that paramedics were travelling to the arena,
 23 but he was directed to remain at the fire station for
 24 a period thereafter .
 25 It is clear from the evidence of a number of those

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 assessment and casualty management, not the treatment of
2 casualties .

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

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

11 MR GREANEY: I did indeed, sir:
12 "Delayed the holding of the first strategic holding
13 group."

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

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

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

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

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

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

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

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

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

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

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

25 Moreover, even as between areas in which the concept

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

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

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

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

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

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

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

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

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

17

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

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

18

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

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

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

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

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

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

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

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

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

20

1 The terms and concepts we'll seek to explain, at
 2 least in basic terms, are, first, what is meant by JESIP
 3 and what it should involve. Second, the levels of
 4 command that are expected to deploy in response to an
 5 incident such as the Manchester attack. Third, what is
 6 meant by a major incident. Fourth, what is meant by
 7 Operation Plato, which we've mentioned a number of times
 8 already, emphasising its importance. Fifth, the concept
 9 of primacy, that is to say whether GMP or BTP had
 10 principal responsibility for preparing for and
 11 responding to an attack at the arena and that,
 12 of course, is an issue that also received consideration
 13 in chapter 7, demonstrating that to some extent at any
 14 rate some of the chapters we're exploring are
 15 intertwined. Sixth, a term important for the
 16 Ambulance Service in particular and describing the use
 17 of an area is designated as having — following an MTFA,
 18 that term being casualty clearing station. And seventh,
 19 an equally important and related term, casualty
 20 collection point, which describes a different area
 21 operated by the Ambulance Service, one closer to the
 22 seat of the attack itself.
 23 We don't pretend that we'll be providing detailed or
 24 definitive definitions of terms such as JESIP at this
 25 stage because that, of course, will be for the evidence.

1 Instead, we're simply seeking at this stage to make what
 2 we say in the balance of this opening statement
 3 comprehensible and to assist once we start to hear from
 4 the witnesses.
 5 In part 2 of what we have to say today, we'll deal
 6 with some general evidence about the role of the
 7 Greater Manchester Resilience Forum in planning for the
 8 response to a terrorist attack such as that carried out
 9 at the arena. We will explain what a Local Resilience
 10 Forum is and what it should do and we'll identify the
 11 issues that arise for the inquiry to consider in respect
 12 of the Greater Manchester Resilience Forum, which will
 13 often be referred to as GMRF.
 14 In part 3 we will provide a very brief overview of
 15 the emergency response. Of course, we went through the
 16 events in some detail during the course of our initial
 17 opening statement. Furthermore, once this opening
 18 statement has concluded later today, we will begin,
 19 probably tomorrow, to work through the sequence of
 20 events with Detective Inspector Russell. As a result,
 21 we will do no more than provide a summary of what
 22 happened in the period between the explosion and 1 am on
 23 23 May.
 24 In part 4 we will deal with whether there is any
 25 basis for considering that a different emergency

1 response may have saved lives. Most of those who died
 2 suffered injuries in the bombing that were, on the
 3 expert evidence, unsurvivable even with current advanced
 4 medical treatment. However, we will be drawing
 5 attention to the fact that in two cases, a different
 6 response may, and we deliberately underline that word,
 7 may have led to a different outcome.
 8 Those two cases are John Atkinson, to whom we
 9 referred expressly in September in our opening
 10 statement, and Saffie—Rose Roussos, who we didn't name
 11 at that time for reasons we explained.
 12 Finally, in part 5 we'll identify some of the issues
 13 that we anticipate the chairman will wish to explore as
 14 he hears the evidence in chapter 10.
 15 Having set out the structure we propose to adopt,
 16 we'll turn to deal with part 1, the terms that will be
 17 used extensively in the course of the evidence and
 18 indeed in the course of this opening statement.
 19 First, JESIP. The Blue Light Interoperability
 20 Programme reported in April 2012. That programme had
 21 been run by the Association of Chief Police Officers,
 22 the Chief Fire Officers' Association and the Association
 23 of Ambulance Chief Executives, although with Home Office
 24 oversight.
 25 The joint emergency services interoperability

1 programme, or JESIP, emerged out of the report of that
 2 programme. The aim of JESIP was to improve
 3 interoperability between the emergency services and it
 4 established to that end a set of apparently simple
 5 principles. We'll have on the screen a diagram that
 6 we have seen before, which is from the overview report
 7 of the policing experts, which sets out those
 8 principles. This is {INQ024271/54}.
 9 So we can see what those principles are, if we can
 10 just enlarge the bottom half of the page or scroll it
 11 up, we can see the principles are: co—locate, that is to
 12 say co—locate with commanders as soon as practicably
 13 possible at a single safe and easily identified location
 14 near to the scene. A principle that we'll be looking
 15 at, I have no doubt, in detail during the evidence.
 16 Communicate. That is to say, communicate clearly,
 17 using plain English.
 18 Coordinate. That is to say, coordinate by agreeing
 19 the lead service and identify priorities, resources and
 20 capabilities for an effective response, including the
 21 timing of further meetings.
 22 Jointly understand risk. So jointly understand risk
 23 by sharing information about the likelihood and
 24 potential impact of threats and hazards to agree
 25 potential control measures.

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

5 Thank you, we can take that from the screen.
6 Situational awareness, that term we've just used, is
7 the idea that the emergency services should have
8 a common understanding of the circumstances, immediate
9 consequences and implications of the emergency they are
10 concerned with, along with an appreciation of the
11 available capabilities and priorities of those emergency
12 services.

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

- 20 M. Major incident. Has a major incident or stand
- 21 by been declared?
- 22 E. Exact location. What is the exact location or
- 23 geographical area of the incident?
- 24 T. Type of incident. What kind of incident is it?
- 25 H. Hazards. What hazards or potential hazards can

25

- 1 be identified?
- 2 A. Access. What are the best routes for access and
- 3 egress?
- 4 N. Number of casualties. How many casualties are
- 5 there and what condition are they in?

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

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

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

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

26

1 on to describe a number of stages.
2 First, gathering information and intelligence .
3 Second, assessing risk and developing a working
4 strategy. Third, considering powers, policies and
5 procedures. Fourth, identifying options and
6 contingencies. And, fifth, taking action and reviewing
7 what happened.

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

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

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

27

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

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

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

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

28

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

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

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

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

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

21 MR GREANEY: Thank you very much, sir.

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

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

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

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

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

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

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

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

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

14 JESIP defines a major incident as follows:

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

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

1 The events at Manchester Arena on the night of
2 22 May 2017 undoubtedly, it seems to counsel to the
3 inquiry, amounted to a major incident. Further, we do
4 not understand any core participant to suggest that it
5 was otherwise. In the course of the evidence, we will
6 need to investigate which of the emergency services
7 conducted a METHANE assessment and whether they declared
8 a major incident, when they did so, and why. As part of
9 that, we'll need to explore whether those emergency
10 services that conducted a METHANE report shared it with
11 their partners. Our current understanding is that BTP
12 and NWS each declared a major incident before
13 23.00 hours and GMP did so at about 1 am on 23 May. We
14 do not understand that any organisation shared its
15 METHANE report.

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

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

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

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

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

18 On that date, the night of the attack,
 19 Operation Plato was declared by a GMP officer,
 20 Inspector Dale Sexton, who performed the role of force
 21 duty officer or FDO. He did so at 10.47 pm, so
 22 16 minutes after the bomb had been detonated. The
 23 inquiry will need to consider whether that declaration
 24 was correct, whether it was communicated to other
 25 emergency services, and, if so, whether it was

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

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

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

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

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

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

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

14 We'll begin with a reminder of just the very basic
 15 facts. The freehold for the arena and City Room was
 16 owned by Network Rail. As a result, by reason of
 17 section 31 of the Railways and Transport Safety Act of
 18 2003, the City Room was within the jurisdiction of BTP.
 19 In this context, the word "jurisdiction" means the parts
 20 of the country in which BTP officers have powers to
 21 operate as a constable. In other words, BTP, British
 22 Transport Police, had jurisdiction within the City Room.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 Sir, I'm mindful that I have now been going for
 18 an hour, but if everyone will bear with me for another
 19 5 minutes, I will just conclude this part of the opening
 20 statement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 If they are right about this, it seems that the

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

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

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

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

17 SIR JOHN SAUNDERS: Okay. Thank you very much. 12 o'clock.
18 (11.38 am)

19 (A short break)

20 (12.00 pm)

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

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

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1 for civil protection in the United Kingdom. That Act
 2 deals with emergencies. It contains a detailed
 3 definition of an emergency and, unsurprisingly, that
 4 definition includes a terrorist attack such as that
 5 which occurred at Manchester Arena on the night of
 6 22 May.

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

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

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

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

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

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

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

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

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

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

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

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

25 Mr Argyle goes on to explain that whilst an LRF does

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

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

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

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

1 fit for purpose. GMRF also facilitated training and
 2 exercising events, some delivered by members of the
 3 resilience forum and some by external providers.
 4 A number of these exercises concerned terrorist
 5 incidents. Exercise Winchester Accord took place, as we
 6 know, in May 2016. The exercise scenario was an MTFA at
 7 the Trafford Centre. It was a multi-agency response
 8 with the aim of testing and evaluating the response to
 9 a major terrorist attack.
 10 The policing experts comment extensively upon this
 11 exercise in their report and express, moreover, serious
 12 concerns about whether the necessary lessons were learnt
 13 from it, and the other experts appear to share their
 14 concerns.
 15 Subsequent exercises included Exercise Sherman in
 16 2016 and Exercise Hawk River in March 2017. Both were
 17 multi-agency tabletop exercises focused upon an MTFA and
 18 participants included GMP, GMFRS and NWAS. We've
 19 already considered, of course, Exercise Sherman, which
 20 was of interest to the inquiry because it was based upon
 21 a terrorist attack in the City Room, the very thing,
 22 of course, that happened on 22 May.
 23 In response to the report of Lord Kerslake and his
 24 panel, Kathy Oldham, the chief resilience officer for
 25 GMCA, wrote to the Mayor. In doing so, she emphasised

1 that regular meetings now take place to ensure that
 2 lessons have been learnt and that plans are in place to
 3 ensure that this is achieved. It will be necessary to
 4 consider whether the report of Ms Oldham represents much
 5 by way of concrete proposal. The current chair of GMRF
 6 is Nick Bailey, the assistant chief constable of Greater
 7 Manchester Police. He has provided the lessons learned
 8 statement on behalf of GMRF, the Local Resilience Forum.
 9 In it, he observes, perhaps with a degree of
 10 understatement, the following:
 11 "It was clear in the immediate aftermath of the
 12 attack that there had been some issues with multi-agency
 13 communication and the deployment of some agencies."
 14 He goes on to describe the process of debriefing and
 15 reporting undertaken by the resilience forum with a view
 16 to ensuring that such issues did not recur. ACC Bailey
 17 expresses the view:
 18 "GMRF has taken an extremely robust and methodical
 19 approach to identifying areas of learning and
 20 development from the multi-agency briefings and the
 21 Kerslake Report."
 22 The inquiry will need to consider whether this is
 23 correct and in any event whether there are further
 24 lessons that should be learned about the operation of
 25 GMRF and indeed about LRFs more generally.

1 We are going to turn next to part 3 of our
 2 chapter 10 opening. As we indicated at the outset of
 3 what we've had to say today, this will involve a brief
 4 summary of the events in the period between the
 5 explosion and 1 am on 23 May, both on the ground and in
 6 control rooms. The purpose of what we intend to say is
 7 to provide a structure for the evidence once we start to
 8 hear it and an introduction to the evidence of
 9 Detective Inspector Russell.
 10 We will not be dealing, at least not in detail at
 11 this stage, with the movements of each and every
 12 individual person who died, but may we emphasise that
 13 this is not because we consider those matters
 14 unimportant. On the contrary, they are of the utmost
 15 importance. However, those movements will generally be
 16 considered in chapter 12, whereas in chapter 10 we will
 17 maintain our focus upon the emergency services, when
 18 they arrived and what they did when they arrived, and on
 19 what difference any failures may have made.
 20 Before we embark upon this part of our opening
 21 statement, it is important that we acknowledge publicly
 22 the pressure that those who responded to the attack,
 23 both members of the public and emergency responders,
 24 came under. It must, we acknowledge, have been
 25 enormous. Which of us who was not there and not

1 required to make critical decisions in the agony of the
 2 moment can understand what they felt like. This
 3 process, by which we mean the process of this inquiry,
 4 must understand that and will understand that, and our
 5 investigation must not be used to vilify those who did
 6 their best on the night, even if they made mistakes or
 7 could have done better.
 8 Still, what we must do is to probe deeply, but
 9 always fairly, into the emergency response that night.
 10 If there were mistakes or failures, they will need to be
 11 revealed, not because our purpose is to criticise but
 12 instead so that the bereaved families may know the truth
 13 and also so that the real lessons may be learned and
 14 things be improved for the future.
 15 We'll turn then to our summary. But again, before
 16 we do so, we recognise that even a summary of the events
 17 we are about to describe is capable of being distressing
 18 and we give that warning before we start.
 19 In the seconds immediately after the explosion,
 20 PC Bullough and a group of BTP colleagues ran, together
 21 with a number of Travel Safe officers, towards the
 22 City Room, entering there no more than 2 minutes after
 23 the bomb had detonated. ETUK medics also made their way
 24 there.
 25 At 22.34 hours, PC Corke entered the station and

1 made his way to the City Room. All will recall that
 2 he is the BTP officer with considerable experience of
 3 policing events at the arena but whose deployment there
 4 that night had unfortunately been delayed.
 5 By 22.41 hours, 10 minutes after the explosion,
 6 three PCSOs, Browne, Renshaw and Morrey, eight PCs,
 7 Bullough, Corke, Trow, Campbell, Ayers, Bridgewater
 8 Edwards and Martin, all 11 of them BTP officers, had
 9 made their way to or very near to the City Room. As
 10 this period, the first 10 minutes after the explosion
 11 evidenced, a 12th officer, police Sergeant Wilcock, had
 12 just entered the arena complex.
 13 Some of those who were captured responding in these
 14 first minutes were already within the Victoria Railway
 15 Station, others arrived from elsewhere. Those who
 16 arrived in vehicles brought first aid kits. Other such
 17 kits were fetched by those who were first into the
 18 City Room.
 19 So far as other organisations are concerned, four
 20 ETUK medics reached the City Room within those first
 21 10 minutes, with a fifth, Ken O'Connor, entering seconds
 22 later.
 23 In relation to the staff of the station itself, one
 24 had brought first aid equipment to the City Room and two
 25 large NHS first aid bags had been brought out on to the

1 station concourse before being carried up to the
 2 City Room. That is what was occurring in those first
 3 10 minutes.
 4 In the next 10 minutes, so between 22.41 hours and
 5 22.51 hours, a significant number of GMP officers
 6 arrived at Victoria Railway Station. These included
 7 four double-crewed patrol vehicles, two TAU or tactical
 8 aid unit carriers, and several armed response vehicles.
 9 Among those who arrived during that period were
 10 Inspector Michael Smith, who assumed the role of GMP
 11 Bronze, that is to say operational commander, along with
 12 at least 19 other unarmed officers and a minimum of ten
 13 firearms officers, including the operational firearms
 14 commander.
 15 Before this period, that's to say the 10 minutes
 16 prior to 22.51 hours, was over, four firearms officers
 17 had passed through Victoria Railway Station and over the
 18 raised footbridge into the City Room, whilst another
 19 four had passed through the arena itself and the arena
 20 concourse in order to reach the City Room. Firearms
 21 officers had passed from one side of the City Room to
 22 the other and by the end of this period, fewer than
 23 20 minutes after the explosion, had assumed defensive
 24 positions on both the raised footbridge entrance to the
 25 City Room and the arena concourse entrance to that area.

1 This, we emphasise, during the course of our
 2 summary, may be important when we consider whether
 3 Operation Plato should have been maintained for the
 4 period it was, assuming it was correct to call Plato in
 5 the first place, and in this regard we note that
 6 Operation Plato was only formally declared as this
 7 period we are just considering was drawing to a close.
 8 We hope that point is clear. The fact of the deployment
 9 of firearms officers during this early stage and the
 10 number of firearms officers and what they did must be
 11 relevant to our consideration of Plato.
 12 To consider the CCTV evidence another way,
 13 approximately 15 minutes after the explosion the first
 14 armed officers are recorded as entering the City Room.
 15 The GMP Bronze Commander entered the City Room fewer
 16 than 3 minutes after that. And also arriving at the
 17 very end of this period was the first NNAS paramedic,
 18 Patrick Ennis. The number of ETUK medics operating in
 19 and around the City Room by 22.51 hours was six.
 20 In the following 10 minutes, so in the period
 21 between 22.51 hours and 23.01 hours, additional members
 22 of the emergency services arrived. Patrick Ennis was,
 23 of course, already there and by 22.53 hours, or shortly
 24 afterwards, he had entered the City Room, made contact
 25 with the GMP Bronze Commander, Inspector Smith, and

1 spoken to a representative of ETUK. He then left the
 2 City Room having spent approximately 5 minutes there,
 3 just as another paramedic and a doctor were arriving.
 4 By the conclusion of this period, and so 30 minutes
 5 after the explosion, there were a total of six NNAS
 6 paramedics at Victoria Station, including an advanced
 7 par, a senior paramedic, and a consultant paramedic,
 8 Dan Smith, who took up, as we have said, the role of
 9 Bronze Commander, along with an NNAS MERIT doctor,
 10 Michael Daley.
 11 A further ambulance also arrived at the end of this
 12 period, but both of those within that vehicle got no
 13 closer to the City Room than Trinity Way because its
 14 occupants tended to and transported Saffie—Rose Roussos,
 15 who by then had been carried out of the City Room via
 16 the Trinity Way link tunnel.
 17 Saffie is seen being carried out of the City Room
 18 via the Fifty Pence entrance at 22.57.08 and by
 19 22.58.33, she had reached the end of the Trinity Way
 20 tunnel. As we are going to explain, on the basis of
 21 material which has been generated since we made our
 22 opening statement, survivability is an issue in the case
 23 of Saffie.
 24 Additional, highly specialist firearms support
 25 in the form of three counter-terrorism specialist

1 firearms officers , or CTSFOs, had already arrived by the
 2 end of this period and entered the arena itself .
 3 The subsequent 10 minutes, so those minutes between
 4 23.01 and 23.11, take us to the point 40 minutes after
 5 the explosion had occurred. During that period,
 6 Patrick Ennis spoke in person to the NWAS
 7 Bronze Commander, Dan Smith, outside the City Room and
 8 then returned into that area. At least eight ambulances
 9 had by now attended Victoria Railway Station together
 10 with other NWAS employees in other vehicles. During
 11 this period, moreover, the NWAS Bronze Commander,
 12 consultant paramedic Smith, had established himself
 13 visibly as such and three off-duty doctors had briefly
 14 entered Victoria Railway Station.
 15 However, the only deployment of a stretcher in the
 16 City Room had occurred and another injured person had
 17 been transported out of the City Room on a makeshift
 18 carrying platform. It is notable, we suggest, that by
 19 23.11 hours, 40 minutes after the explosion, despite the
 20 presence of numerous members of NWAS staff within the
 21 station , Patrick Ennis was the only NWAS paramedic to
 22 have been within the City Room. Why that is so is
 23 plainly something that will need to be closely examined
 24 during the evidence in chapter 10.
 25 On the policing side, more police officers had

1 entered the City Room during this period up to
 2 23.11 hours and six more firearms officers were at the
 3 scene.
 4 Turning to the period between 23.11 hours and
 5 23.21 hours. At 23.14 hours members of the NWAS
 6 Hazardous Area Response Team, or HART, arrived at the
 7 station. That team had been established by NWAS in 2009
 8 in response to the national terrorism level and, as the
 9 NWAS website explains, uses specialist equipment and
 10 skills to safely access and treat patients in difficult
 11 and hazardous conditions.
 12 One of the issues the inquiry will want to consider
 13 is why such a specialist team, with obvious skills to
 14 bring to bear in the circumstances of the aftermath of
 15 the arena attack, did not arrive until 43 minutes after
 16 the explosion.
 17 The members of HART who arrived were paramedics
 18 Lea Vaughan and Christopher Hargreaves. They made their
 19 way directly to the City Room. Once in the City Room,
 20 they spoke to Patrick Ennis and then started to move
 21 between casualties. Also during this period we're
 22 considering, at 23.17.40, and so more than 45 minutes
 23 after the explosion, the evacuation of John Atkinson
 24 from the City Room commenced as he was moved on
 25 a display board across the floor of the City Room

1 towards the raised footbridge.
 2 The issue of John Atkinson's survivability is, as we
 3 said in September, and as we shall explain, a matter
 4 that will need to be investigated. During this period,
 5 GMP firearms officers were conducting a systemic sweep
 6 of the arena, again a matter that will be relevant to
 7 our consideration of Plato.
 8 We turn then to the final 10 minutes of the hour
 9 after the explosion. At 23.23 hours, up on the raised
 10 footbridge, a metal barrier had been obtained to be slid
 11 under the display board used to move John Atkinson. By
 12 23.24.25, John had been moved in this way to the area by
 13 the war memorial entrance where he was placed and tended
 14 to by an NWAS paramedic, Philip Keogh. He remained at
 15 this location for the next 24 minutes.
 16 At 23.26.14, a party of police officers began to
 17 carry Georgina Callander out of the City Room on
 18 a makeshift stretcher taking her to Station Approach,
 19 where she was tended to by three paramedics.
 20 As the hour after the explosion came to an end, both
 21 John Atkinson and Georgina Callander were carried out of
 22 the City Room. Whilst all of that was happening, three
 23 more paramedics walked into the station, and Lea Vaughan
 24 and Christopher Hargreaves and Patrick Ennis were still
 25 in that area in the City Room.

1 GMP Chief Inspector Dexter, the ground assigned
 2 tactical firearms commander, or GATFC, had also arrived
 3 during this period. That occurred at 23.24 hours and
 4 a minute later he entered the City Room.
 5 What happened in the next 90 minutes, so between
 6 23.31 hours and about 1 am on 23 May, we can summarise.
 7 John Atkinson and Georgina Callander continued to
 8 receive treatment. At 23.47.50, chest compressions were
 9 started on John, who was still at that point in the area
 10 of the war memorial entrance. The chest compressions
 11 continued as he was wheeled towards an ambulance.
 12 At 23.40.32 the final casualty was evacuated from
 13 the City Room on a makeshift stretcher comprised of
 14 cardboard and a crowd barrier.
 15 Activity continued during those 90 minutes on the
 16 part of representatives of NWAS, GMP and BTP, with Chief
 17 Inspector Andrea Graham of BTP arriving and entering the
 18 City Room at just after midnight, where she approached
 19 Inspector Smith of GMP, the Bronze Commander.
 20 Shortly after this, NWAS deputy director of
 21 operations, Stephen Hynes, had arrived and relieved
 22 Dan Smith of his role as NWAS operational commander.
 23 And at 00.27 hours, Detective Chief
 24 Superintendent Worth, the GMP duty senior investigating
 25 officer , entered the station .

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

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

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

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

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

11 As we have stated already, officers of BTP were the
12 first into the City Room. They quickly made their
13 supervision aware of what had happened. At 22.32.19,
14 PCSO Renshaw made a radio broadcast stating:

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

17 And at 22.33.50, PC Bullough broadcast:

18 "It's definitely a bomb, people injured, at least
19 20 casualties."

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

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

25 BTP has two control rooms, one in Birmingham and one

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

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

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

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

1 meant in practice for BTP.

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

7 "It's our jurisdiction, confirmed."

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

10 As part of his METHANE report, at 23.01.37,
11 Sergeant Cawley stated that there were at least
12 100 casualties. It appears to be the position that,
13 contrary to the expected practice, BTP did not share its
14 METHANE report with any other agencies.

15 Steps were taken by BTP to fill command roles. At
16 23.31.00, the command structure is recorded in the BTP
17 incident log as being as follows: ACC Robin Smith was
18 appointed the BTP Gold Commander. Shortly after 1 am
19 in that role, and whilst travelling to Manchester from
20 the south—east, ACC Smith spoke to the GMP
21 Gold Commander, ACC Ford. During this conversation it
22 was agreed between the two of them that GMP would lead
23 the overall response to the incident.

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

1 group meeting, which took place at 4.15. It was at this
 2 meeting that ACC Smith first learned that GMP had
 3 declared Operation Plato. Why he did not learn this
 4 earlier , given that Operation Plato had been declared at
 5 22.47 hours, is an obviously important issue for the
 6 inquiry to investigate .
 7 During the first hour after the explosion, the role
 8 of BTP Silver Commander was performed by
 9 Inspector Dawson, the FIM. However, at 23.34 hours,
 10 he was relieved by Chief Superintendent Gregory.
 11 Shortly after midnight, Chief Superintendent Gregory
 12 attempted to contact GMP Silver. His records indicate
 13 that he was seeking to establish which force held
 14 primacy and exchange contact details. The BTP log
 15 indicates that he, that is to say Chief Superintendent
 16 Gregory, was informed that he would be called back.
 17 Chief Superintendent Gregory states that he tried at
 18 least one more time. However, and notwithstanding this,
 19 it appears that the BTP Silver Commander did not speak
 20 to the GMP Silver Commander throughout the course of the
 21 critical stage of the incident. Indeed, it was to take
 22 until nearly 1.20 the following morning for BTP systems
 23 even to record the name of the GMP Silver Commander.
 24 It is also worth noting that Chief Superintendent
 25 Gregory, the BTP Silver, states he was never made aware

1 that GMP had declared Operation Plato. This is, we
 2 suggest, one example, albeit a highly significant one,
 3 with the potential ramification for the safety and
 4 well-being of BTP officers and/or those they were
 5 assisting of the inter-agency communication failure
 6 which is criticised by the policing experts and which
 7 the inquiry will inevitably investigate .
 8 Chief Superintendent Gregory, BTP Silver, spoke to
 9 Superintendent Gordon of BTP at a time that will need to
 10 be investigated in the evidence and appointed him as
 11 Bronze Commander, notwithstanding that
 12 Superintendent Gordon was some distance away in
 13 Blackpool. The reasoning for this recorded in the
 14 Silver Commander's statement is as follows. He said:
 15 "It was important to have senior command on the
 16 scene in order to have an accurate picture of what was
 17 happening on the ground and how the situation was
 18 developing."
 19 This is a decision which will be the subject of
 20 careful scrutiny by the inquiry. The choice of
 21 Superintendent Gordon, as we shall see, led to there
 22 being no nominated BTP commander on the ground until
 23 after 1 am, despite the fact that BTP's internal
 24 contemporaneous records may record in the first hour
 25 that they regarded themselves as having primacy, that is

1 to say that they were taking the lead over GMP in terms
 2 of the policing response.
 3 In the result , by the time Superintendent Gordon
 4 arrived at the scene, primacy had been formally agreed
 5 to rest with GMP in the conversation between ACC Smith
 6 and ACC Ford shortly after 1 am. The inquiry will need
 7 to investigate this and whether or not the absence of
 8 a BTP operational commander affected the adequacy and
 9 effectiveness of the emergency response. And one part
 10 of this will be to consider whether the decision to
 11 appoint Superintendent Gordon, as opposed to someone who
 12 was there or nearby, was the correct one.
 13 As we explored during the course of the evidence in
 14 chapter 7, conduct of the BTP officers who were deployed
 15 to the station on 22 May is open to criticism
 16 in relation to the period before the explosion, although
 17 the question of whether they were instructed and
 18 supervised adequately during that period also arises .
 19 Any fair and balanced assessment of the junior
 20 officers ' conduct must, in any event, recognise that
 21 following the explosion, they acted selflessly and
 22 without apparent regard for the danger they themselves
 23 might be in and that they did so in order to seek to
 24 help those who needed it. Whether they, the junior
 25 officers of BTP, were provided during that period after

1 the explosion with the level of support they needed and
 2 whether there was the degree of coordination needed at
 3 command level within BTP more generally are issues for
 4 investigation .
 5 As we have made clear, from an early stage the
 6 assistance of GMP was sought in response to the arena
 7 attack. The GMP command structure that was put in place
 8 in response appears to have been as follows: the role of
 9 force duty officer , or FDO, on the night of 22 May was
 10 undertaken by Inspector Dale Sexton. As the initial
 11 commander he automatically assumed both the Silver, so
 12 tactical , and Gold, so strategic , command roles until
 13 others took up those positions. The FDO is also the
 14 initial tactical firearms commander, or ITFC, in the
 15 event that firearms are deployed, as obviously they
 16 were, so Inspector Sexton also assumed the role of ITFC.
 17 At 22.39 hours, the GMP Night Silver Commander,
 18 Superintendent Arif Nawaz, was notified of an explosion
 19 at the arena by Ian Randall, who occupied the role of
 20 force duty supervisor or FDS, the FDS being FDO's direct
 21 support.
 22 At that point, Superintendent Nawaz became Silver
 23 Commander, so that's at 22.39. It is, as we have
 24 explained, the Silver Commander's role to activate
 25 emergency plans and formulate a tactical plan.

1 Superintendent Nawaz spoke to the FDO, Inspector Sexton,
 2 at 22.50, during which conversation he was told that
 3 10 people had been killed by a terrorist and that
 4 Operation Plato had been declared. As we shall learn,
 5 Superintendent Nawaz did not know, at least as we
 6 understand the evidence, what Operation Plato was. If
 7 that's correct, we suggest it is surprising .

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

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

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

5 The on-duty tactical firearms commander was
 6 Chief Inspector Rachel Buckle. She was notified around
 7 22.45 hours. In the event she did not take over from
 8 Inspector Sexton as the TFC. The reason for this was
 9 that her superior, Superintendent Craig Thompson, a
 10 specialist tactical firearms commander, was notified by
 11 Chief Inspector Dexter and so he took this role,
 12 deploying to GMP Headquarters. And so it was that at
 13 15 minutes past midnight, Inspector Sexton handed over
 14 the ITFC role to Superintendent Craig Thompson.

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

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

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

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

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

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

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

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

1 practice.

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

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

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

1 For now, we'll stay with Inspector Sexton, who at
 2 22.46 activated his dictaphone. One of the first things
 3 the recording from that device captures is that 1 minute
 4 later, at 22.47, he declared Operation Plato. Once
 5 Plato had been declared, policy required that zones be
 6 applied and for the declaration to be communicated to
 7 other emergency services as a joint response is required
 8 under the JOPs, which were developed for this very
 9 scenario, as we have explained, and indeed the third
 10 joint operating principle of JOPs requires all other
 11 interested organisations be informed of the declaration
 12 of Operation Plato. This document and its implications
 13 will need to be the subject of detailed consideration in
 14 the course of the oral evidence hearings.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 But to give just one example of a difficulty faced
10 by Mr Myerscough, shortly before midnight he spoke to
11 GMFRS Station Manager Andy Berry on the FDO line. The
12 discussion was about forward control points.

13 Mr Myerscough, after a substantial delay, came back with
14 an RVP, which was dismissed by SM Berry. After further
15 delay and obviously relaying what he had been told,
16 Mr Myerscough offered another location, but that was
17 also rejected by SM Berry. The conversation was plainly
18 unsatisfactory and the very antithesis, we suggest, of
19 promoting the joined-up approach which was required
20 in the circumstances and which JESIP dictated.

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

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

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

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

4 SIR JOHN SAUNDERS: Yes, certainly. Thank you very much.

5 2 o'clock.

6 (12.57 pm)

7 (Lunch adjournment)

8 (2.00 pm)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 The final GMP commander to further introduce at this

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

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

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

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

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

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

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

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

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

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

25 Following his arrival at headquarters, he commenced

1 his decision log at 00.35. By this time, all patients
2 had been evacuated from the City Room and all of the
3 22 deceased had been declared dead. So in those
4 circumstances the inquiry will need to consider whether
5 Neil Barnes made any real contribution to the emergency
6 response.

7 Annemarie Rooney is the NWAS sector commander for
8 central Manchester and also holds a role as a tactical
9 commander. She was NWAS Silver Commander on the night
10 of the bombing. She was informed of the bombing at
11 22.38 by the duty manager of the NWAS emergency
12 operations centre, the EOC, and the name of the duty
13 manager is Nicola Pratt.

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

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

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

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

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

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

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

11 In his statement, Dan Smith recalls that at
 12 23.00 hours the HART team arrived, although in fact it
 13 was about 15 minutes later. As we've made clear, this
 14 was the team that was trained and equipped to operate in
 15 a hazardous area. Mr Smith was advised that two members
 16 of that team had volunteered to enter the City Room. He
 17 said that whilst he could not guarantee their safety,
 18 he was, as he puts it, "fairly happy" that an MTFA was
 19 not underway and that the presence of "vast numbers of
 20 firearms officers" was sufficient to ensure safety.

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

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1 Officer O'Reilly in a phone call for the attendance of
 2 12 trauma-trained firefighters and a commander.

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

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

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

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

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1 at Victoria Station."

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

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

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

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

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

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

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

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

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

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

23 However, what is clear is that by 23.11, some
 24 40 minutes after the explosion, Patrick Ennis was the
 25 only NWSA paramedic to have been into the City Room. As

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

4 As we explained this morning, at 23.14.04, NWSA HART
 5 paramedics, Lea Vaughan and Christopher Hargreaves,
 6 entered Victoria Railway Station. The CCTV indicates
 7 that they made their way directly to the City Room,
 8 where they arrived 1 minute later. As we have
 9 explained, the evidence indicates that they volunteered
 10 to enter that area. Once in the City Room, they spoke
 11 to Patrick Ennis and then started to move between
 12 casualties. Those two were the only HART paramedics to
 13 enter the City Room and the inquiry will need to
 14 consider why that is so, given that other HART
 15 paramedics were present in the station and they were, as
 16 we have now said a number of times, trained and equipped
 17 to enter a hazardous environment, even assuming that by
 18 23.15 the City Room could properly have been described
 19 as such.

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

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

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

10 First, initial notification and response. The first
 11 notification to NWFC of an incident at the arena came at
 12 22.34, so 3 minutes after the detonation by Salman Abedi
 13 of his bomb. The NWFC control room operator -- we will
 14 refer to people in that role as CROs -- David Ellis was
 15 informed at that time of reports of an explosion in the
 16 foyer of the arena whilst talking to GMP about an
 17 incident that was unrelated. During the same call, GMP
 18 advised him that a bomb had exploded.

19 Later in the call, GMP told NWFC that injuries
 20 at the arena appeared to have been caused by shrapnel,
 21 that it was believed that there were between 30 and
 22 40 casualties, but that was unconfirmed, and that they
 23 were still looking for a secondary device. It follows
 24 that NWFC had early notice that a shrapnel bomb appeared
 25 to have exploded in the foyer to the arena, in other

1 words within the City Room, resulting in multiple
 2 casualties .
 3 At 22.37, NWFC CRO Joanne Haslam received a call
 4 from NWAS Control stating that a bomb had gone off
 5 at the arena. Between 22.43 and 22.46, during the same
 6 call, NWAS informed NWFC that there were reports of an
 7 active shooter, that there were potential gunshot
 8 injuries, and that there were approximately
 9 60 casualties .
 10 NWFC, in common with other emergency responders, had
 11 action cards which dictated particular responses to
 12 particular events. CRO Ellis initially accessed the
 13 explosion action card. A short time later, on the
 14 initial accounts of the NWFC witnesses, it appears that
 15 NWFC duty team leader Michelle Gregson and her
 16 colleague, team leader Lisa Owens, instead reverted to
 17 following the bomb action card. If correct, this choice
 18 was significant as the two cards dictated different
 19 responses. Had the explosion card been adopted, NWFC
 20 would have directed GMFRS resources, including the
 21 specialist technical rescue units, TRUs, and a NILO
 22 directly to the arena, whereas the bomb action card
 23 required the duty NILO first to obtain an RVP before any
 24 fire and rescue service resources were mobilised to that
 25 location .

1 We've just said on the initial accounts because
 2 further statements of the relevant witnesses have been
 3 served on the inquiry by NWFC in which it is explained
 4 that NWFC staff did not in fact open or follow the bomb
 5 action card and it appears that there is independent
 6 support for that from the NWFC records.
 7 As with all issues of fact, this will need to be
 8 explored in the evidence and a determination made on
 9 that basis. As we have said a number of times now,
 10 no one should jump to conclusions. A determination
 11 about the decision—making within the NWFC control room
 12 will need to be made on the basis of an assessment of
 13 the evidence that's actually given by the relevant
 14 witnesses and by reference to contemporaneous
 15 documentation.
 16 At all events, at 22.40, while NWFC's calls to GMP
 17 and NWAS continued, NWFC duty team leader
 18 Michelle Gregson contacted station manager, as we have
 19 said, SM Andy Berry, the GMFRS on—call duty NILO. The
 20 NILO, SM Berry, was informed that there had been an
 21 explosion at the arena, that there were 30 casualties
 22 reported, that the police had declared an RVP at
 23 Cathedral Car Park, and he was asked to get in touch
 24 with GMP, which in context seems likely to have been
 25 a request to contact the GMP FDO, Inspector Sexton.

1 In that call, SM Berry rejected the Cathedral Car
 2 Park RVP and suggested that the fire and rescue service
 3 would normally muster and added that, "The RVP should
 4 not be that close, we would not want central", to use
 5 his actual words.
 6 SM Berry suggested Philips Park Fire Station, some
 7 3 miles from the scene, and Michelle Gregson accepted
 8 that. Philips Park was not a multi—agency RVP and the
 9 reasons for the fire and rescue service locating there
 10 will need to be scrutinised along with NWFC's reasons
 11 for agreeing to that.
 12 The recording of that call that we've just described
 13 will be played during the evidence of Inspector Russell .
 14 When it is played, it will be important to bear in mind
 15 that in his witness statement SM Berry states that
 16 he was concerned that the RVP at Cathedral Car Park was
 17 a predetermined RVP and would not be safe. He states:
 18 "It was a bit quick for an RVP to be issued if the
 19 explosion had just occurred."
 20 However, given the timing of the call, the explosion
 21 had of course occurred nearly 10 minutes earlier .
 22 SM Berry suggests in his witness statement that NWFC had
 23 made the decision that GMFRS would not mobilise. An
 24 assessment of whether that is or is not correct will
 25 need to be made in the light of the call and in light of

1 all of the evidence.
 2 In due course SM Berry made efforts to contact the
 3 GMP FDO, but without success. At the same time SM Berry
 4 ordered four fire engines and three additional NILOs to
 5 attend the RVP at Philips Park Fire Station. SM Berry
 6 decided to travel to Philips Park, leaving home at
 7 approximately 22.47. His location at the time was some
 8 22 miles from the incident.
 9 As SM Berry was identifying Philips Park as the RVP
 10 for the fire and rescue service and commencing his
 11 journey, a number of calls were taking place. At 22.41,
 12 NWFC received a call from a member of the public who
 13 stated that there had been a bomb blast that had caused
 14 shrapnel injuries. The caller suggested that based on
 15 looking at the casualties, the blast may have been the
 16 result of "a dirty bomb of some description". While on
 17 the line to SM Berry, NWFC asked whether he wanted the
 18 information that had been received from this member of
 19 the public at that moment, to which SM Berry replied,
 20 "No".
 21 At 22.42, NWFC received a call from GMP confirming
 22 that there had been an explosion at the arena.
 23 Two minutes later at 22.44, NWFC received a call from
 24 BTP, requesting confirmation of the number of Fire
 25 Service units being deployed to the arena. The NWFC CRO

1 confirmed that none had been deployed and stated they
 2 would call BTP back once they had further information.
 3 At the same time NWFC CRO Rochelle Fallon called
 4 SM Berry and left a voicemail message relaying reports
 5 from NWAS that people were being shot. The next minute,
 6 22.45, NWFC contacted Philips Park advising that it was
 7 to act as the fire and rescue service RVP. NWFC stated,
 8 it seems, that there were confirmed gunshot wounds.
 9 At 22.48, SM Berry called NWFC and spoke to
 10 CRO Dean Casey. CRO Casey stated that they had received
 11 reports of a bomb exploding, 60 casualties, and reports
 12 of an active shooter. SM Berry stated that further
 13 GMFRS resources were going to rendezvous at Philips Park
 14 until, and again we quote his words, "We are instructed
 15 otherwise and we get some more information about this
 16 incident".
 17 While travelling to Philips Park, SM Berry continued
 18 his efforts to contact the GMP FDO, Inspector Sexton.
 19 He was again unsuccessful. SM Berry called NWFC at
 20 approximately 22.52 and 22.57, requesting additional
 21 NILOs and MTFA capability to the Philips Park RVP.
 22 While SM Berry was on his way, NWFC received updates
 23 indicating that GMP officers and ambulances were
 24 travelling to the scene and that casualties were
 25 receiving treatment. In other words, NWFC received

1 information that some emergency services were deploying
 2 to the arena and the inquiry will plainly need to
 3 consider what impact this should have had on the
 4 decision—making of the fire and rescue service and NWFC.
 5 In other words, should they have thought: other
 6 emergency services are deploying to the scene, would it
 7 be sensible for the fire and rescue service to do the
 8 same? Whether that's a fair question will need to be
 9 answered once the evidence has been heard.
 10 SM Berry arrived at Philips Park at approximately
 11 23.41, an hour after first being informed of the
 12 incident, following delays caused, it would seem, by
 13 roadworks and traffic difficulties on the route.
 14 Next, multi—agency communication and the fire and
 15 rescue service and NWFC. Although Cathedral Park had
 16 been the initial multi—agency RVP nominated by GMP at
 17 22.37, the RVP was updated to Hunts Bank at
 18 approximately 22.54. The RVP was yet further updated by
 19 GMP to the Old Boddington's Brewery at approximately
 20 23.30. The time at which NWFC and GMFRS were made aware
 21 of these RVP changes will need to be considered
 22 thoroughly given GMFRS's lengthy absence from any
 23 multi—agency RVP.
 24 As we have explained already, BTP declared a major
 25 incident at 22.39. NWAS made a similarly timely

1 declaration and the GMP FDO declared Operation Plato at
 2 22.47.
 3 At 22.54, an NWAS officer at the scene provided
 4 METHANE information relating to scene, situational
 5 awareness, casualty numbers and the types of injuries
 6 sustained.
 7 At 22.58, BTP sent a METHANE message from the scene,
 8 containing information regarding the specific location
 9 of the incident, the approximate number of casualties
 10 involved, the nature and type of injuries sustained,
 11 existing resources already at scene, and those that were
 12 required to assist.
 13 Evidence from GMFRS and NWFC staff indicates that
 14 this information, indeed this important information, was
 15 not communicated to the fire and rescue service and NWFC
 16 until significantly later. The time at which NWFC and
 17 GMFRS were made aware of this information and the
 18 reasons for any delay will require careful examination.
 19 There was plainly, from an early stage, much
 20 information to provide to GMFRS and NWFC. The question
 21 is: when was it provided? If not promptly, as may be
 22 the case, then why not? These are issues, among others,
 23 that we will need to explore given that the procedures
 24 and indeed good sense required the emergency services to
 25 be working together to respond to the arena attack.

1 Next, the response of GMFRS and NWFC from
 2 22.50 hours and onwards. At 22.52, NWFC notified
 3 Dean Nankivell, the GMFRS duty group manager, of the
 4 incident. He proceeded to the headquarters not of GMP
 5 but of GMFRS to begin setting up the command support
 6 room or CSR. Several other GMFRS senior officers also
 7 attended the CSR at the GMFRS headquarters, including
 8 the then Chief Fire Officer, CFO Peter O'Reilly.
 9 At 23.35, Station Manager Mick Lawlor, who was off
 10 duty and at home, mobilised to GMP HQ to obtain
 11 situational awareness directly with GMP and to support
 12 the fire and rescue service deployment. SM Lawlor
 13 arrived at GMP Headquarters at 00.04. He obtained
 14 accurate operational information which he transmitted to
 15 the GMFRS NILO talk group.
 16 Meanwhile, the team of GMFRS NILOs and responders
 17 who were still assembled at Philips Park RVP, a little
 18 under 3 miles from the arena, had already become aware
 19 that NWAS was using the Manchester central fire station
 20 as a holding area prior to deploying to the scene.
 21 Conversations were held between those at Philips Park
 22 and the CSR and it was eventual agreed they would travel
 23 to Manchester central station and co—locate with NWAS.
 24 They arrived at central station at approximately 00.13.
 25 At approximately 00.12, just 1 minute earlier, the

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

8 As we observed earlier today, between 00.37 and
 9 00.39, three fire engines and SM Berry arrived at the
 10 station. This was the first GMFRS deployment at the
 11 scene. That attendance was subsequently supplemented by
 12 the attendance of two further engines and another
 13 officer. GMFRS specialist resources were never deployed
 14 to the scene.

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

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

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

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

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

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

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

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1 Mr Cooper would like to say something.

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

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

10 MR GREANEY: Thank you very much.

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

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

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

25 Chapter 12 will be concerned, as we said earlier

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

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

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

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

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1 going to deal next, in a little detail, with both John
 2 and Saffie, detail which is capable of being
 3 particularly distressing, we recognise, for their loved
 4 ones, and as such we'll give just a moment for people to
 5 prepare themselves or to walk away from their screen.
 6 If it helps, we estimate this next part of our opening
 7 statement will take about 5 minutes. Anyone wishing to
 8 step away will be able to return after that period.
 9 (Pause)
 10 First, sir, we'll deal with John Atkinson. John
 11 entered the City Room at 22.30.49. When the bomb went
 12 off, he was about 6 metres away. Immediately following
 13 the explosion, John managed to drag himself away in the
 14 direction of the Fifty Pence staircase. Fewer than
 15 2 minutes after the explosion, John was being tended to
 16 by Ronald or Ron Blake. Mr Blake was at the arena to
 17 pick up his daughter. He stayed with John for just
 18 short of an hour until John started to receive treatment
 19 from paramedics. He applied a tourniquet to John's leg.
 20 A number of people interacted with John whilst he was
 21 in the City Room and during this period he was conscious
 22 and able to speak.
 23 At approximately 23.17 hours, John was placed on to
 24 an advertising board and dragged by a number of people
 25 out of the City Room. The intention was to take him in

1 the lift but it proved to be unsuitable. As a result he
 2 spent a period of time on the raised footbridge whilst
 3 a metal crowd barrier was found and placed underneath
 4 the advertising board. John finally reached the war
 5 memorial entrance to Victoria Railway Station at
 6 23.25.47, just under 10 minutes after he left the
 7 City Room. John was then treated by a number of
 8 paramedics.
 9 At 23.34, his pulse was recorded as 62 beats per
 10 minute, but at 23.48 he suffered a cardiac arrest. At
 11 23.59, the ambulance John was subsequently placed in
 12 departed for Manchester Royal infirmary, where he
 13 arrived 7 minutes later. Despite the efforts of those
 14 treating him, he was declared dead at 00.24.
 15 Conducting the post-mortem examination, the
 16 pathologist, Dr Naomi Carter, found that John had
 17 sustained very severe leg injuries. He also had
 18 abdominal injuries. Dr Carter concludes that John's
 19 collapse from hypovolaemic shock, so cardiac arrest due
 20 to inadequate blood volume filling the circulation,
 21 would accord with a history of initial consciousness
 22 when first formally treated by NWS, followed by
 23 a cardiac arrest.
 24 In the course of her examination, Dr Carter
 25 identified that John had significant heart disease,

1 known medically as ischaemic heart disease. Dr Carter
 2 considers that this may have contributed to his death by
 3 making his heart more susceptible to failure and/or that
 4 it potentially reduced the chances of resuscitation. As
 5 such, she recorded it as a contributing factor in John's
 6 death.
 7 The blast wave experts characterised John's injuries
 8 as being potentially survivable, subject to the extent
 9 to which his ischaemic heart disease may bear upon this
 10 question. The blast wave experts state that the impact
 11 of the heart disease is a matter outside of their
 12 expertise. By reason of the comments of Dr Carter and
 13 the fact that the blast wave experts consider the impact
 14 of John's heart disease as being outside their area of
 15 expertise, the inquiry instructed Dr Paul Rees.
 16 Dr Rees is a consultant in cardiology, general
 17 internal medicine and pre-hospital emergency medicine.
 18 He has considered the circumstances of John's death by
 19 particular reference to what effect John's ischaemic
 20 heart condition may have had and his conclusions are
 21 stark.
 22 On the balance of probabilities, Dr Rees considers
 23 that John's heart condition did not contribute to John's
 24 blood loss, to his cardiac arrest or to the inability
 25 successfully to resuscitate John. In short, Dr Rees'

1 opinion is that John's heart condition did not make any
 2 difference to whether or not John would have died and it
 3 follows therefore that the opinion of the blast wave
 4 experts remains that John's injuries were potentially
 5 survivable.
 6 Second, Saffie—Rose Roussos. Saffie entered the
 7 City Room at 22.30.45 with her mother and sister.
 8 Saffie was standing about 5 metres from the explosion.
 9 About 4 minutes after the blast, Saffie was approached
 10 by Paul Reid, who was present at the arena with a view
 11 to selling posters after the concert had finished.
 12 Mr Reid was to stay with Saffie until she was taken to
 13 hospital in an ambulance. He was joined by a member of
 14 staff from SMG.
 15 Approximately 10 minutes after the explosion, two
 16 medics of ETUK, Marianne Gibson and Elizabeth Woodcock,
 17 started to tend to Saffie. At 22.53.07 an off-duty
 18 nurse, Bethany Crook, began to help. Ms Crook's
 19 attempts to help those in the City Room were, it might
 20 properly be said, nothing short of heroic.
 21 In Saffie's case she took charge of the situation
 22 and sought to assist Saffie with a number of police
 23 officers. A piece of advertising board was used as
 24 a makeshift stretcher and Saffie was carried through the
 25 Trinity Way link tunnel. A passing ambulance was

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

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

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

25 They observe Saffie sustained serious injuries to

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

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

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

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

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

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

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

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

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

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

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1 level of training in order to be able to contribute
 2 meaningfully to the work of the emergency services. And
 3 whilst we'll begin to consider this during chapter 10,
 4 we anticipate hearing from the majority of the
 5 first —aiders themselves during chapter 12.
 6 Second, BTP and GMP. For present purposes, we take
 7 both policing services together. As we said when we
 8 made the opening statement in September and have
 9 repeated today, there are important issues for the
 10 inquiry to explore in relation to each surrounding
 11 primacy. As we have said, this is an issue in relation
 12 to which the inquiry has already generated a discourse
 13 between the two police services which had not previously
 14 existed and we will await an update.
 15 The involvement with and commitment to the Local
 16 Resilience Forum by both GMP and BTP. Whether police
 17 officers responding to the incident were adequately
 18 equipped and/or trained in relation to the latter both
 19 in terms of their role within JESIP and in first aid.
 20 Also, the adequacy of command, which is a topic
 21 encompassing whether GMP Silver should have gone to the
 22 scene through to whether or not BTP's command structure
 23 made any positive material contribution to the response
 24 at all.
 25 Third, NWSA. As we've already said, there exists

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1 a very important question about the location of the
 2 casualty collection point. Was the bottom of the
 3 staircase to the City Room the correct location or
 4 should it have been the City Room itself may be the
 5 critical question or a critical question when it comes
 6 to the life of at least one of those who died. Allied
 7 to this is the question about why so few paramedics
 8 entered the City Room at all, particularly given the
 9 difficulty in evacuating the most seriously injured,
 10 which undoubtedly existed.
 11 Fourth, and finally, GMFRS and NWFC. As is now
 12 widely known, the single biggest question surrounding
 13 the fire service's response is why the on-scene
 14 attendance occurred as late as it did. Was this
 15 a failure in NWFC's procedures, an aberrant decision at
 16 a command level, a product of the unavailability of the
 17 GMP FDO, a combination of all three or some other
 18 reason? Connected to these is the question of whether
 19 the delay in attending by GMFRS made a material
 20 difference.
 21 In short, we are determined to ask these questions
 22 in the course of the evidence in order to discover what
 23 GMFRS's role was and what it might have been.
 24 That brings us to the end of our opening statement
 25 on chapter 10 and it remains only to say that the

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1 inquiry continues to be, as the chairman has said,
 2 a search for the truth.
 3 Sir, the next stage is for Inspector Russell to be
 4 called to take us through the sequence of events and to
 5 introduce the relevant audio recordings. We've been
 6 going for just an hour and in any event we would request
 7 a break before that starts. May we have a break for
 8 20 minutes, please?
 9 SIR JOHN SAUNDERS: Yes, certainly. Let's make it 3.25. So
 10 that's just over the time. Thank you.
 11 MR GREANEY: Sir, may I indicate before we go to the holding
 12 screen that Mr de la Poer will be calling this next
 13 section of the evidence.
 14 SIR JOHN SAUNDERS: Right. Thank you, Mr Greaney, for that
 15 extremely clear opening of what the issues are going to
 16 be in chapter 10. Thank you for that.
 17 MR GREANEY: Thank you, sir.
 18 (3.03 pm)
 19 (A short break)
 20 (3.25 pm)
 21 SIR JOHN SAUNDERS: Mr de la Poer.
 22 MR DE LA POER: Sir, can I begin by confirming that you can
 23 see and hear me, please.
 24 SIR JOHN SAUNDERS: I can, yes, thank you.
 25 MR DE LA POER: Thank you, sir. In terms of the shape of

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1 the remainder of the day, with your agreement, sir, what
 2 I propose is that we go until about 4.30, which will
 3 follow the pattern that Mr Greaney has established of
 4 periods of hearing of about an hour.
 5 SIR JOHN SAUNDERS: That's fine. You choose the time when
 6 we finish.
 7 MR DE LA POER: Thank you very much indeed, sir.
 8 Next I hope that you will be able to see, sir, that
 9 we have in the witness box Detective Inspector
 10 Mike Russell.
 11 SIR JOHN SAUNDERS: Yes, I can. Thank you very much indeed,
 12 Mr Russell, for coming to the hearing.
 13 A. You're welcome, sir.
 14 MR DE LA POER: Can I please confirm with you, sir, that you
 15 are content, bearing in mind that the detective
 16 inspector has previously been sworn, there's no need to
 17 re-swear him now?
 18 SIR JOHN SAUNDERS: Absolutely, thank you.
 19 DETECTIVE INSPECTOR MIKE RUSSELL (recalled)
 20 Questions from MR DE LA POER
 21 MR DE LA POER: Thank you. Before I begin my questioning of
 22 the detective inspector, can I say this about the
 23 evidence that we are about to embark upon and which will
 24 continue tomorrow and into Wednesday. The sequence of
 25 events we are going to consider shows images after the

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

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

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

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

25 It is important to stress in the judgement of the

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

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

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

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

24 A. Yes, that's correct.

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

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1 will arise as we hear the evidence in chapter 10?

2 A. Yes.

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

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

12 A. Yes, they are.

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

16 A. That's correct.

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

20 A. Yes, they are.

21 Q. Included within that work there's one piece of work in
 22 particular I want to ask you about. When we began
 23 looking at the sequence of events during chapters 6 and
 24 7 we were told on behalf of Operation Manteline that
 25 there was a concern in terms of calibration of cameras

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1 within the station concourse.

2 A. That's right.

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

5 A. Yes, that's right .

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

8 A. They have.

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

13 A. Yes, they have.

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

16 A. Yes, that's right , sir .

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

21 A. No, that's correct.

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

25 A. It does.

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

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

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

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

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1 officers , PCSO Lewis Brown, making his way to the
 2 station barriers again in the direction of the
 3 Fifty Pence entrance to the City Room?
 4 A. Yes, we do.
 5 Q. We heard from those two BTP officers and indeed PCSO
 6 Lewis Brown during chapter 7; is that right?
 7 A. That's right.
 8 Q. The fourth of those officers -- {INQ035612/7}, please --
 9 PCSO Mark Renshaw, again clearly moving at pace in the
 10 direction of the City Room?
 11 A. Yes, that's correct.
 12 Q. Approximately 48 seconds after the detonation?
 13 A. That's right.
 14 Q. We are now going to hear the 999 call that we heard
 15 during Mr Greaney's opening statement back in September.
 16 It begins 4 seconds after the image that is on screen.
 17 {INQ019523/1}, please. So that everybody understands
 18 its duration, and as I have already warned people, its
 19 content is plainly capable of being highly distressing ,
 20 particularly to the family of John Atkinson, with whom
 21 Mr Blake had positioned himself. Four minutes and
 22 33 seconds is its duration. Before we play it, there
 23 are three speakers we're going to hear, is that right?
 24 A. Yes, that's correct.
 25 Q. Who are those three speakers, please?

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

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

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

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

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

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

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

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

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1 A. Yes, that's correct.
 2 Q. And has it pulled up essentially outside the war
 3 memorial entrance?
 4 A. Yes.
 5 Q. So we can see that that BTP vehicle response arrived at
 6 22.34.05?
 7 A. Yes.
 8 Q. So just over 3 minutes after the detonation?
 9 A. Yes, that's correct.
 10 Q. Back to the City Room at {INQ035612/22}, again an
 11 entirely redacted image, but can you confirm please that
 12 what the CCTV depicts is that at 22.34.35, the first of
 13 the ETUK medics, Liz Woodcock, entered the City Room?
 14 A. Yes, that's right.
 15 Q. Next, please, {INQ035612/23}. Help us with this slide,
 16 please.
 17 A. This is PC Stephen Corke's arrival into the station.
 18 Q. Is he the officer who we know from the other evidence in
 19 chapter 7, who had been allocated to attend the concert,
 20 is this the time he first arrives that night?
 21 A. Yes, sir.
 22 Q. And we heard his voice, didn't we, in that BTP audio,
 23 indicating that he was on his way in response to these
 24 first transmissions?
 25 A. That's correct.

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

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

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

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1 response vehicles, police vehicles, and we also see some
 2 of those who have emerged from the arena area?
 3 A. That's correct.
 4 Q. Returning to what is taking place inside, can we go,
 5 please, to {INQ035612/30}. There we have an image of
 6 PC Campbell of the British Transport Police, who we
 7 earlier saw running together with PC Ayres up the
 8 Trinity Way link tunnel?
 9 A. That's right.
 10 Q. And shortly behind him, at {INQ035612/31}, do we see
 11 PC Ayres and pick up again with the Travel Safe officer
 12 Reece McKay, who we saw earlier, leave the City Room?
 13 A. Yes, we do.
 14 Q. We are now going to pause in the sequence of events to
 15 listen to two pieces of radio traffic. The first,
 16 can you confirm who we will be hearing from?
 17 A. Yes. From GMP Control, we have Dianne Bowden, we have
 18 Inspector Mike Smith and Robert Rudkin(?).
 19 Q. In terms of Inspector Smith, is that the same
 20 Inspector Smith who assumed the role of Bronze Commander
 21 on behalf of GMP?
 22 A. Yes, it is.
 23 Q. So the timing of this, 22.35.11 is when it starts, and
 24 the reference is {INQ018644_C1/1}, 2 minutes and
 25 8 seconds.

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

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

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

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1 Q. The red bag in PC Edwards' hand?
 2 A. Again, we believe it to be first aid equipment.
 3 Q. {INQ035612/37}, do we see PC Corke again?
 4 A. Yes, we do.
 5 Q. In his case we know he's arrived in that vehicle with
 6 PC Martin, he has made his way directly into the
 7 station, and does he then at this point, 22.36.04, begin
 8 to ascend the staircase towards the City Room?
 9 A. Yes, he does.
 10 Q. Seconds behind him, at {INQ035612/38}, do we see,
 11 22.36.10, those two PCs from BTP who entered the station
 12 seconds previously?
 13 A. Correct.
 14 Q. We're going to go back to the arena concourse now and
 15 ETUK, {INQ035612/39}, please. It is the second of the
 16 ETUK staff identified to date. Is this Mr Ian Parry?
 17 A. Yes, it is.
 18 Q. And is he, as you understand it, the principal of ETUK?
 19 A. That's correct, sir, yes.
 20 Q. I've used that word in a non—technical sense. It is
 21 of course a limited company, but he is, as far as your
 22 investigation has been able to establish, the senior
 23 person within that organisation?
 24 A. Yes, he is.
 25 Q. We can see in this image, 22.36.15, Mr Parry making his

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1 way towards the City Room?
 2 A. Yes, that's right.
 3 Q. As he was doing so, if we go back to GMP and what is
 4 going on internally, at exactly that time, 22.36.16, did
 5 there begin a conversation between two members of GMP?
 6 A. Yes, there was.
 7 Q. Can you identify for us who those two people are?
 8 A. The force duty officer, Mr Dale Sexton, and Paul Lawton,
 9 who's a firearms officer, who was a tactical adviser on
 10 the night.
 11 Q. So are we going to hear a discussion between them about
 12 firearms deployment?
 13 A. Yes, we are.
 14 Q. This is a call lasting 47 seconds. It's identified by
 15 {INQ018855_C1}.
 16 (Audio played to the inquiry)
 17 I'm not going to ask you to give expert evidence
 18 about firearms, but did we hear there mentioned from
 19 Mr Lawton the phrase "emergency search"?
 20 A. Yes, we did.
 21 Q. And in due course we will receive evidence about what
 22 that means and what it was that he was intending to
 23 convey to the FDO.
 24 We will return now to the scene. Whilst that call
 25 is taking place between those officers, {INQ035612/40},

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

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

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

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

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

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

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1 that there is a good line of dialogue and I hope that,
 2 if this is the right phrase, people have had
 3 a satisfactory technological experience with accessing
 4 the information. Yes, sir , to answer your question,
 5 10 o'clock.
 6 SIR JOHN SAUNDERS: Yes. So certainly some of the audio is
 7 not always that easy to hear, but I suspect that's the
 8 nature of the audio rather than anything else.
 9 MR DE LA POER: That is certainly right and sometimes it
 10 will stutter and that shouldn't be taken to be
 11 a reflection of our technology but rather the technology
 12 that was used at the time and which came under
 13 increasing pressure.
 14 SIR JOHN SAUNDERS: Right. Thank you very much, everybody.
 15 10 o'clock tomorrow. Thank you.
 16 (4.30 pm)
 17 (The inquiry adjourned until 10.00 am
 18 on Tuesday, 19 January 2021)
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