

OPUS2

Manchester Arena Inquiry

Day 55

January 25, 2021

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1 Monday, 25 January 2021
 2 (10.00 am)
 3 SIR JOHN SAUNDERS: Mr Greaney.
 4 MR GREANEY: Good morning, sir. As everyone knows, we are
 5 returning now to chapter 7 in order to hear the closing
 6 submissions of the core participants. We are starting
 7 slightly late this morning because some had technical
 8 difficulties. Those have now been solved and they were
 9 nobody's fault.
 10 We have circulated a schedule of speakers for
 11 Monday, Tuesday and Wednesday of this week. The
 12 schedule is not rigid in the sense that if any core
 13 participant finishes earlier than their allotted time,
 14 we'll call on the next core participant in the list
 15 after a break.
 16 We will hear first today from the bereaved families.
 17 They have helpfully agreed between themselves the order
 18 of submissions and have divided up topics and we'll
 19 begin with Mr Atkinson on behalf of the families
 20 represented by Hogan Lovells.
 21 SIR JOHN SAUNDERS: Mr Atkinson, good morning. I have your
 22 helpful note. I have it in front of me. I'm not
 23 expecting you necessarily to follow it, but if you are
 24 going to a part of the note, it would be helpful to me
 25 to know and then I will follow on the note as well as

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1 typing my own notes.
 2 Closing submissions on CHAPTER 7
 3 Submissions by MR ATKINSON
 4 MR ATKINSON: Yes, of course, sir.
 5 As you appreciate, sir, these submissions are made
 6 on behalf of the following families.
 7 Lisa and Mark Rutherford, the parents of
 8 Chloe Rutherford, the 17-year-old and considerably
 9 talented singer.
 10 Caroline Curry, the mother of Liam Curry,
 11 a 19-year-old sportsman who adored and was adored by
 12 Chloe.
 13 Harriet, Isabelle and Lily Taylor, the much-loved
 14 daughters of Jane Tweddle.
 15 Tony Kiss, the husband of Michelle Kiss, 45-year-old
 16 mother of three adored children.
 17 Andrew Hardy and Sharon Cain, father and stepmother
 18 of Olivia Campbell-Hardy, a 15-year-old with
 19 considerable skill as a dancer and singer.
 20 And Deborah Hutchinson, mother of Courtney Boyle,
 21 a 19-year-old criminology student of whom it was said,
 22 "She made good times great and bad times bearable".
 23 As a starting point for these submissions, the
 24 families submit that it is important to recall that the
 25 core purpose of this inquiry is to investigate both how

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1 and in what circumstances these 22 innocent persons lost
 2 their lives. We, of course, agree with those core
 3 participants who have observed in their closing
 4 submissions that each of the 22 was unlawfully killed in
 5 a murderous terrorist attack executed by Salman Abedi,
 6 aided and abetted by his brother, Hashem, as he has so
 7 belatedly accepted.
 8 However, we submit that the question of how and in
 9 what circumstances these innocent lives were lost has
 10 a much wider ambit in terms of how Abedi was able to
 11 detonate a bomb in so public a location, a location that
 12 was covered by a security regime, and in which the
 13 families should have been entitled to consider that
 14 their loved ones would be safe.
 15 Equally, that wider ambit requires the inquiry to
 16 consider whether this most heinous act could have been
 17 prevented by reference to the murderer's detection
 18 and/or exclusion before he was able to deploy his bomb
 19 in the location and with the devastating consequences
 20 that he did.
 21 The families submit, again as a starting point to
 22 these closing submissions, that Salman Abedi was
 23 obviously suspicious and out of place in the City Room.
 24 That is not, contrary to the submissions of some CPs,
 25 a conclusion reached through the application of

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1 hindsight. It was, by way of example only, the
 2 conclusion of the two experts, reached by them having
 3 considered objective factors against the background of
 4 their considerable security experience.
 5 It was also the instinctive view of several entirely
 6 untrained members of the public, who saw Abedi as out of
 7 place, very strange, or someone that security needed to
 8 know about.
 9 Given those facts, it is striking that he was not
 10 identified as suspicious by the security team who were
 11 responsible for keeping concertgoers safe and that even
 12 when concerns were reported to them, nothing meaningful
 13 was done to prevent or mitigate the tragic loss of life
 14 which followed.
 15 Rather, what we submit the evidence has clearly
 16 shown during the course of chapter 7 is that this was
 17 the consequence of significant failures, serious,
 18 unacceptable and unjustifiable failures, principally by
 19 British Transport Police, SMG, SMG Facilities Management
 20 or FM, and ShowSec in the security arrangements and
 21 practices within and outside the Manchester Arena.
 22 The evidence has shown a security operation that was
 23 under-resourced, malcoordinated and insufficiently
 24 focused on counter-terrorism and especially the threat
 25 from a person-borne improvised explosive device. This

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1 made the arena an attractive target for terrorists and
 2 led to a series of missed opportunities to prevent,
 3 deter, detect and/or mitigate the attack.
 4 In short, we submit the evidence shows the attack to
 5 have been at least in significant part the result of
 6 a failure of reasonable foresight, a failure to
 7 anticipate and to address a risk that should have been
 8 obvious rather than a failure that only hindsight
 9 reveals.
 10 The families submit that you can now conclude on the
 11 evidence that there were these serious failures to keep
 12 their loved ones safe and that you can make
 13 recommendations so that the public are not left
 14 similarly unprotected in the future.
 15 Sir, as we indicated in writing, given the breadth
 16 of the issues with which the family teams are involved
 17 in relation to chapter 7, these submissions are focused
 18 in particular on those issues which have emerged from
 19 the evidence on which we on behalf of our team took the
 20 lead.
 21 That is principally on the evidence of the experts,
 22 witnesses employed by ShowSec and, to a lesser extent,
 23 SMG. This focus reflects the division of labour between
 24 the family teams during the course of the evidence and
 25 has been adopted, we hope helpfully, in order to ensure

1 that all issues can be covered between the families in
 2 an appropriate level of detail. But it's important for
 3 me to emphasise at the outset that the families that
 4 I represent do not consider the topics addressed by
 5 others to be of secondary importance.
 6 Those submissions, which we have seen in writing,
 7 including now those on behalf of Slater & Gordon, are
 8 adopted by us and we adopt in advance the submissions to
 9 be made later today on behalf of the other family teams.
 10 SIR JOHN SAUNDERS: Mr Atkinson, if I may say so, it has
 11 been a helpful approach for me for you to have divided
 12 things up in the way that you have, so thank you for
 13 that.
 14 MR ATKINSON: Sir, in our written submissions, from
 15 paragraph 5, we sought to assist you, sir, as to the
 16 approach that we submit you should adopt to the standard
 17 of proof to be applied to the fact-finding exercise.
 18 Can I say, we do not seek to develop those submissions
 19 orally now. For the reasons we've set out there, we
 20 submit that you can adopt a flexible approach to this
 21 issue, taking as a starting point the civil standard of
 22 proof but considering the need for findings to be made
 23 to a different standard as and when appropriate.
 24 Equally, within our written submissions, we made
 25 submissions in relation to the issue of causation,

1 particularly your assessment of which factors in the
 2 security arrangements were potentially causative of the
 3 attack in the sense that had things been different, they
 4 would have increased the opportunity that Salman Abedi
 5 could have been stopped.
 6 That of course ties in with issue 4(vi) of the terms
 7 of reference of the inquiry:
 8 "The impact, if any, of any inadequacies in the
 9 security arrangements, including whether any
 10 inadequacies contributed to the extent of the loss of
 11 life that occurred."
 12 We recognise that can only be an analysis of
 13 possibilities, but we submit they are realistic
 14 possibilities and we will address those as we go along
 15 and seek to summarise the conclusions that we submit you
 16 can reach. They are dealt with from paragraph 95 of our
 17 written document in more detail.
 18 As we indicated before Christmas, sir, we on behalf
 19 of the families we represent welcome your decision to
 20 issue an interim report that addresses chapter 7,
 21 including recommendations for the future. We recognise
 22 the value that there is in you making such
 23 recommendations as soon as you can. We have set out our
 24 submissions as to recommendations from paragraph 97 of
 25 our written document. Those recommendations in our

1 document, as you will appreciate, sir, address only some
 2 of the issues identified in the inquiry's note of
 3 30 November, which are those that we will address today,
 4 namely issues 7 through to 19, and 26. Again we adopt
 5 in advance the submissions made by the other family
 6 teams as to other recommendations that we collectively
 7 submit that you should make.
 8 In particular, we agree with the other family teams
 9 that the starting point for recommendations from this
 10 chapter is the proposed creation of the statutory
 11 Protect duty in Martyn's Law. We have set out from
 12 paragraph 99 of our written document submissions
 13 in relation to that, together with our submissions as to
 14 the ways in which the Licensing Act 2003 can be made to
 15 offer better counter-terrorism protection for licensed
 16 premises. That's from paragraph 106.
 17 Again, we don't seek to further develop those
 18 submissions here orally and we adopt that which others
 19 are to say.
 20 So we turn, first, to issue 7 and the issue of the
 21 adequacy of risk assessment. This is, we submit,
 22 a topic of critical importance because the failure to
 23 appreciate a risk properly makes a failure to mitigate
 24 that risk almost inevitable. The families submit that
 25 you can reach a sure conclusion that risk assessment

1 in relation to security at the Manchester Arena was
2 inadequate.

3 The totality of written assessment of risk that was
4 available for consideration has been analysed before
5 you, sir, during the evidence and considered by the
6 experts. Each and every one was either inadequate in
7 its assessment of terrorism or contained no assessment
8 at all.

9 Indeed, as the experts identified, there was in
10 their words no effective terrorism related risk
11 assessment at the Manchester Arena at all. There
12 appears to be little dispute now from those responsible
13 that this scandalous state of affairs was the case.

14 The overall SMG risk assessment was, as Ms Stone
15 described it, obviously flawed. It identified the same
16 nonsense low level of terrorism risk on event days as on
17 non-event days. On its own terms, as Mr Allen accepted,
18 a national threat level of severe should have put all
19 events into the high risk category. The overall SMG
20 risk assessment was a static document and it did not
21 focus on updated attack methodologies identified to them
22 through the PSIA process.

23 Similarly, the event-specific risk assessment of SMG
24 was flawed. The risk of terrorism, in contrast to
25 a host of mundane matters, was not addressed. Neither

1 of the SMG documents took account of the wealth of
2 NaCTSO guidance on risk assessment that was available to
3 them. Those flaws are, we submit, at least partly the
4 result of SMG's failure to understand that
5 responsibility for risk assessment lay with them.
6 Instead, they were inappropriately reliant on the CTSA
7 whose role did not involve an audit of security or the
8 event-specific assessment of risk and who was, in any
9 event, provided with the wrong information.

10 The ShowSec risk assessment for events stands, we
11 submit, in stark contrast to the forensic and proactive
12 identification of counter-terror risk of which ShowSec
13 directors boasted in their company's presentation to the
14 National and European Arenas Association security
15 seminar, or the NEAA seminar, on 20 April 2016.

16 Their risk assessment was introduced company wide,
17 and therefore across many sites, in January of 2017 by
18 Sharon Pates, who was responsible for health and safety.
19 Contrary to the contention on the company's behalf that
20 there was little guidance as to what a proper risk
21 assessment should contain, this ShowSec risk assessment
22 was introduced at a time when there was a wealth of
23 NaCTSO guidance on risk assessment. For example, their
24 advice to stadia had been issued in 2006 and their
25 advice to bars and clubs, which was used by ShowSec for

1 their training materials, had been issued in 2007.

2 The risk assessment using Ms Pates' prototype was
3 completed for the Ariana Grande concert by Mr Rigby, who
4 had no obvious training for the role. It was circulated
5 to Ms Stone and to Messrs Allen, Bailey, Ms Pates and
6 Mr Wallace without any concern being raised by any of
7 them. It was an obviously flawed document. Indeed,
8 Mr Bailey accepted in evidence that it was meaningless.
9 It focused on the risk to staff rather than the risk to
10 customers. It failed to identify the risk from certain
11 attack methodologies, such as person-borne IED, and it
12 wrongly assessed the risk for that event as low.

13 The ShowSec supervisors' briefing sheet referred to
14 a different level of risk based on the selection of the
15 head of security, an assessment that took no account of
16 the risk to the crowd at all. The sheet did not
17 identify that limitation and indeed gave a misleading
18 impression to supervisors.

19 That neither authors nor recipients at either
20 ShowSec or SMG identified any issue with the calculation
21 of risk nor disputed the low overall rating, although
22 Mr Allen seemed to think that that was okay, shows that
23 risk assessment by both companies had, as Ms Stone
24 admitted, become a tick-box exercise divorced from the
25 national threat level.

1 That the risk assessments were not fully shared
2 between the companies demonstrates a lack of necessary
3 coordination between them. As their documented
4 assessment demonstrates, neither company addressed their
5 minds properly to the risk from terrorism either
6 generally or in relation to specific events. They were
7 each focused on the risk of the audience and not the
8 risk to the audience. One factor in that failure
9 is that their staff were not properly trained in
10 terrorism risk assessment. In ShowSec's case, its
11 internal training failed to incorporate those parts of
12 the NaCTSO guidance.

13 Another feature was the absence of expert input into
14 the creation of the document. As the experts said about
15 the whole security operation, if the companies lacked
16 expertise, they should have sought independent advice.
17 They should not, contrary to SMG's submissions, have
18 needed others to tell them that. It was for them to
19 identify areas where they needed assistance in relation
20 to security as much as they recognised it in relation to
21 crowd management, first aid or, for that matter, stage
22 lighting.

23 SMG has now, of course, created a post of group
24 security manager. They say that the creation of this
25 post was driven by the attack and yet Miriam Stone's

1 interview indicates that it had been discussed prior to
 2 the attack and dismissed at that stage on cost grounds.
 3 ShowSec has suggested that there is a lack of
 4 evidence to show where a company like them could have
 5 got such independent advice. But there is also a lack
 6 of evidence that they sought to find it and indeed the
 7 fact that SMG were able to engage Guidepost so quickly
 8 after the attack strongly suggests that such expertise
 9 had been and was available.
 10 Another important cause which plainly contributed,
 11 given the number of obvious mistakes, is that the
 12 companies had become complacent, and we will return to
 13 that submission in a moment. Ultimately,
 14 counter—terrorism risk assessment appears to have
 15 become, we submit, a sterile record—keeping exercise
 16 rather than a meaningful analysis of risk so that
 17 neither company identified the further measures needed
 18 to mitigate either in general or at the Ariana Grande
 19 concert in particular .
 20 As Mr Allen accepted, the level of identified risk
 21 should have had a significant impact on the security
 22 posture for the arena, including extended bag searching
 23 and the levels of staff . Staffing was said to be
 24 dependent on the risk assessment in the stewarding
 25 agreement and indeed for that matter the ShowSec service

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1 delivery management document. It follows that had the
 2 risk been properly analysed as high, it should have led
 3 ShowSec to advise and SMG to take further measures to
 4 address that higher risk .
 5 Instead, as the experts identified , SMG and ShowSec
 6 did not take appropriate steps to mitigate the actual
 7 risk because, as the experts opined:
 8 " If you have a flawed risk assessment, what follows
 9 will be flawed."
 10 In terms of recommendations in relation to issue 7,
 11 and first in relation to risk assessment, the evidence
 12 has demonstrated that the existence of guidance on risk
 13 assessments and mitigating measures provided by NaCTSO
 14 is not always followed by corporate bodies. We submit
 15 that as a necessary corollary of the introduction of
 16 Martyn’s Law the legislation should also provide for the
 17 government to issue guidance to assist venues to comply
 18 with their obligations and should require that in
 19 fulfilling their Protect duty venues should have regard
 20 to that guidance.
 21 The guidance should address issues including risk
 22 assessment, counter—terrorism expertise and mitigating
 23 measures. These measures should be supported, we
 24 submit, with guidance from NaCTSO, from the SIA, and
 25 from membership bodies such as the National Arenas

14

1 Association. In addition to the vulnerability
 2 assessments that all venues should perform in accordance
 3 with part 2 of Martyn’s Law, we submit, sir, that you
 4 should recommend that large crowded spaces and tiered
 5 sites are required to conduct a full counter—terrorism
 6 risk assessment.
 7 The development of an appropriate risk assessment
 8 should be performed by those with counter—terror
 9 experience, either employed or contracted for. It
 10 should be informed by comprehensive and comprehensible
 11 advice from CTSA’s and from NaCTSO. It should be
 12 implemented by those trained in risk assessment and it
 13 should be reviewed and updated regularly, for example,
 14 to take account of evolving attack methodologies. It
 15 should consider risks from egress and ingress and
 16 measures to detect and prevent hostile reconnaissance.
 17 It should be supported by regular CCTV surveys to
 18 identify and address blind spots.
 19 The risk assessment should identify mitigating
 20 measures including person—searching, extended perimeters
 21 where feasible, and alternative arrangements capable of
 22 delivering comparable stand—off and protection where
 23 not.
 24 It should also include CCTV monitoring, the
 25 provision of communication equipment to staff with

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1 a counter—terror function who are working in isolated
 2 positions, and it should address the staff briefings .
 3 There should, we submit, also be a requirement in
 4 the statutory guidance and accredited contractor scheme
 5 that venues, security contractors, local authorities and
 6 local police forces, including their CTSA’s, should
 7 liaise to ensure a consistent, coherent and
 8 comprehensive approach to risk assessment and the
 9 mitigation of risk .
 10 In terms of counter—terror expertise, we submit that
 11 the inappropriate reliance of SMG on the CTSA assessment
 12 and the protestations of ShowSec as to the lack of
 13 necessary expertise demonstrates the need for you to
 14 recognise that venues over a certain size and security
 15 companies who work at such venues should obtain
 16 counter—terrorism expertise. For the relevant venues
 17 there should be a requirement in the statutory guidance
 18 that they either employ a security adviser with such
 19 expertise, as the arena has done since the attack, or
 20 they should retain the services of such an adviser on
 21 a consultancy basis to assist them both in the
 22 assessment of risk and the identification and
 23 implementation of necessary mitigation measures.
 24 The CTSA or responsible police force engaging with
 25 such venues should have a role in ensuring that

16

1 CT expertise is obtained. The adviser should also
2 advise the company on the adequacy and content of their
3 counter-terror training.

4 For security companies providing security and crowd
5 management services at such venues, there should equally
6 be a requirement in the statutory guidance and elsewhere
7 that either they employ an adviser with such expertise
8 or they retain the services of such an adviser on
9 a consultancy basis.

10 Sir, I'm turning next to issue 8, which starts at
11 paragraph 29 of our written note. This is the extent to
12 which there were adequate systems and/or competent
13 personnel to identify hostile reconnaissance.

14 The families submit that the evidence shows that
15 there was no adequate system in place to identify and
16 respond to hostile reconnaissance. Indeed, we agree
17 with the contention on behalf of Mr Lawler that:

18 "The documentary evidence and the evidence of what
19 happened has demonstrated that neither he nor his
20 colleagues were adequately equipped to recognise
21 suspicious behaviour".

22 While there were some historic examples of good
23 practice, the absence of a systemic, consistent response
24 is demonstrated by the lack of coherent action taken in
25 response to the hostile reconnaissance reports made by

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1 Jonathan Lavery on 18 May and Brandon Couper-Phillips on
2 21 May.

3 Mr Lavery, one of the very first witnesses from whom
4 you heard, identified a male acting very suspiciously,
5 wearing all black and with a large black bag. He
6 reported that to the Sierra Control Room, he recorded
7 that the male was Asian. He informed the BTP. But SMG
8 did not follow up, as Ms Stone accepted they should have
9 done, on what he had said.

10 It was recorded in the ShowSec radio log and the
11 supervisors' reports but not in the Whiskey Control Room
12 log or anywhere else.

13 The incident was not included in subsequent ShowSec
14 briefings beyond possibly that on the following night
15 because, as Mr Lavery explained, there was no system to
16 embed hostile reconnaissance into briefings for a period
17 of time after an incident. This was, as the experts
18 observed, a missed opportunity to make those briefings
19 more meaningful and engaging.

20 Although it was not Abedi who conducted that hostile
21 reconnaissance, the description Mr Lavery gave bears
22 a strong resemblance to his appearance on 22 May. Had
23 it been disseminated to ShowSec staff on the night of
24 the attack, with CCTV skills which Whiskey Control could
25 have provided, it is more likely, we submit, that he

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1 would have been recognised as a threat and therefore
2 this was a missed opportunity to detect and mitigate his
3 attack.

4 On 21 May, at the same time that Abedi was
5 conducting his hostile reconnaissance,
6 Mr Couper-Phillips recorded on his briefing sheet an
7 incident of suspected hostile reconnaissance that he had
8 seen. He did report it to his supervisor but only at
9 the end of his shift because, as he explained, he had
10 been told to stay in post and he did not have a radio.

11 Nothing was done about what Mr Couper-Phillips
12 reported. Neither SMG nor ShowSec considered it further
13 because steward and supervisory reports were not
14 reviewed by either company except when a complaint had
15 been received from a member of the public.

16 There were also repeated recorded issues from 2012
17 through to 2017 with the timely and complete provision
18 of reports from ShowSec to SMG.

19 In the final analysis, at least at the time of the
20 attack, we submit that the evidence shows that stewards'
21 reports had become another tick-box exercise.

22 The potential significance of these two separate
23 incidents of suspected hostile reconnaissance on two of
24 the four nights before the attack should have been
25 recognised and further measures put in place to meet the

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1 heightened risk they may have indicated. As Tom Bailey
2 recognised, ShowSec could have advised SMG about staff
3 increases and police engagement in response to these
4 incidents.

5 You, sir, will of course guard against the
6 assessment of the system for identifying hostile
7 reconnaissance by reference to hindsight because you
8 know that Abedi was in fact hostile. However, the risk
9 of hostile reconnaissance was entirely foreseeable and
10 addressed by applicable guidance, and you, sir,
11 therefore are entitled to test the adequacy of the
12 measures in place by reference to such shortfall.

13 The incidents on 18 and 21st were not isolated
14 examples of the absence of a proper system. By way of
15 example, Mike Edwards of FM did not recall a single
16 instance in 11 years where he recorded an incidence of
17 hostile reconnaissance and only a few occasions where FM
18 had spotted something suspicious. This is but an
19 example of the absence of appropriate coordination
20 between FM, SMG and ShowSec.

21 It is acknowledged that the identification of
22 Abedi's hostile reconnaissance in the City Room posed a
23 challenge, but the absence of adequate CCTV monitoring,
24 training and briefing still further reduced the chance
25 that this challenge would be met.

20

1 By way of recommendations for hostile
 2 reconnaissance, we submit that all venues and security
 3 companies employed by them should be required to collate
 4 and regularly review reports of hostile reconnaissance
 5 and suspicious behaviour and to identify trends, risks
 6 and measures that should be implemented to address those
 7 risks. This process should be undertaken in liaison
 8 with CTSAs and/or the responsible police force and the
 9 SIA should make this process a requirement of the
 10 accredited contractor scheme. Relevant bodies such as
 11 the National Arenas Association should also include this
 12 in their guidance to venues and it should be a part of
 13 the role of CTSAs to ensure that venues understand their
 14 responsibilities in this regard.

15 I turn next, sir, to issue 9 and the adequacy of the
 16 bag check and person-searching system, which is at
 17 paragraph 35 of our written note. It appears now to be
 18 accepted that the system of bag checking and person
 19 checking at the arena was inadequate. On the evidence
 20 it could hardly have been suggested otherwise.

21 At ingress, there were insufficient staff in the
 22 City Room: two who were SIA-licensed and present only
 23 intermittently and eight stewards. There were therefore
 24 insufficient staff to profile and search persons and
 25 large bags for an event of the size of the Ariana Grande

1 concert. There were also insufficient staff to meet the
 2 standard that SMG had apparently set of 1 in 10
 3 attendees being searched and all bags being searched.
 4 It is unclear, in fact, whether that
 5 person-searching standard had in fact been set or more
 6 particularly communicated to staff required to implement
 7 it. It is not recorded in any document, Access Control
 8 did not refer to it, and the management on the night had
 9 redeployed the Access Control team to the Trinity Way
 10 entrance during the ingress period.

11 It should, we submit, have been obvious to SMG and
 12 ShowSec management that this standard was impossible to
 13 meet as there were only two staff in the City Room whose
 14 intended role was to carry out the hundreds of searches
 15 that would be required. In fact, on 22 May, Mr Beak was
 16 in the City Room for ingress for just 39 minutes between
 17 17.41 and 19.30 hours.

18 It is a serious failing that for a significant
 19 period during ingress, no one was available beyond
 20 a supervisor with broader responsibilities and who was
 21 often on the concourse to conduct searches in the
 22 City Room.

23 It is not at all clear, we submit, that the
 24 distinction between checking and searching was
 25 understood by ShowSec staff. Some stewards performed

1 what SMG and ShowSec at the arena would have agreed
 2 at the time amounted to searches. The focus of others
 3 was on preventing food and drink being brought into the
 4 venue.

5 The search regime was, in any event, contrary to
 6 ShowSec's training and breached the mandatory condition
 7 in the licence that required SIA staff to perform
 8 security activities.

9 ShowSec directors were told unequivocally and
 10 correctly by the SIA that bag checking was a licensable
 11 activity. ShowSec staff at the arena, from stewards
 12 through to the heads of security, universally thought
 13 that it was not. Ms Stone, copying in James Allen,
 14 asked ShowSec directors to clarify the position back in
 15 July 2013. But it appears the directors did not provide
 16 a written answer, leading to the conclusion that either
 17 ShowSec directors allowed SMG, and for that matter its
 18 own staff, to think that it was not a licensable
 19 activity or they advised SMG of the correct position and
 20 both companies agreed tacitly or otherwise to continue
 21 to use stewards inappropriately.

22 The evidence that tends to show that SMG were aware
 23 includes that Ms Stone had asked, that SMG was sensitive
 24 to the slightest commercial considerations and using
 25 stewards saved them money, that Mr Allen was known to

1 ShowSec to be resistant to more SIA staff, that SMG told
 2 the CTSA, Mr Upham, that it conducted 100% bag searches,
 3 and that Mr Upham had made it clear to David Scally
 4 at the National Football Museum that specialist staff
 5 would be required for searching, so it is likely he
 6 would have said the same to SMG.

7 The explanation from Mr Harding of ShowSec that the
 8 unlawful search operation was a "simple management issue
 9 confined to the arena" is, we submit, implausible and
 10 indeed we invite you, sir, to reject it.

11 The system persisted for 4 years after the SIA put
 12 the position beyond doubt to ShowSec. Staff worked at
 13 multiple venues including, for example,
 14 Manchester City's football stadium and at festivals.
 15 ShowSec would have noticed that far fewer SIA staff were
 16 engaged at the arena as compared with other similar
 17 venues in their portfolio. Some of those venues were
 18 also operated by SMG, such as the First Direct Arena in
 19 Leeds and the Metro Radio Arena in Newcastle.

20 Regrettably, it appears that Mr Harding attempted to
 21 mislead the inquiry through his assertion that it would
 22 have been to ShowSec's commercial advantage for SMG to
 23 order more SIA staff in that they would have been more
 24 lucrative. ShowSec's 2017 accounts signed by him
 25 identify that:

1 "The largest risk facing ShowSec [was] the potential
 2 impact of the shortage of SIA workers."
 3 And that:
 4 "Too few licence—holders could mean that ShowSec
 5 could maintain fewer contracts."
 6 The more likely explanation is that ShowSec
 7 knowingly and deliberately used unlicensed staff to
 8 conduct licensable activities for commercial gain.
 9 It is, we submit, no answer to these concerns to submit,
 10 as CPs like SMG and ShowSec do, that Abedi did not seek
 11 to pass the bag checkpoint in the City Room. The real
 12 significance of the clear issues with the search
 13 operation is that they are indicative of deficiencies
 14 in the security operation as a whole. The search
 15 operation, like the wider security operation, was
 16 under—resourced.
 17 Traditional approaches trumped proper procedure and
 18 written policy and they were not reviewed. As
 19 Colonel Latham put it:
 20 "'We've always done it this way' means you're
 21 probably doing it wrong in my experience."
 22 Breaches arose and were allowed to continue as a
 23 result of, at best, a proper lack of communication and
 24 oversight or, at worst, a deliberate blind eye turned to
 25 licenced premises breaches.

25

1 There is evidence that the companies prioritised
 2 commercial concerns above security compliance with the
 3 law. Each of these factors not only demonstrates the
 4 general complacent attitude of the companies to exposing
 5 concertgoers to unacceptable risks to their health and
 6 safety, but also contributed to the lax impression of
 7 security, which must have fortified Salman Abedi in his
 8 conclusion that the arena was an attractive target.
 9 Issue 10: the concept of extending the perimeter,
 10 our paragraph 41. Miriam Stone and James Allen and
 11 others at both SMG and FM were aware of the possibility
 12 of extending the perimeter at the arena as a security
 13 measure following the NEAA seminar in 2016 but appear to
 14 have dismissed it without proper consideration beyond
 15 a short chat.
 16 The issue was also, of course, raised in NaCTSO
 17 guidance. We agree with the submissions of CTPHQ that
 18 CTSA's were not limited to matters within a site albeit
 19 that this particular CTSA appears to have considered
 20 that he was.
 21 The anticipated resistance from other stakeholders
 22 was assumed and untested, notwithstanding that (a) there
 23 was a forum to discuss issues with the landlord, which
 24 was in fact generally underutilised, (b) that SMG had at
 25 least thought it could use the City Room for events in

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1 the past, and (c) that SMG had in fact used the
 2 City Room for merchandise stands and search lanes. At
 3 least the first two of those required liaison and
 4 permission from stakeholders and the third involved
 5 a perimeter within the City Room.
 6 Greater Manchester Police's assessment now in their
 7 written submissions is that the decision not to move the
 8 perimeter was based on commercial pragmatism. Certainly
 9 commercial considerations appear to have played
 10 a significant part in the decision not to explore an
 11 extended perimeter, as Ms Stone identified in interview.
 12 The SIA bridge staff did not operate as an extended
 13 perimeter because they did not provide, as suggested in
 14 NaCTSO guidance, search and screening on the approach or
 15 outside the area, City Room, for which SMG had
 16 responsibility for security at all times. The staff
 17 were in any event redeployed after ingress. SMG gave no
 18 consideration to any alternative approach to preventing
 19 a hostile actor entering the City Room.
 20 The suggestion by some witnesses that perimeter
 21 extension serves only to move the problem from one place
 22 to another is, we submit, simplistic and unsustainable
 23 in relation to the City Room. It was and remains an
 24 enclosed and relatively small crowded space, as compared
 25 with other open spaces that permitted significantly more

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1 room for queues and those awaiting for attendees.
 2 Similarly, attempts by some CPs, such as BTP, to
 3 argue that the City Room was no different to other
 4 entrances to the arena ignores the reality that it was
 5 also recognised, not least by BTP officers who normally
 6 patrolled the venue, as an important ingress and egress
 7 point. That analysis is underscored by the post—attack
 8 recommendations of SMG's security experts to move the
 9 perimeter.
 10 The failure to move the perimeter was, we submit,
 11 a missed opportunity to prevent or deter the attack.
 12 I make clear that the families do not suggest it was the
 13 only answer to the threat, but as the experience of
 14 other venues by the beginning of 2017 was showing, it
 15 was one that ought to have been considered in detail.
 16 Importantly, as the experts agreed, if the perimeter
 17 was not to be moved, a series of other measures to
 18 mitigate the counter—terror risk, including patrols and
 19 CCTV monitoring, should have been considered and taken,
 20 which they were not.
 21 Issue 11: the effectiveness of liaison between SMG,
 22 ShowSec and BTP, our paragraph 45. Far from necessary
 23 liaison being, as BTP have suggested, effective, the
 24 families submit that the evidence shows that the liaison
 25 between these organisations was ineffective, resulting

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1 in a fragmented security operation. Whilst ShowSec can
 2 point to the primary role that police have in relation
 3 to counter-terrorism, as the experts agreed, effective
 4 counter-terrorism depends on the various components of
 5 an effective security operation working together.
 6 We adopt that which we anticipate Mr Welch is to say
 7 about BTP and GMP later today. Here, the evidence shows
 8 that ShowSec did not liaise with the BTP at all. For
 9 example, Mr Bailey, the most senior head of security,
 10 did not know how many BTP officers were deployed at
 11 Victoria Station and it did not occur to him to ask.
 12 ShowSec staff did not introduce themselves to the lead
 13 police officer at events in accordance with their own
 14 operational plan, which is another example of written
 15 policies that were not implemented in practice.
 16 SMG's liaison with the BTP was irregular. By way of
 17 two further examples, Mr Allen said he was unaware of
 18 the possibility that SMG could pay for policing services
 19 and the BTP were not informed, nor any other
 20 organisation on which SMG relied for CT support, about
 21 issues with the security systems such as CCTV blind
 22 spots.
 23 The lack of such liaison not only undermined the
 24 potential effectiveness of the security operation, but
 25 diminished what might have been an effective check by

1 each on the activities of the others. For example,
 2 BTP's practice of, in Ms Bullough's words, of generally
 3 putting your feet up during events might have been less
 4 likely to develop and an up-to-date written BTP risk
 5 assessment for events might have been more likely to
 6 have been maintained had there been closer coordination
 7 between these three organisations.
 8 Whilst it may be difficult, to quote Mr Gibbs, to
 9 quantify on a written risk assessment the implication of
 10 the background threat for a specific event, it is more
 11 difficult to expect different agencies to have
 12 a coordinated approach to that threat where it is not
 13 put into black and white, shared and acted upon. These
 14 failures of coordination and liaison mirror the
 15 demonstrable failure of wider multi-agency coordination
 16 in the period before the attack.
 17 The evidence, commented on by the experts, showed
 18 that GMP, and more especially BTP, did not regularly
 19 attend quarterly multi-agency meetings. The minutes of
 20 these meetings reveal a lack of concerted assessment of
 21 the risk for terrorism for a vulnerable venue such as
 22 the arena and by way of recommendation in this regard we
 23 submit, sir, that you should recommend that the
 24 attendance of relevant public authorities, including
 25 police forces, should be required at regular

1 multi-agency meetings, concerns should be shared in
 2 advance of such meetings, minutes should be taken and
 3 circulated. We submit that such meetings, to be
 4 effective, should be compulsory.
 5 Issue 12: whether the Ariana Grande concert was
 6 staffed by appropriate numbers of adequately trained
 7 staff, paragraph 48 in our written note. As our written
 8 note makes clear, we submit there are three essential
 9 components to this issue: staffing levels, training and
 10 briefings. On the evidence, we submit that none was
 11 adequate.
 12 Staffing levels. In general terms, we submit there
 13 were insufficient staff to provide an appropriate
 14 security operation or, as the experts put it, staffing
 15 levels were sub-optimal.
 16 Mr Allen observed in April of 2016 that the
 17 operation provided the "minimum but necessary number of
 18 staff". It is clear that staffing fell below even that
 19 level, as two examples show. First, Stephen Noone, the
 20 second FM patrol officer in Whiskey on the night of the
 21 attack described it as normal practice, ShowSec
 22 backstage manager Keith EtcHELLS asking one of the
 23 Whiskey staff to guard a door when the artists were
 24 coming off stage so that the guard would be unable,
 25 of course, to monitor the CCTV during egress.

1 Second, for much of the Ariana Grande show, Mr Agha
 2 working his first shift as an SIA operative focused,
 3 like other staff, on customer service rather than
 4 suspicious activity and, it is submitted on his behalf,
 5 that he was there to watch the crowd, not to look out on
 6 their behalf, is revealing.
 7 Certainly he was alone in the City Room, a large
 8 space that could not be seen in its entirety from any
 9 single location or on CCTV for long periods. And his
 10 solitary presence was no deterrent to Abedi and the
 11 level of staffing in the City Room represents a missed
 12 opportunity to have deterred, detected or mitigated his
 13 attack.
 14 The evidence demonstrates that there was no increase
 15 in staffing or any security resources, whether
 16 temporarily, as there had been for a few shows after
 17 Charlie Hebdo, or permanently following the highly
 18 relevant attacks at entertainment venues in Paris, the
 19 Bataclan and Stade de France, on 13 November 2015.
 20 There was not even a consideration of an increase,
 21 notwithstanding the fact that (a) SMG were aware, as
 22 demonstrated by Ms Stone's April 2016 review, that:
 23 "Most other arenas across the UK were increasing
 24 staff numbers and many were conducting full searches."
 25 And (b) that both SMG and ShowSec had been told on

1 20 April 2016 at the NEAA seminar that the
 2 Paris Accor Arena, which was not attacked, had increased
 3 its security staff by 20% from 160 to 190, had moved its
 4 perimeter, and had secured the attendance of more police
 5 officers and had begun undertaking full searches.

6 The measures that were taken by SMG focused on the
 7 private areas of the arena and demonstrated complacency
 8 and a passive approach about the public-facing security
 9 operation. It is, we submit, striking that the number
 10 of ShowSec staff at work on the night of the attack was
 11 almost identical to the number at the similarly sized
 12 Accor Arena before the Paris attack, 164, and that
 13 following the respective attacks the stewarding level at
 14 both venues was increased by 20%.

15 It also appears that there was no increase in
 16 staffing when the national terrorism threat level moved
 17 from substantial to severe, as it did from January 2010
 18 until July 2011, and from August 2014 until the attack.
 19 Instead, SMG's focus was on reducing its costs,
 20 including through staffing reductions, a state of
 21 affairs that, in view of the above, Mr Allen agreed was
 22 unacceptable. That focus resulted from the sustained
 23 pressure applied by senior management to the arena's
 24 management over 7 or 8 years and particularly at times
 25 when the minimum wage was increased.

1 Against that background, Ms Stone agreed that she
 2 was not in a position to argue for increases. There is
 3 evidence to suggest that staffing cuts were in fact
 4 made. First, an October 2016 review conducted by
 5 Mr Battersby following his inspection of a Justin Bieber
 6 concert, which was itself a product of negotiations
 7 in April and focused on reducing costs, identified that
 8 bridge SIA staff, which ShowSec had identified had
 9 a role in counter-terrorism, could be redeployed during
 10 shows. This of course happened on the night of the
 11 attack and Ms Stone agreed that it appeared to have
 12 followed from these recommendations.

13 Second, the concept of redeployment advanced as an
 14 alternative to cuts necessarily involved a reduction in
 15 staffing levels, as Mr Allen accepted, if it was to save
 16 money, according with Ms Stone's observation that
 17 staffing on the doors, an area critical to safety, had
 18 been "mined to a very large extent".

19 Third, the late disclosure provided by SMG is
 20 revealing. On 29 March 2016, John Sharkey asked
 21 Mark Harding to make the April 2016 minimum wage
 22 increase cost neutral for both companies. On 31 March,
 23 they worked on an email together to SMG's general
 24 managers that set them a target of a 4% reduction in
 25 hours for stewards and SIA staff "to allow ShowSec to

1 pass on some costs to allow SMG to be able to absorb the
 2 increase without an overall increase".

3 Notwithstanding Mr Allen's defence of the current
 4 arrangements at the arena in his document of April 2016,
 5 on the 11th of that month, Mr Harding emailed
 6 Mr Sharkey, later forwarded to James Allen, to make
 7 clear that savings could only be made largely through
 8 efficiencies and reductions, that ShowSec were anxious
 9 to remain competitive and to achieve cost neutrality.

10 He attached a Word document that referred to
 11 a reduction in overall stewarding hours across three
 12 venues of 4,850 hours a year. He noted higher savings
 13 on SIA hours and that:

14 "SMG and ShowSec have done an analysis that showed
 15 reductions can be made by the removal of non-safety
 16 critical positions."

17 Although how it was achieved is not set out
 18 explicitly, later communications at the end of April
 19 between Mr Harding and Mr Sharkey suggest that cost
 20 neutrality was achieved and the only available
 21 explanation is that the measures identified earlier that
 22 month had been implemented. The threat from terrorism
 23 was not mentioned in any of those communications.

24 Fourth, certain witness evidence on this topic was
 25 internally inconsistent and contradicted by documents

1 subsequently disclosed. For example, Mr Harding was
 2 asked directly:

3 "Were you aware of SMG at least investigating
 4 a reduction in staffing levels?"

5 He replied no, but that is incorrect. He co-wrote
 6 the email with Mr Sharkey setting a 4% target in
 7 reductions.

8 Finally, SMG and ShowSec have provided no
 9 documentary evidence to substantiate the assertion that
 10 there were no cuts.

11 Although SMG were ultimately responsible for
 12 staffing levels, ShowSec failed to advise its clients
 13 that is the staffing levels were inadequate to keep
 14 attendees safe and that the proposed cuts would, as
 15 Ms Stone feared, compromise safety. Instead, ShowSec
 16 was overly focused on remaining competitive, as indeed
 17 the evidence in relation to bag checks illustrates.

18 Whether or not ShowSec held themselves out as
 19 counter-terrorism experts, as SMG understood them to be,
 20 the company undoubtedly provided counter-terror advice
 21 to the arena on the basis of its experience; see, for
 22 example Mr Bailey's positional analysis and
 23 Mr Battersby's presentation.

24 We therefore submit that you can conclude, sir, that
 25 staffing levels were inadequate in general and in

1 particular insufficient SIA—licensed staff were present
 2 to perform licensable activities .
 3 In relation to training, and despite the submissions
 4 made on its behalf, the families submit that you, sir ,
 5 can conclude that ShowSec staff that were available were
 6 inadequately trained. It was incumbent upon ShowSec,
 7 having developed a business model that in Mr Battersby's
 8 description relied on delivering a security operation
 9 with a casual workforce who security companies had no
 10 real hold on, to ensure otherwise.
 11 Project Griffin was aimed at staff at all levels ,
 12 but only 13 of the 164 staff working at the arena on the
 13 night had attended such training and only one of them
 14 was in the City Room. The low number of attendees may
 15 be explained by the fact that Griffin was delivered in
 16 a classroom, which, according to the 2018 HMRC audit of
 17 ShowSec, would have required ShowSec to pay its workers
 18 to attend. That may also explain why ShowSec moved its
 19 training to an online portal.
 20 That online training was deficient in numerous
 21 respects, which are, we submit, a long way from
 22 nitpicking: there was no practical or interactive
 23 element; it was not focused on attack methodologies most
 24 relevant to the arena; and, critically , ShowSec did not
 25 have a system of supervision in place to ensure that

1 staff undertook the mandatory training models or to test
 2 that they had understood them. As a result, the company
 3 did not (inaudible: distorted) its staff spent on parts
 4 of its syllabus .
 5 Whilst ShowSec now suggests this was an issue
 6 limited to Mr Agha, the evidence shows it to have been
 7 systemic. Of the 10 staff for whom information has been
 8 provided, only three had spent anything like sufficient
 9 time on the training and those were all either
 10 supervisors or managers.
 11 Although ShowSec suggests a need for caution
 12 in relation to them, it is submitted that the records
 13 are sufficiently reliable for you to make findings based
 14 on them. It is of note, first , that ShowSec did not
 15 provide any such caveat to the time—spent evidence when
 16 it first volunteered it in relation to Mr Agha. The
 17 letter from the solicitors only raised that issue after
 18 further records were provided.
 19 Second, the caveat in the letter that the records
 20 will not show if staff did modules more than once does
 21 not appear to be born out by the records themselves, and
 22 we give examples of that in our written note.
 23 Third, as the time spent provides dates and times
 24 for each module, the caveat in the ShowSec letter would
 25 only apply if a member of the public retook all sections

1 of the counter—terror module on another day. The record
 2 shows that, for example, Mr Beak undertook most of his
 3 on one day but revisited it in June 2017, some time
 4 later . The same analysis can be applied to two others
 5 but no one else.
 6 The evidence does not support the suggestion that
 7 other staff voluntarily revisited their
 8 counter—terrorism training after they had begun work.
 9 There was no financial incentive or managerial pressure
 10 for them to do so.
 11 Finally, the records are relatively consistent. To
 12 conclude that they do not demonstrate that most or all
 13 junior staff rushed through their training, you, sir ,
 14 would need to conclude that most or all of those junior
 15 staff completed their training properly and then
 16 completed it again at speed. That, we submit, is simply
 17 implausible.
 18 It is important that nothing that Mr Harding told
 19 SMG, that ShowSec would directly review their online CT
 20 training on 14 November after the Bataclan attack, is
 21 reflected in the message he actually sent to staff which
 22 is :
 23 "They [were] always open if you wish to refresh the
 24 key points in your training."
 25 The only evidence provided by ShowSec shows that

1 only 5.28% of recipients of an email clicked any link
 2 and some of those were to social media accounts of
 3 ShowSec's.
 4 The time spent records show that none of the staff
 5 working in the City Room or on the bridge on the night
 6 of the attack had revisited their training as a result
 7 of that e—shot. Like the Battersby presentation, it is
 8 demonstrative of a company that presented itself to the
 9 market in a way not reflected in its practices. And
 10 it is no answer, we submit, to say that ShowSec's
 11 training or any other aspect of its operation was
 12 "market leading" or "met industry standards".
 13 Not only is that an assertion made by the company
 14 without reference to any evidence external to its own
 15 directors but there were clear deficiencies in the
 16 training as identified by the experts. What matters is
 17 whether the company had taken all reasonable measures to
 18 address the risk from terrorism. ShowSec had not.
 19 SIA training for those staff who'd undertaken it was
 20 similarly not a sufficient substitute. It was not venue
 21 specific, it was not refreshed, and you, sir, heard
 22 evidence raising concerns, for example, from Mr Lavery
 23 and Mr Agha in relation to that training.
 24 In terms of briefings, the counter—terror content in
 25 the stewards' briefings was inadequate in particular.

1 The balance of evidence shows that there was no
 2 counter-terrorism content in the briefing to the
 3 City Room stewards on 22 May. Mr Middleton, who
 4 delivered the stewards' briefing, said, until prompted,
 5 that he understood that severe meant only that an attack
 6 was a likelihood and the counter-terror content of his
 7 briefing might amount to, "Keep your eyes open and look
 8 out for anything suspicious".

9 The document from which staff were briefed made no
 10 reference to counter-terrorism. It included
 11 a misleading assessment of risk.

12 Our footnote 126, sir, helps with references to
 13 other evidence on that point.

14 When on other occasions counter-terrorism was
 15 included, it was confined to an oral instruction -- or,
 16 as Mr Couper-Phillips described it, a general blanket
 17 statement -- in a crowded field of information to look
 18 out for suspicious packages or characters without any
 19 explanation as to what that meant or how to respond to
 20 it.

21 So not a single witness said briefings referred to
 22 the matters identified in the 2017 ShowSec
 23 counter-terrorism awareness document such as behavioural
 24 traits or identifying a change in approach following
 25 a company-wide October 2016 meeting in which ShowSec

1 identified that briefings were inadequate, that
 2 counter-terrorism needed inserting, and that hostile
 3 reconnaissance should be engendered in every briefing.
 4 It is of note that Mr Rigby, who briefed supervisors,
 5 had no recollection of any changes following that
 6 October 2016 recommendation.

7 It is also notable that former employees of ShowSec
 8 record only limited CT content whilst current employees
 9 recalled more. That's indicative that they were
 10 recalling the present position rather than the position
 11 in May of 2017.

12 In relation to Mr Agha, he was not briefed on his
 13 role at the grey doors, save he was told that was his
 14 position and he shouldn't leave it. It was essential
 15 that his role was properly briefed because ShowSec staff
 16 in the City Room, save for the supervisor, were not
 17 required to have any experience.

18 His explanation for not asking any questions at the
 19 briefing accorded with Mr Middleton's remarkable answer,
 20 when asked if he was approachable that he was "strict
 21 and not at work to make friends".

22 There was no mechanism to guard against
 23 underconfident staff or unapproachable supervisors.
 24 Staff were not provided with written instructions as to
 25 their roles and the City Room training module developed

1 by SMG and ShowSec was deficient as it said nothing
 2 about the operation of fire doors or the grey doors.

3 In terms of recommendations for issue 12,
 4 in relation to training, part 1 of the Martyn's Law
 5 proposals suggest that every venue should have at least
 6 25% of their staff counter-terrorism awareness trained,
 7 have one on-duty manager who's received the relevant ACT
 8 awareness training course. We endorse that
 9 recommendation. Indeed, we submit you, sir, could go
 10 further in relation to large crowded spaces and tiered
 11 sites and recommend that the requirement for statutory
 12 guidance and accredited contractor scheme that all
 13 security, stewarding and management staff should
 14 undertake ACT courses in relation to their roles.

15 Such venues are particularly attractive to
 16 terrorists and the evidence has shown that security,
 17 stewarding and management have significant
 18 counter-terrorism functions. We also submit that you,
 19 sir, should recommend that the statutory guidance and
 20 accredited contractor scheme require staff to be paid
 21 for such training. This will ensure that staff are
 22 incentivised to undertake it and to do it properly. If
 23 there is a concern that casual workers may not work
 24 after completing such training, then you could recommend
 25 that staff are required to complete that training

1 a short time after they have commenced work. You, sir,
 2 could also recommend that Ofqual examine the quality of
 3 SIA training in this regard.

4 Issue 13: the nature and adequacy of pre-egress
 5 checks, our paragraph 66. The short answer, we submit,
 6 is that the pre-egress checks of the City Room were
 7 inadequate. In an example of the carousel of blame in
 8 full rotation, both during the evidential hearings and
 9 in their closing submissions, each of SMG, FM and
 10 ShowSec has sought to minimise its role in conducting
 11 such checks and their adequacy at the expense of the
 12 others. The truth is that all were responsible for the
 13 failure of adequacy of pre-egress checks.

14 FM failed to conduct any patrols during shows when
 15 risk was at its highest despite the fact that its manual
 16 drew no distinction between event and non-event days for
 17 the number of patrols. The facilities management
 18 agreement required patrols to be electronically
 19 monitored, yet ShowSec were not instructed to do that.
 20 Had they and FM discussed patrols directly, events may
 21 have been different.

22 The starting point for consideration of ShowSec's
 23 role is, we submit, that as the experts agreed, the need
 24 to check the mezzanine for threats to attendees in the
 25 wider City Room was or should have been apparent to any

1 responsible security provider, whether they had written
 2 instructions to that effect or not.
 3 Such a straightforward step did not require the use
 4 of personal protective equipment or extensive specialist
 5 training. The unambiguous language of the pre-egress
 6 check sheets that we looked at so often required ShowSec
 7 to check the whole City Room wall to wall. Their CT
 8 awareness documents required their supervisors to
 9 undertake regular patrols of their sector as a further
 10 observatory patrol. Neither happened on the night:
 11 Mr Middleton was static or absent from the City Room
 12 entirely.
 13 The cursory pre-egress checks that you saw
 14 undertaken by Mr Beak involved at most a glance across
 15 towards the staircase at a distance from which nothing
 16 meaningful could have been learned. Such checks had
 17 become yet another tick-box exercise.
 18 The attempt to argue that ShowSec was not
 19 responsible for the mezzanine by certain of its
 20 witnesses whose accounts frequently used the same word
 21 of jurisdiction were, we submit, fanciful.
 22 There was ample evidence that ShowSec knew
 23 differently : from the position of Mr Lavery, from the
 24 fact that Mr Beak went up on to the mezzanine, that
 25 Mr Rigby and others did not raise any questions about

1 being called to take action on the mezzanine, that the
 2 pre-egress check sheet had been reviewed without any
 3 questions being raised, that it was envisaged that
 4 ShowSec would undertake patrols on event days.
 5 It was at the very least another example of
 6 a failure of liaison between SMG and ShowSec and
 7 a failure of ShowSec management to communicate to its
 8 staff and, at worst, a further incidence of knowingly
 9 cutting corners.
 10 The failure to check the mezzanine was, we submit,
 11 a missed opportunity to detect and/or mitigate the
 12 attack. Whilst SMG seeks now to assert that any breach
 13 was internal to ShowSec and of its own making, this does
 14 not recognise that SMG itself failed to ensure that its
 15 written agreement with ShowSec on patrolling during
 16 events was put into place, which would have ensured that
 17 there was no doubt about respective responsibilities of
 18 the two.
 19 It failed to check that ShowSec was meeting its
 20 expectations. The completion of pre-egress check sheets
 21 was a KPI in the service level agreement. It should
 22 have involved spot-checks to ensure that it was being
 23 done correctly.
 24 In relation to pre-egress checks in terms of
 25 recommendations, sir, we observe that the current NaCTSO

1 crowded place guidance of June 2017 applies to all
 2 sectors but does not address specifically the risks at
 3 ingress and egress. We submit that you should recommend
 4 that NaCTSO reviews that guidance to ensure that it does
 5 address specific risks at those times and mitigating
 6 measures available.
 7 Issue 14: CCTV monitoring, our paragraph 73. We
 8 submit that the evidence shows overwhelmingly that the
 9 CCTV monitoring during events was inadequate. The
 10 division of responsibility for CCTV monitoring was not
 11 clearly understood between Whiskey and Sierra Controls.
 12 By way of example, Mr Edwards, the duty control room
 13 operator, who according to Mr Johnson was the staff
 14 member principally responsible for monitoring CCTV,
 15 wrongly understood that there would be someone in Sierra
 16 watching the CCTV throughout the event.
 17 In his first witness statement Mr Allen said that
 18 during an event, the duty manager would:
 19 "... have control of and actively monitor the CCTV
 20 cameras covering the arena and the entrances and exits
 21 and Whiskey were on hand as an extra pair of eyes on the
 22 CCTV public areas."
 23 In fact, the duty manager and the head of security
 24 in Sierra watched the CCTV reactively or, as Ms Stone
 25 said, they used it but did not monitor the cameras for

1 egress.
 2 There was insufficient staff to monitor the number
 3 of cameras that were required. In Whiskey there were
 4 the same number of staff available during events as on
 5 non-event days. There was no single staff member
 6 dedicated to CCTV. All staff might be involved but they
 7 also had other responsibilities to do. Particularly ,
 8 the fire safety officer would often be in his office ,
 9 and at critical times during egress, patrol officers
 10 could be required to guard a door at the request of
 11 ShowSec, further reducing the capacity for CCTV
 12 monitoring.
 13 If a patrol officer had conducted patrols during
 14 events or had to deal with other issues , such as faulty
 15 radios or lifts , that would further reduce the capacity.
 16 Given the number of cameras and responsibilities, two
 17 staff had to be allocated solely to that job.
 18 In any event, staff were insufficiently trained.
 19 FM staff were not aware of the national threat level and
 20 the limited CT training did not address person-borne
 21 IEDs. SMG had not implemented Mr Battersby's suggestion
 22 in his NEAA seminar presentation that CCTV operators
 23 should be prioritised on behaviour patterns of people
 24 outside the venue.
 25 Learning from SMG's training exercises was not

1 disseminated. FM staff did not undertake SIA CCTV
 2 courses, which, unlike other SIA courses, did have
 3 a dedicated section on IEDs, and they received no other
 4 formal training, nor apparently did ShowSec staff who,
 5 as private contractors providing cover in Whiskey, were
 6 required to have an SIA CCTV licence.

7 Fourth, the CCTV system itself was inadequate. The
 8 large number of cameras and the small size of the
 9 monitors meant that the identification of hostile actors
 10 was difficult.

11 The existence of the blind spots — issue 15, our
 12 paragraph 78, sir — should, we submit, have been
 13 obvious as it appears to have been to Mr Abedi from
 14 a simple look at the walls and the positions and angles
 15 of the cameras.

16 There had been a review of the CCTV system in
 17 November 2016 by SMG and FM that involved the
 18 identification of blind spots and the drawing up of
 19 plans for new cameras. Against that context and the
 20 evidence of Mr Edwards, who said that everyone knew
 21 about the CCTV blind spots, the denial of knowledge of
 22 its existence by all other witnesses from FM, SMG and
 23 ShowSec is unconvincing. As Mr Allen accepted, SMG
 24 should have been aware of it and taken steps to address
 25 it.

1 Even if, contrary to Mr Edwards' evidence, it were
 2 found that they were not aware, insufficient thought was
 3 given to its existence and the risk it posed,
 4 particularly after McDonald's was closed, and there was
 5 a lack of coordination between the respective control
 6 rooms and the relevant companies in relation to the risk
 7 posed from blind spots.

8 By way of recommendations in relation to CCTV,
 9 section 33.2 of the Private Security Industry Act 2001
 10 provides that if a person provides a licensable activity
 11 in connection with any contract for service, he or she
 12 requires a licence to do so. FM staff provided
 13 a security service pursuant to an agreement with SMG who
 14 in turn were contracted with the arena to provide such
 15 service. It would appear therefore that FM staff
 16 monitoring CCTV should have had an SIA CCTV licence. We
 17 submit that the distinction between in-house security
 18 staff who may monitor the public crowded spaces as part
 19 of their role and staff providing the same service
 20 subject to a contract is difficult to justify.

21 As here, it may lead to confusion about licensing
 22 requirements and undertrained staff performing roles
 23 with counter-terrorism functions without any formal
 24 training in hostile reconnaissance and suspicious
 25 behaviour. For those reasons, we submit, sir, that you

1 should recommend the Home Office and the SIA should
 2 review the distinction drawn in the 2001 Act.

3 Issue 16: why it was not noticed that Mr Abedi had
 4 visited the City Room on 22 May? Our paragraph 80.
 5 This is an issue that cuts across all the failings
 6 described in these submissions. I say no more than
 7 we have put in writing about it.

8 Issue 17: the extent to which commercial pressures
 9 played any role in the adequacy of security arrangements
 10 and systems, our paragraph 81. The evidence
 11 demonstrates, as we have already seen, that commercial
 12 considerations played a role in each aspect of the
 13 security operation provided by the businesses, including
 14 SIA levels, staffing levels, search operation, the
 15 perimeter and CCTV provision.

16 It is important to note the families are not
 17 unrealistic about commercial pressures. It is
 18 inevitable that companies will compete, including by
 19 striving to reduce their costs. However, in this
 20 instance, commercial considerations were, as Ms Stone
 21 put it, given too much weight. In other words, cost
 22 concerns were prioritised ahead of the provision of all
 23 reasonable measures to address the risk from terrorism.

24 Both companies were profitable in 2017. Both were
 25 on notice from multiple sources of the risk to

1 entertainment venues and transport hubs and the measures
 2 that would be needed to meet those risks. Both
 3 companies should have done more to reduce and mitigate
 4 the risks of a successful attack.

5 The families note the inevitable incentives for
 6 commercial organisations to minimise their outgoings.
 7 The fact that these companies had prioritised commercial
 8 considerations over safety in each aspect of their
 9 security operation underlines the importance of
 10 recommendations to address each of those issues. This,
 11 of necessity, must involve the imposition of clear rules
 12 and duties, the application of which is properly and
 13 effectively overseen and enforced.

14 Sir, issues 18, 19 and 26, which flow from
 15 paragraph 85 of our note, all concern contact of
 16 Messrs Agha and Lawler and considerations in relation to
 17 the grey doors. It is convenient to take those
 18 together, not least given the time.

19 The evidence shows Mr Agha failed to respond
 20 promptly and adequately, that Mr Lawler failed to
 21 respond adequately. Their accounts have changed
 22 repeatedly and none is consistent with the
 23 incontrovertible CCTV evidence. Mr Lawler's evidence is
 24 not consistent with the evidence from multiple witnesses
 25 that radio traffic did not prevent a transmission to

1 Sierra Control. The evidence, by no means limited to
 2 that of Mr Agha, demonstrates a failure to ensure that
 3 he knew how to communicate to others.
 4 In relation to him and the grey doors, the CCTV
 5 shows that he did what he had been trained and briefed
 6 to do: he stayed in his position. This was a flawed
 7 system that resulted in a serious delay in the
 8 transmission of time-sensitive security information.
 9 Whilst of course he should have recognised the situation
 10 was so serious that it required him to take commonsense
 11 measures, reliance on a casual workforce, many of whom,
 12 like Mr Lawler and Mr Agha are teenagers, and many are
 13 under 25 and who are not paid to complete their
 14 training, created an obvious risk that commonsense
 15 measures would not be (inaudible: distorted). A robust
 16 system was required to safeguard against such obvious
 17 problems.
 18 Given the importance of the isolated position
 19 Mr Agha was in, he should have had a radio; condition 87
 20 of the premises licence required it. He should have
 21 been trained and briefed about different methods of
 22 communication and how his doors operated. His
 23 supervisor should have visited him. A number of
 24 alternative means of communication have been advanced by
 25 ShowSec but none of them is to be found in its training,

1 in its briefing sheets or in the degree of understanding
 2 of options available to its staff.
 3 The failure to train or brief Mr Agha properly led
 4 to a delay in the communication of time-sensitive and
 5 safety-critical information to another member of staff,
 6 which reduced the opportunity to detect or mitigate the
 7 impact of the attack.
 8 In relation to the actions of first Mr Agha and then
 9 Mr Lawler to the presence of Mr Abedi and Mr Wild's
 10 concerns about him, the first question arises is why
 11 they failed to respond adequately. Mr Lawler ultimately
 12 accepted that it was not because of the radios. We
 13 invite you, sir, to reject the belated suggestion by
 14 him, given that his accounts have altered in material
 15 respects over time and that he's admitted that he lied
 16 to the police, that he failed to report Mr Abedi because
 17 he feared being accused of racism.
 18 That unattractive attempt to deflect responsibility
 19 from his actions on to liberal society is an explanation
 20 undermined entirely by his calm and jovial demeanour and
 21 careful body language when he left the City Room and his
 22 own attempts in his own account to try on his radio to
 23 contact Sierra.
 24 Rather, the only credible explanation for his
 25 actions, consistent with all the evidence, including the

1 evidence of Mr Wild as to Mr Agha's attitude to him,
 2 is that neither Mr Agha nor Mr Lawler recognised the
 3 threat that Abedi posed. Mr Agha reported it to
 4 Mr Lawler only because it had been raised by a member of
 5 the public and Mr Lawler did not report it at all.
 6 Instead, like Mr Couper-Phillips on 21 May, he appears
 7 to have thought it sufficient to write it down on his
 8 now lost briefing sheet, as the CCTV suggests.
 9 The second question is why these two SIA-licensed
 10 ShowSec staff, warned by Mr Wild, failed to recognise
 11 that Mr Abedi needed to be reported to Sierra. The
 12 answer is not that there was nothing to report, clearly
 13 there was after a member of the public had flagged it.
 14 The answer is found throughout the submissions that
 15 I have taken, I know, too long over this morning: the
 16 ShowSec and SIA training was inadequate. These men had
 17 not completed their training properly, had not been
 18 briefed properly, had not been informed about the
 19 hostile reconnaissance seen by Mr Lavery, they had not
 20 been informed that Mr Abedi had been sat in a blind
 21 spot.
 22 Mr Agha and Mr Lawler should have done more but
 23 equally SMG and ShowSec should have had a robust system
 24 in place to ensure that they were properly trained,
 25 briefed and monitored, and to address the issues that

1 are likely to arise within a low-paid and relatively
 2 casual workforce.
 3 Final issue, number 27, our paragraph 92: what would
 4 have happened if a report of suspicious behaviour had
 5 been made to the arena control room before egress on
 6 22 May? The answer to this question, we submit, is that
 7 steps would have been taken which might have made a real
 8 difference. Contrary to the suggestion of some CPs,
 9 this is not a speculative assertion when timings are
 10 taken into account. The CCTV, sir, shows that Mr Wild
 11 spoke to Mr Agha at 22.14.49. It shows that he spoke to
 12 Mr Lawler at 22.23.15.
 13 By reference purely to those whose families we
 14 represent, at 22.14.49 none of those six was in the
 15 City Room. By the time that Mr Agha spoke to Mr Lawler,
 16 only two of them were. The evidence of James Allen and,
 17 especially given that she was on duty that night, of
 18 Miriam Stone shows that exits from the arena to the
 19 City Room would have been closed within a minute or two
 20 of a report of suspicious individuals being reported to
 21 Sierra before and during egress. Attendees would have
 22 then been diverted to alternative exits. The public
 23 in the City Room would have been warned to move away.
 24 ShowSec staff would have investigated, BTP staff would
 25 have been contacted. It is likely, we submit, that the

1 deaths of the 22, with which you are concerned, would
 2 not have taken place for those reasons.
 3 Of course, had Abedi realised he had been
 4 identified, it is possible that he would have detonated
 5 his bomb. But it is, we submit, highly likely that
 6 fewer people would have died and been injured by
 7 detonation on the mezzanine before egress than
 8 a detonation in the midst of the crowd at the height of
 9 egress.
 10 In our written note, from paragraph 95, we have set
 11 out the missed opportunities and the potential
 12 consequences they had in terms of causation. Because of
 13 time, I will not take you through those orally now, sir,
 14 but I commend that analysis to you.
 15 Finally then, we repeat our support for the
 16 recommendations both for the introduction of
 17 Martyn's Law but also for supporting guidance and the
 18 tightening of the licensing regime. But in doing so,
 19 sir, we recognise that legislation is only as effective
 20 as a means of its enforcement. The evidence has
 21 demonstrated that existing legislation has not only been
 22 misunderstood or ignored by those to whom it applied but
 23 such issues, where they arose, appear to have passed
 24 undetected.
 25 Breaches of the premises licence and of the Private

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1 Security Industry Act 2001 had persisted with impunity
 2 for years before they were discovered, sir, by you and
 3 this inquiry in the course of this investigation. They
 4 were not and would not have been detected by those
 5 responsible for enforcement at that time because of
 6 a lack of inspections. There does not appear to have
 7 been an inspection of the arena by Manchester City
 8 Council and, if there were inspections, they certainly
 9 failed to identify myriad breaches of the premises
 10 licence.
 11 The licensing compliance and enforcement team is, as
 12 you heard, permanently understaffed. The SIA have only
 13 one enforcement officer for 18,000 licence holders in
 14 Manchester and had undertaken no checks at the arena
 15 in the 12 months before the attack, neither had there
 16 been before that.
 17 We therefore submit, sir, that you should recommend
 18 that local authorities, including Manchester City
 19 Council, should ensure that licensing regimes and
 20 Martyn's Law are properly enforced through regular
 21 inspection. You should also recommend that the SIA, as
 22 part of its review of its accredited contractor scheme,
 23 consider the introduction of additional inspections to
 24 ensure compliance with the provisions of the 2001 Act by
 25 its members.

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1 Sir, we submit that it is through such measures as
 2 the recommendations that we have set out in our written
 3 submissions from paragraph 97 that it will be possible
 4 for you, sir, through your report to bring in measures
 5 that will ensure, insofar as of course as is ever
 6 possible, that no other families are required to endure
 7 the same suffering as the families of those who lost
 8 their lives on 22 May 2017.
 9 I apologise for going beyond my time. I'm grateful
 10 for your attention.
 11 SIR JOHN SAUNDERS: Thank you very much, Mr Atkinson, that
 12 was extremely helpful and very detailed, as it needed to
 13 be.
 14 Mr Greaney.
 15 MR GREANEY: Sir, in fact Mr Atkinson went only 5 minutes
 16 beyond his allotted time, but may we now have a break
 17 until just beyond 11.45 at which point we will hear from
 18 Mr Weatherby on behalf of the families represented by
 19 Broudie Jackson Canter and Hudgells?
 20 SIR JOHN SAUNDERS: Thank you. At 11.47, I will switch on
 21 my computer. Thank you.
 22 (11.32 am)
 23 (A short break)
 24 (11.47 am)
 25 SIR JOHN SAUNDERS: Mr Weatherby.

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1 Submissions by MR WEATHERBY
 2 MR WEATHERBY: Thank you.
 3 SIR JOHN SAUNDERS: Thank you very much for your speaking
 4 note, for which I'm very grateful.
 5 MR WEATHERBY: I'm glad that you have that.
 6 Sir, as you know, I make submissions on behalf of
 7 seven of the families: the families of Saffie—Rose
 8 Roussos, Alison Howe, Lisa Lees, Georgina Callander,
 9 Olivia Campbell—Hardy, Philip Tron and
 10 Sorrell Leczkowski.
 11 SMG took the money for ensuring security and public
 12 safety in the City Room, but very plainly failed to
 13 discharge those responsibilities. If they had taken
 14 reasonable and proportionate measures to discharge those
 15 responsibilities then the bombing could not have
 16 happened because Salman Abedi could not have entered and
 17 remained in the City Room with his large device prior to
 18 detonation for two extended periods totalling about
 19 1 hour and 20 minutes.
 20 Others have dealt with and this afternoon will deal
 21 with in more detail, but let me set it out in bullet
 22 points.
 23 Firstly, SMG allowed a CCTV blind spot to exist for
 24 many years, so obvious that even Salman Abedi spotted
 25 it. If that blind spot had been dealt with, he should

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1 have been easily seen by SMG CCTV staff, assuming
 2 that is that there were dedicated and properly trained
 3 CCTV monitors actually watching.
 4 The failure to have properly trained CCTV monitors
 5 actually monitoring the City Room at the relevant time
 6 is therefore the second obvious failure by SMG.
 7 Thirdly, SMG had contractual obligations to patrol
 8 the City Room and its raised area and failed to do so
 9 during the relevant periods or ensure that their
 10 subcontractor ShowSec had done so. If there had been
 11 even the most minimal of patrols, which included the
 12 raised area, during the event period or pre-egress,
 13 Salman Abedi would have been spotted and seen to be
 14 suspicious and challenged.
 15 Fourthly, SMG failed to have any meaningful
 16 arrangement with BTP regarding joined-up working between
 17 the security operation in the City Room and the policing
 18 of it. If there had been such an arrangement, then it
 19 should have ensured that there was an understanding that
 20 British Transport Police officers would have been
 21 visible, patrolling the City Room at relevant periods
 22 and once again it is inconceivable that Salman Abedi
 23 would have been able to perpetrate this outrage.
 24 Fifthly, SMG failed to have what Colonel Latham
 25 termed defensive communications, sending the deterrent

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1 signal out to would-be attackers that this was a bad
 2 target for them.
 3 Sixth, SMG, having recognised the threats following
 4 the Paris attacks, failed completely to take any
 5 measures to extend the perimeter or at least provide
 6 stand-off layers of security to prevent a suicide bomber
 7 getting into the City Room. What those measures might
 8 have been is a matter for discussion, but the central
 9 point is that there was no provision at all for
 10 monitoring those entering the City Room or their bags.
 11 A remarkable feature of the evidence is that various
 12 core participants, including SMG, have emphasised the
 13 difficulties posed by the City Room. Yet it's SMG who
 14 had responsibility for security, as we have just said,
 15 and failed to put in place any measures -- any
 16 measures -- to effectively monitoring persons entering
 17 or remaining in the City Room during what were obviously
 18 vulnerable times. The adage "when in a hole, stop
 19 digging" springs to mind.
 20 The fact that a space presents challenges and
 21 difficulties requires that those complexities have to be
 22 met face-on. A threat does not go away because it's
 23 complex. The recognition of the problems posed by
 24 a thoroughfare and access for other stakeholders
 25 emphasises the failures of SMG and others. It does not

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1 absolve them in any way.
 2 The really obvious point about the major
 3 transnational corporation SMG is that its directors and
 4 senior managers failed to see the importance of their
 5 role in preventing a terrorist outrage of this nature or
 6 perhaps, more importantly, their responsibility.
 7 They were entitled to expect MI5 and others to do
 8 everything possible to prevent attacks, but they were
 9 not entitled to be under any illusion that the first
 10 line of defence in preventing such plots would always
 11 succeed. Far from it. The state had made publicly
 12 clear that the threat was severe, despite its attempts
 13 to prevent attacks. Given the size of their enterprise
 14 and the fact that they were managing the security and
 15 safety of huge numbers of the public, it was blindingly
 16 obvious that they needed a senior counter-terrorism
 17 director or senior counter-terrorism manager with
 18 expertise and experience.
 19 Had SMG employed a Colonel Latham or Dr BaMaung,
 20 would we be here today asking how the outrage in the
 21 City Room came to pass? We say very plainly not. It is
 22 no excuse to say that it was not industry practice
 23 at the time to have a CT expert employed in-house. SMG
 24 are a massive presence in this industry and therefore
 25 a significant maker of industry practice, and of course

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1 places like the O2 did have their Colonel Lathams.
 2 The sad reality is that SMG were unwilling to pay
 3 for the expertise that was so obviously called for and
 4 relied instead only on the free advice and guidance
 5 provided by NaCTSO and the CTSA system. More on that
 6 later, but whether that advice and guidance was good or
 7 not so good, sufficient or obviously not, it did not
 8 shift the responsibility from SMG.
 9 What about those others I have mentioned? Again,
 10 the detail has been dealt with by other advocates,
 11 particularly Mr Atkinson. ShowSec subcontracted and
 12 held some of the responsibility for security and public
 13 safety in the City Room at event times. ShowSec, again
 14 a huge company with extensive experience, abjectly
 15 failed to take any or sufficient measures to stop
 16 obviously suspicious characters, such as Salman Abedi
 17 with his large device on his back, from entering the
 18 City Room.
 19 ShowSec then failed to take any measures to monitor
 20 who remained within the City Room, such as Salman Abedi.
 21 It failed to provide any effective patrolling, which
 22 would obviously have raised Salman Abedi as a concern
 23 and dealt with that concern long before the time he
 24 detonated his bomb.
 25 ShowSec had no role in the CTSA process, despite

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1 being the regular event security contractor. They had
 2 little or no meaningful contact with BTP to join up the
 3 event security operation and the policing of it.
 4 ShowSec had no CT expert director or senior manager and
 5 apparently chooses not to still. That is a fact that
 6 one would hope that event practices and insurers would
 7 take account of and it is a fact that we would urge that
 8 the inquiry addresses quickly.

9 Again, ShowSec seem to have been eager to take the
 10 cheque for protecting the public but were less eager to
 11 ensure that their contracted responsibilities were
 12 discharged.

13 In both cases, SMG and ShowSec, we have emphasised
 14 the fact that they are extremely large companies. SMG
 15 is part of a worldwide operation. ShowSec is part of
 16 another. If current legal provisions and frameworks
 17 have failed to ensure that they discharge their
 18 responsibilities, and in such stark ways, then what hope
 19 is there that others with less resources and less
 20 experience will do so?

21 Again, I will return to that later in the context of
 22 the need for urgent change.

23 Before I do, I again bullet point the failures of
 24 the police.

25 Firstly, BTP who had primacy for policing the

1 City Room. BTP's failure to ensure that officers were
 2 patrolling at relevant times are obvious to see. If
 3 those who were suspicious of Salman Abedi in the
 4 City Room had seen a BTP officer, they would obviously
 5 have reported to them rather than just to a young and
 6 inexperienced steward. The outcome would have been
 7 different.

8 If the officers had been there patrolling, would
 9 Salman Abedi have been deterred? Quite possibly. But
 10 even if he wasn't, effectively patrolling BTP officers
 11 would plainly have seen and challenged Salman Abedi as
 12 he hid on the raised area of the City Room with his bomb
 13 for those two extends periods. BTP officers accepted
 14 that had they seen Salman Abedi, they would have
 15 challenged him. As others will deal with in detail, BTP
 16 failed to have a sufficient deployment with sufficient
 17 experience or supervision. BTP abjectly failed to
 18 ensure proper joined-up working between the security
 19 operation and the policing of the City Room.

20 British Transport Police failed to engage with the
 21 Greater Manchester Police CTSA, advising SMG or to
 22 ensure joined-up working between the GMP and BTP CSAs
 23 for the arena complex and the station respectively.

24 Most strikingly, senior officers failed to properly
 25 risk assess event days and failed to learn any lessons

1 from the Sherman exercise they attended in July 2016
 2 which used a marauding terrorist firearms attack on the
 3 station and the City Room as its scenarios.

4 Worse perhaps is the evidence of Assistant
 5 Chief Constable O'Callaghan, who even in hindsight said
 6 that he did not see the purpose in any deployment of BTP
 7 officers for an event of this kind.

8 Although GMP had no operational primacy for policing
 9 the arena or the station, for reasons which remain
 10 uncertain, its CSAs assumed the role of advising SMG on
 11 protective CT measures. In doing so, GMP did not assume
 12 responsibility for security; that remained with others,
 13 primarily SMG.

14 However, objectively, the CTSA input was far from
 15 helpful. First, it remains a moot point whether the
 16 CTSA made it sufficiently clear to SMG what the role of
 17 the CTSA system was. Legally, this is neither here nor
 18 there, but factually it could have led to a position
 19 whereby SMG considered it did not need expert senior
 20 staff to plan and oversee CT protective measures. The
 21 CTSA system allows for twice annual visits to a venue
 22 such as the arena. The CTSA in this case had quite
 23 a bit more involvement than that. However, the system
 24 he worked within and the decisions he took highlight the
 25 fact that such a system is completely inadequate for

1 a venue with a capacity of 21,000, and complex
 2 surroundings.

3 Firstly, the CTSA survey was far from the assessment
 4 or audit of CT needs and existing measures that any
 5 competent contracted or employed expert would undertake
 6 as a matter of course before being in a position to give
 7 competent advice. The CTSA system relied upon what SMG
 8 told them and the CTSA was not expected to, nor was he
 9 resourced to, observe or analyse the operation of any
 10 protective measures, whether physical or human systems.

11 The CTSA PSIA system concentrated on the footprint
 12 of a venue itself and only considered the risks created
 13 by its activities in the surrounding areas to the extent
 14 that those risks impacted on the security within the
 15 footprint. Whether or not the CTSA made it sufficiently
 16 clear to SMG that the service was one of advice and
 17 guidance, the most obvious protective measure and advice
 18 should have been that a venue and operation as large as
 19 the arena needed expert CT management on a day-to-day
 20 basis. It was well beyond the role or resources of the
 21 CTSA system to provide that and that should have been
 22 entirely clear to any competent CTSA and the first base
 23 for any CT advice given.

24 I make that point absolutely clear: we are saying
 25 that, irrespective of whether the CTSA properly

1 explained the role of their service, the first and most
 2 important advice should have been that an operation of
 3 the size of the arena needed dedicated expertise
 4 contracted or employed by SMG.
 5 In their written submissions, GMP set out in some
 6 detail, helpfully, the size and reach of SMG's worldwide
 7 operation, describing it correctly as "an enormous
 8 corporate enterprise".
 9 Why then did the CTSA not say to Ms Stone and
 10 Mr Allen, "Look, this is an enormous corporate
 11 enterprise dealing with a footfall of millions of paying
 12 customers, you need to employ or contract in expert CT
 13 advice and management"? It was a failure of SMG not to
 14 have this, but it was also a failure of the CTSA for not
 15 telling them that this would be the first and best
 16 advice and guidance that he could give them. It was
 17 a failure of those devising and supervising and managing
 18 the CTSA system not to make this absolutely clear to
 19 CTSA's.
 20 The "something is better than nothing" ethos seems
 21 to have produced a resignation that no particular
 22 minimum standard could be set or achieved. Although
 23 a corporation could have ignored advice from a CTSA,
 24 that it needed dedicated in-house or contracted CT
 25 expertise, it may have had serious insurance problems if

1 it did.
 2 Further failures of the CTSA service were that the
 3 CTSA did not deal with the obvious vulnerabilities of
 4 the City Room at all or provide any advice on stand-off
 5 security measures. The CTSA failed to ensure that
 6 ShowSec or BTP were properly involved in the process and
 7 failed to do any joined-up work with the BTP CTSA who
 8 undertook the advice to the station.
 9 That is all I intend to say with respect to the
 10 evidence of multiple failures by the relevant private
 11 corporations and public authorities responsible in their
 12 different ways for providing protective security to the
 13 City Room as at 22 May 2017 and the multiple missed
 14 opportunities which should have prevented this outrage.
 15 We frame our submissions in stark terms.
 16 This was a foreseeable outrage committed at a time
 17 when the known threat level meant that all involved
 18 should have ensured that they had fully discharged their
 19 responsibilities. There were reasonable and
 20 proportionate measures which could and should have been
 21 taken, which would have prevented the bombing and such
 22 loss of life, reasonable and proportionate measures
 23 lying within the legal responsibilities of those
 24 corporations and the duties of the public authorities.
 25 Having scrutinised the evidence so carefully, the

1 inquiry should set out the factual narrative but it must
 2 also analyse and set out missed opportunities.
 3 Sticking wholly within the chapter 7 tramlines this
 4 was a foreseeable and readily preventable outrage. The
 5 complexities of the City Room geography and thoroughfare
 6 and the fact that the probability of terrorist attacks
 7 happening at a particular spot on a particular night are
 8 low are part of the picture. However, the overwhelming,
 9 devastating loss caused by such attacks and the
 10 relatively straightforward and cheap protective measures
 11 which prevent one such as this are the other.
 12 An Article 2 inquiry such as this is a quest for
 13 a definitive narrative, but it also involves and
 14 requires accountability, which means robust forensic
 15 findings regarding failings.
 16 At an early stage of this process, much was said
 17 about candour and position statements. Our observation
 18 is that the ruling that you made on 20 January 2020,
 19 requiring detailed opening statements and setting out
 20 lists of issues that corporate and public authority core
 21 participants should address has significantly enhanced
 22 the parts of the process heard to date.
 23 However, that does not mean that each of those core
 24 participants have assisted the process to the extent
 25 that they should. This is an inquisitorial process to

1 get at the truth and accountability and to attempt to
 2 prevent future loss of life. There has been
 3 a significant amount of finger pointing and, frankly,
 4 little acceptance of the obvious failings we've already
 5 highlighted in the bullet points I made a few moments
 6 ago.
 7 One aspect of the chapter 7 process merits
 8 particular attention: the treatment of the experts,
 9 Colonel Latham and Dr BaMaung. Highly accomplished
 10 advocates for both British Transport Police and ShowSec
 11 launched quite extraordinary and personal attacks on
 12 them. This process is not a blood sport, and the
 13 granting of CP status is not a licence to be rude to any
 14 witness. How the attacks on the experts were meant to
 15 assist you in your task or indeed advance the interests
 16 of BTP or ShowSec eludes us, but it's fair to say that
 17 the families found these attacks quite at odds with
 18 earlier statements of condolences or sympathy with them.
 19 Faced with measured, objective, considered
 20 criticism, BTP and ShowSec reverted to denial and
 21 institutional and corporate defensiveness. It is one
 22 thing for them to put disagreements to the experts, an
 23 entirely legitimate function of their involvement, but
 24 it is another to attack them in the way in which they
 25 did. You will need no reminding, but it appears others

1 do, that Colonel Latham and Dr BaMaung were provided by
2 you and not at the behest or suggestion of any of the
3 CPs. They represent no party and they were no doubt
4 expressly instructed that these were inquisitorial and
5 not adversarial proceedings.

6 The letters of instruction and their CVs were shared
7 with all CPs. We do not recall objection to their
8 appointment before they provided reports. We are not
9 aware that other experts were suggested or that other
10 expert opinions were provided to the inquiry. Given
11 their lengthy careers as state agents working within
12 counter-terrorism for public authorities and
13 corporations, quite how their expertise could properly
14 be challenged by public authorities remains a mystery to
15 us.

16 The fact that neither had given expert evidence in
17 a previous public inquiry or court case reflects the
18 limited requirement for expert opinion in this area and
19 is not a reflection upon them. If the approach to these
20 witnesses were to cause you to reflect upon their
21 expertise, we would anticipate that you would
22 emphatically determine that they are accomplished
23 experts in the traditional sense: they have expertise
24 which assists the inquiry on areas beyond its own
25 experience and learning.

1 Of course, expert evidence does not have to be
2 accepted, as every jury is told and every civil judge
3 reminds himself or herself in every case where experts
4 are called. It is no different in an inquiry. No doubt
5 you will find particular issues and questions where you
6 do disagree with their opinions, but in general we
7 invite you to find that they were extremely helpful and
8 knowledgeable and gave evidence with integrity,
9 impartially, with care and in clear terms.

10 Was the question, and I quote, "Do you think you're
11 in a better position to judge that than someone who's
12 spent his life in court, including as a High Court
13 judge?", if it was a question at all, really designed to
14 assist you? Of course it wasn't. It was designed to
15 knock the witness off course and to demean the evidence
16 he was giving, which was adverse to BTP.

17 Was the question, and I again quote, "Or is the
18 truth actually, Colonel Latham, that come what may
19 you're just, as it were, pathologically incapable of
20 acknowledging error or omission or oversight or
21 exaggeration?", a real question or does it in reality
22 illustrate that ShowSec struggle to counter the
23 criticisms made of them by independent experts?

24 Putting the question of the experts on one side,
25 what you might think would have been a better product of

1 core participants assisting this process might have been
2 an unequivocal acceptance by SMG that it had
3 responsibility for security and public safety in the
4 City Room. But although it did make efforts to address
5 terrorist threats, it failed to take measures which
6 would have made a difference and prevented this attack
7 and, in particular, that immediately after the attack,
8 SMG did what they ought to have done long before and
9 took advice from Guidepost as to what it really needed
10 to do, employ a CT expert to devise and manage
11 reasonable and proportionate physical protective
12 measures and human systems to deter and prevent such
13 outrages.

14 There is, of course, no problem in SMG drawing
15 attention to the concurrent failures of others, such as
16 ShowSec and BTP, to present the full rounded picture,
17 but what SMG has done in opening and closing submissions
18 is to present a picture that although security was its
19 responsibility, in most regards SMG discharged that
20 responsibility because it relied upon the advice of
21 ShowSec and Ken Upham regarding counter-terrorism issues
22 and relied upon ShowSec to discharge their event day
23 security obligation.

24 Moreover, BTP patrols were or should have been
25 better trained and briefed and equipped to deal with

1 threats in the City Room than SMG or ShowSec.

2 Although expertly put, SMG's approach is completely
3 flawed. The concurrent failures of others may have
4 compounded SMG's own failures but they do not excuse or
5 mitigate them.

6 Likewise, ShowSec. Whereas it is fair enough for
7 ShowSec to highlight the concurrent failures of others,
8 ShowSec are a security company, a huge security company.
9 Is it really okay for ShowSec to say it was not within
10 its remit to discuss with SMG why and how suspicious
11 characters should be deterred or prevented from entering
12 an enclosed, high footfall space which they were
13 guarding?

14 If ShowSec want to offload on to SMG or general
15 policing, might it not be appropriate for them to
16 indicate that going forward, ShowSec will have CT
17 measures front and central? If they are contracted to
18 do security in a space such as this, ShowSec will be
19 proactive to determine exactly by whom and how obvious
20 CT threats will be met and mitigated. Might it not be
21 more appropriate for ShowSec to acknowledge that it
22 needed -- needs -- in-house counter-terrorism expertise?
23 To acknowledge that it needs to determine with respect
24 to each contract what is and isn't within its remit in
25 regard to counter-terrorism measures? Might it not be

1 appropriate for ShowSec to acknowledge and recognise
2 that it failed to engage with the CTSA process for this
3 major security contract or to properly liaise with the
4 police force with operational primacy, British Transport
5 Police?

6 Is it okay for British Transport Police to say in
7 opening that others were engaged in a "carousel of blame
8 in which they were not going to join", but then to
9 attack the experts in the way indicated or indeed to
10 criticise counsel to the inquiry for putting a series of
11 questions to PC Bullough, which carried a "heavy
12 suggestive load"? Might BTP reflect that people in
13 glass houses should not throw stones? Having eschewed
14 the carousel, they have indeed jumped on to it with some
15 alacrity.

16 On behalf of the families, we do not criticise SMG,
17 ShowSec or BTP for completing the picture by
18 highlighting the failures of others, but their first
19 base must be to be upfront about their own shortcomings
20 and what they have done about it and not to offload on
21 others to hide or excuse their own failures.

22 Patrolling and conducting pre-egress checks of the
23 raised area provides a good example, as Mr Atkinson has
24 already adverted to. SMG should unequivocally accept
25 that it was responsible for security and public safety

1 of the City Room but failed to patrol or check the area
2 as Salman Abedi kept a low profile for those two
3 extended periods or ensure that competent others did so
4 on its behalf or liaise with the police force with
5 operational responsibility for that area.

6 ShowSec should unequivocally accept that they were
7 contracted to take on security and public safety in the
8 City Room at event times but failed to determine the
9 extent of those responsibilities with SMG or discharge
10 obvious functions such as patrolling and sweeping or to
11 take part in the CTSA process for the arena or to liaise
12 with BTP.

13 BTP should unequivocally accept that its policing
14 duties in the City Room meant that it should have
15 deployed and properly supervised a sufficient number of
16 experienced officers in the City Room during high
17 density footfall periods and liaised with SMG and
18 ShowSec in the CTSA process.

19 I have not yet mentioned GMP in this regard. The
20 Greater Manchester Police are in a different position.
21 In its detailed written closing submissions, GMP has set
22 out in clear terms the failures of SMG and ShowSec in
23 a way that will no doubt assist you. We agree with much
24 of what GMP says in this regard and there's considerable
25 overlap, as you'd expect, with various family

1 submissions, including our own.

2 However, GMP's purpose in doing so is undeniably
3 directed at defending its own position regarding the
4 CTSA service. GMP contends, no doubt correctly,
5 Ken Upham was not told by the CCTV blind spot, the
6 absence of patrols or pre-egress checks on the raised
7 area of the City Room, or the lack of BTP presence
8 in the City Room for egress, and GMP contends that there
9 was confusion regarding other things. Mr Upham was
10 advised by SMG that it could only exercise queuing
11 rights, whatever those are, in the City Room.

12 GMP did not have responsibility for security and
13 public safety in the City Room, nor did it have
14 operational policing duties for the arena, and it is
15 therefore in a different position to SMG, ShowSec and
16 BTP regarding the chapter 7 evidence and issues.

17 GMP did not devise the CTSA system and it was
18 therefore not responsible for any shortcomings in that
19 system. Nevertheless, as the force which delivered that
20 service, it should be clear in recognising that not only
21 should the CTSA have made clear that the service was
22 purely advisory, but he should have made clear that SMG
23 and ShowSec too should have had dedicated CT expertise
24 in-house or contracted.

25 Even the directing minds of SMG recognised that in

1 evidence. James Allen on Day 28 said as much in reply
2 to your questions. In respect of the fact that SMG had
3 employed a CT director after the bombing, you asked:

4 "Don't you think you should have done it
5 before May 2017?"

6 And Mr Allen's answer was:

7 "Yes, possibly, yes."

8 If SMG are prepared to accept that a company of
9 their size should have had an expert CT director
10 in-house, will GMP accept that their expert CTSA should
11 have been proactive in saying to operators they needed
12 dedicated expert advice and management because the
13 challenges were manifestly beyond the service they were
14 able and resourced to provide? We will see. Such an
15 acceptance by GMP might be both realistic and a major
16 driver to making things better in the future.

17 On behalf of the families we represent we also call
18 on GMP to reflect on and expressly recognise the lacuna
19 that currently exists in the current legal framework and
20 to recognise that there needs to be tangible standards
21 to be met by operators of major venue and mandatory
22 powers to require compliance and fully joined-up working
23 between all involved: those private entities with
24 responsibility, those with policing responsibility and
25 those who play an important but advisory role.

1 This point does not imply criticism of GMP, as it is
 2 not the author of the system or its failures, but GMP
 3 would be a powerful voice in joining with the families
 4 and GMP would be acting in the public interest in
 5 calling for real meaningful change.
 6 I don't intend to dwell further on the evidence of
 7 failures by the various relevant corporate or
 8 institutional CPs and I agree with the recent comments
 9 with respect to chapter 10 evidence of Mr Greaney that
 10 this inquiry should not descend into the vilification of
 11 individuals for failings on the night. That might be
 12 appropriate in some processes but it misses the point on
 13 the facts of this one.
 14 It would be particularly unsatisfactory in regard to
 15 young inexperienced casual stewards who were poorly
 16 trained and barely supervised or young inexperienced
 17 police officers and PCSOs who were poorly briefed and
 18 trained and completely unsupervised to make them
 19 disproportionately accountable. Some of these
 20 individuals obviously come in for criticism, indeed
 21 severe criticism in some cases, but how were their
 22 failures allowed to happen? That is the most important
 23 question.
 24 I therefore turn to the central theme of our
 25 submissions which is the inadequacy of the legal

1 framework for protective security in the UK. For some
 2 listening, this may seem like a turn from the relevant
 3 facts of the narrative to a lawyer's debate, but it is
 4 very far from it.
 5 Systems fail because they are allowed to. They fail
 6 because they are inadequate or because there is no
 7 compliance and enforcement requirement or mechanism.
 8 What underpins the failure of SMG and ShowSec to protect
 9 their customers and visitors to the City Room is the
 10 lack of an adequate framework of laws and regulations to
 11 require them to provide adequate physical measures and
 12 human security systems.
 13 The BTP failures to fulfil their operational
 14 policing duties, serious though those failures are, are
 15 beyond the lacuna in laws and regulations relating to
 16 protective security. However, had there been an
 17 adequate joined-up framework then all those with
 18 responsibility for protective security and public safety
 19 and those responsible for operational policing would
 20 have had to work together. So the absence of an
 21 adequate framework also had a knock-on effect with
 22 respect to operational policing.
 23 What do we mean by an absence of a regulatory
 24 regime? Article 2, the right to life, requires the
 25 state to protect life to the greatest extent reasonably

1 possible. This obviously constrains the state from
 2 taking life other than in extreme circumstances and it
 3 requires the state to have laws to deter and punish
 4 homicide. It requires the state to take measures where
 5 there is a real and immediate danger to life, but it
 6 also requires the state to take proactive measures or to
 7 require private corporations to do so wherever there is
 8 a foreseeable danger to life.
 9 The problem here is that the only framework of laws
 10 compelling or requiring SMG and ShowSec to take
 11 reasonable precautions to protect against the known
 12 severe threat of a terrorist attack is essentially the
 13 after-the-fact civil claims for negligence and health
 14 and safety criminal offence after a catastrophic attack
 15 has occurred. Yes, there are other more tangential
 16 requirements under licensing and SIA provisions, but
 17 there is a clear and gaping hole, a lacuna, which
 18 objectively provides an open goal to terrorists.
 19 As we have heard, the state has both a systemic and
 20 an operational duty to do everything reasonable to
 21 detect and prevent terrorist conspiracies and plots and
 22 that will be the focus of chapter 14 and evidence
 23 concerning the security services. But the government
 24 itself recognises and recognised that it cannot stop
 25 every plot and that attacks will occur.

1 In terms of foreseeability, the Government is really
 2 upfront. Whilst claiming its security services are
 3 world class and stop many plots, the Government
 4 recognises that the threat level remains severe: it is
 5 foreseeable and indeed highly likely that an attack
 6 in the UK will occur. That was the position at the time
 7 and regrettably it remains so.
 8 The state, through NaCTSO and the CTSA system,
 9 promulgates training and advice and guidance, but there
 10 is no follow-through and take-up and compliance is
 11 voluntary. Enforcement is non-existent because there is
 12 nothing to enforce. So this is not a lawyerly debate,
 13 it is a real and central issue in this inquiry.
 14 The state has identified a present, acute danger to
 15 life. It has recognised that its operational detection,
 16 deterrents and prevention institutions, MI5 and the
 17 police, are unable to stop every attack, that the regime
 18 to maximise protection against these recognised huge
 19 threats to life and limb is voluntary, advisory,
 20 discretionary and, frankly, wholly inadequate.
 21 The recent written argument by HMG asserts that the
 22 framework in place at the time was adequate if only
 23 others had followed advice and guidance. The "let's
 24 blame someone else argument". That simply does not run
 25 here. The Article 2 obligation is on the state to

1 require both public and private operators to make
2 crowded spaces as safe from terrorist attack as is
3 reasonably possible, proportionate to the threat at the
4 particular time.

5 I have identified some shortcomings in the actual
6 CTSA provision to the arena, but in reality, although
7 those deficits are undoubtedly important it is not the
8 individual failings that are at the heart of this
9 tragedy, it's the fact that there was no clear standard
10 of protective measures and security systems with which
11 those responsible for security and public safety in the
12 City Room had to comply. There was no mechanism to
13 require them to take particular actions or even to
14 properly assess their needs or work with others with
15 overlapping responsibilities, such as the police, and no
16 compliance and enforcement mechanism at all.

17 Three and a half years on, it is right to say that
18 there has been some nod to recognise the inadequacy of
19 the legal and regulatory counter-terrorism framework by
20 both senior public officials and public officers who
21 have given evidence to the inquiry, and indeed by the
22 Government. It is a great sadness that it has taken the
23 loss of so much innocent life to get even to that level
24 of recognition. It is remarkable campaigning of the
25 families and their supporters that has focused and

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1 forced the issue, but it's right to say also that
2 although there is a recognition that something has to
3 change, there remains a disappointing inertia. There
4 has been and remains no sense of urgency in the
5 Government's position.

6 Although various witnesses have recognised that the
7 voluntary nature of the current position is inadequate,
8 the Home Office witness, Mr Hipgrave, has failed to
9 properly explain why it has taken so long even to get to
10 the position of a consultation on change and why even
11 that has been delayed already by almost a year.
12 A government intent to doing everything reasonably
13 possible to learn the lessons and make meaningful change
14 would not dither and delay for what will end up being
15 more than 4 years from the bombing before there is even
16 a chance of a coherent plan.

17 The recent Government Legal Department letter in
18 response to a request for the consultation document was
19 a model of aspiration over intent or perhaps, more
20 accurately, a model of avoidance. They say, and
21 I quote:

22 "It is hoped that the pre-consultation write around
23 of ministers will be completed quickly with a view to
24 the consultation process being launched early in the New
25 Year".

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1 Well, we are early in the New Year, at 25 January
2 today, and still the Government chooses not to tell this
3 inquiry and these families and the wider public even its
4 timetable for a consultation on change. Why?

5 We can argue about why the consultation was planned
6 to be launched only 3 years after the bombing and why it
7 then had to be delayed because of the virus, but there
8 is no excuse for the GLD to send a letter of vague
9 platitudes to this inquiry.

10 On 11 December 2020, did the Government not know how
11 long it had given the relevant ministers to reply to the
12 consultation write around? Why is there no timetable?
13 Everyone knows that processes take as long as they are
14 allowed to take. The failure to progress changes which
15 need to be made increases the risk of further outrages
16 such as the arena bombing as every day passes. The
17 failure even to set a timetable for the process
18 evidences a complete lack of commitment by this
19 Government.

20 The families will be listening carefully later this
21 week when submissions are made on behalf of the
22 Home Secretary for explanations as to why these delays
23 continue and why the Government cannot even give the
24 families a timetable.

25 That is why we say that when the inquiry turns its

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1 attention to recommending change, it should approach its
2 task by identifying that the framework's lacuna, the
3 lack of legal requirements on both corporate and public
4 authorities who have responsibility for the safety and
5 security of large numbers of the public, is a continuing
6 one which must be remedied with urgency.

7 As we've emphasised, we welcome the decision to
8 deliver the inquiry report in stages, not only because
9 it is easier for all involved to complete the work on
10 stages whilst the evidence is fresh in the mind, but
11 because change is needed and urgently. Staged reports
12 facilitate earlier recommendations.

13 We have set out the law relating to the requirements
14 on the state to have an adequate framework of laws and
15 regulation to ensure all reasonable measures are taken
16 to prevent or mitigate known threats to life from
17 paragraph 19 of our written submissions and I don't
18 repeat that analysis now. This argument has been raised
19 through this process and was expressly referred to in
20 our opening. No one can have been taken by surprise by
21 our submissions therefore that the current framework
22 does not comply with Article 2, yet the
23 Secretary of State did not address them in her written
24 chapter 7 submissions until last Friday when
25 supplementary submissions were served, asserting that

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1 whatever findings the inquiry makes, it must not find
 2 that there has been a breach of Article 2 with respect
 3 to the failure to establish such a framework of laws and
 4 regulations. It amounts to a submission that if you
 5 find that the regime for ensuring maximum protection
 6 from terrorist attack is inadequate, you may do so only
 7 so long as you do not imply that the state is
 8 responsible.

9 We have never suggested that the inquiry should
 10 determine that the Secretary of State is liable under
 11 the civil law because of a breach of Article 2, but
 12 that is not the same as a finding that the inadequacy of
 13 the current regime is a continuing non-compliance with
 14 Article 2. The former would be a breach of section 2.1
 15 of the Inquiries Act, as the Secretary of State
 16 contends, but the latter is an important finding
 17 permitted by section 2 subsection 2 and I quote its
 18 provisions:

19 "That an inquiry panel is not to be inhibited in the
 20 discharge of its functions by any likelihood of
 21 liability being inferred from facts that it determines
 22 or recommendations that it makes."

23 Without reference to Article 2, to what standard is
 24 adequacy to be determined? Whereas there may be
 25 a logical inference that a finding that a system was

1 non-compliant with Article 2.2 liability, it is not the
 2 same thing at all and that is why section 2 is drafted
 3 in the way it is. At Article 2 inquests the coroner or
 4 jury are entitled to find judgmental facts or indeed
 5 reach a finding of unlawful killing, both of which may
 6 imply liability but they are permissible because they
 7 do not determine it.

8 Section 2 is carefully drafted to allow for findings
 9 which relate to failures in accountability but which
 10 recognise the difference between civil and criminal and
 11 inquisitorial jurisdictions respectively. The
 12 Secretary of State is correct that it is uncontroversial
 13 that you should not rule on liability. No one has
 14 suggested otherwise. The Secretary of State is wrong to
 15 suggest that precludes a finding that the current
 16 framework is non-compliant with Article 2 because
 17 that is both a non sequitur and could negate
 18 subsection 2 of section 2.

19 If an example is needed of an inquiry making
 20 a finding of non-compliance with Article 2, I refer to
 21 chapter 10, paragraph 10.2 of the Grainger report, where
 22 His Honour Judge Teague QC, incidentally now the
 23 Chief Coroner, found that the firearms operation that
 24 had led to the death of Mr Grainger was non-compliant
 25 with Article 2. No breach of section 2 there.

1 The finding was that the operation of the system was
 2 non-compliant with the relevant standard set by
 3 Article 2. It was not a ruling on or reference to
 4 liability. Neither of the two references cited in the
 5 Secretary of State's recent submissions contradict the
 6 approach taken in Grainger or that which we invite you
 7 to take here.

8 As I have stated, the purpose of relating the
 9 evidence of inadequacy to the laws and regulations
 10 relating to protective security to compliance with
 11 Article 2 is partly to provide a calibration.
 12 Inadequacy judged against what? Answer: the obligation
 13 to ensure that everything proportionate is done to
 14 prevent known threats to life by the state itself or by
 15 those it should regulate. So there is a further purpose
 16 in relating the failure to provide a sufficient
 17 framework to ensure all proportionate and reasonable
 18 protective measures are taken.

19 A finding that the current framework is not
 20 compliant with the requirements of Article 2 would
 21 require an urgency, which is sadly lacking, to take
 22 steps to remedy the deficits.

23 This is not an obscure, novel or unflagged
 24 submission by us. It has been there from the outset.
 25 It seems that the Secretary of State is more concerned

1 at avoiding an adverse finding than providing the
 2 inquiry with the consultation documentation and the
 3 range of measures under consideration by Government and
 4 a clear timetable for change, which manifestly needs to
 5 happen.

6 Importantly, it should not be lost on the inquiry
 7 that in her submissions, the Secretary of State seeks to
 8 argue that the current framework is not inadequate
 9 whilst accepting there is a need to codify in law
 10 a protective duty and change the framework to provide
 11 such as yet undisclosed requirement.

12 Of course, adequate systems can be improved, so the
 13 Security of State's position is not a logical
 14 impossibility. However, if the system was adequate,
 15 does the evidence suggest it would have been impossible
 16 for the attack to be thwarted by proper protective
 17 measures? Plainly on the evidence, as we have
 18 articulated, a number of simple, proportionate measures
 19 would have prevented this particular attack: simple
 20 cordons of stewards, proper CCTV monitoring and basic
 21 patrolling are just some examples. So that cannot be
 22 the answer.

23 Was it simply the failures of others acting within
 24 an adequate system that allowed the outrage to occur?
 25 For the reasons we, and just about all others, have

1 stated, it is plainly the case that there were multiple
 2 failures by relevant core participants which contributed
 3 to this tragedy. If the system was adequate, how were
 4 those multiple failures allowed to occur? A system
 5 which provided no standard beyond that provided in civil
 6 law and health and safety legislation, a system which
 7 neither provided nor required proper counter-terrorist
 8 assessment, a system without compliance or enforcement
 9 because there was nothing to enforce, a voluntary,
 10 discretionary system where commercial decisions and
 11 commercial appetite were allowed to dictate engagement.
 12 To suggest that such a system was adequate is
 13 a nonsense. It is to deny common sense, never mind the
 14 evidence.

15 Finally on this point, the Secretary of State
 16 asserts that in any event, the time is not now for
 17 considering the general duty because the evidence so far
 18 has been limited to protective security rather than
 19 preventative measures. The sufficiency or otherwise of
 20 measures requiring protective security are unconnected
 21 to the evidence which will be heard in chapter 14.

22 Given that the Government's own assessment of
 23 22 May 2017 was that a terror attack on a crowded space
 24 such as the City Room was highly likely, despite the
 25 efforts of the security services and police, we do not

1 understand how evidence relating to that topic,
 2 prevention, impacts upon whether the framework of laws
 3 and regulations to require protective security was
 4 compliant with the standards required by Article 2.

5 Apart from determining a definitive factual
 6 narrative and accountability, the third component of an
 7 Article 2 inquiry, and indeed usually other inquiries,
 8 is the making of recommendations to prevent, so far as
 9 is possible, further similar preventable deaths.
 10 Although the making of recommendations is not unique to
 11 inquiries and inquests, judges and tribunal chairs do
 12 not generally prescribe what changes should occur
 13 because that is generally beyond their role to determine
 14 disputes between parties in civil and criminal law and
 15 the supervision of administrative decisions in public
 16 law and may stray over the line in terms of the
 17 separation of powers.

18 So with respect to recommendations, you are being
 19 asked to throw off the usual shackles of judicial
 20 restraint and, on behalf of the families, we would urge
 21 you to be forthright and bold in doing so. If the
 22 Government or legislature disagree with your
 23 recommendations they will not follow them, but the
 24 recommendations will have a stature which will compel
 25 careful attention. Recommendations from inquiries both

1 inform and assist policy and lawmakers and provide
 2 a means by which their actions can be scrutinised by
 3 others.

4 With regard to recommendations we note the written
 5 submissions of the Secretary of State labour under the
 6 misunderstanding that proposals for change are not
 7 currently sought. On 15 December, the solicitor to the
 8 inquiry made expressly clear in an email to all core
 9 participants that closing submissions were to address
 10 and include, and I quote "any proposed recommendations
 11 arising from the evidence heard in chapter 7".

12 The email was an update setting out your intention
 13 to issue a report by 22 May 2021, including, and again
 14 I quote, "findings on the key evidential issues from
 15 chapter 7 and to make recommendations for the future".

16 Given that the Secretary of State set up this
 17 inquiry partly to seek recommendations we recognise that
 18 she is in a different position because she will have to
 19 consider and respond to those that are made. However,
 20 this misunderstanding compounds the failure to feed the
 21 consultation document and the changes which are being
 22 considered into this process at this time.

23 We make no apology for having set out a detailed
 24 discussion regarding recommendations and some proposals
 25 in the appendix to our written submissions. We have

1 paid particular attention to framework requirements,
 2 which I'll return to in a moment, but we've also
 3 addressed policing and changes which are needed to the
 4 SIA regime. In particular, we note that we will stay
 5 off the grass as far as Martyn's Law is concerned
 6 because others are going to address it more fully, but
 7 in doing so we also make clear the support for
 8 Martyn's Law from all of our families.

9 Our discussion looks at how to ensure that whatever
 10 changes are made are meaningful and effective rather
 11 than consisting of platitudes and mere aspiration. As
 12 we have repeated a number of times, the whole purpose of
 13 Article 2 is to protect life to the greatest extent
 14 reasonably possible. Article 2 must be applied in
 15 a practical and effective manner and it imposes a number
 16 of duties. The requirements of Article 2 are widely
 17 construed and do not sit easily with a voluntary or
 18 discretionary approach. Relevant to this case, the
 19 state must ensure it has adequate systems and provision
 20 to do everything reasonably practicable to prevent
 21 terrorist outrages and it must ensure its agents do so
 22 operationally.

23 Quite separate and in addition to that, the state
 24 must have an adequate framework of laws and regulations
 25 and help other actors to do everything reasonably

1 possible to prevent loss of life . We have set out the
2 case law in our written submissions and we don't
3 perceive that that analysis is controversial. No doubt
4 others will tell us if they disagree so that it can be
5 properly argued.

6 As we have said, there is currently no enforceable
7 framework for the safeguarding of life from the threat
8 of terrorism. The possibility of negligence claims or
9 prosecutions under health and safety legislation are
10 inadequate: too little too late and after the fact.

11 The provision of advice and guidance by NaCTSO and
12 the CTSA system is not minimised by us, but on its own
13 it is manifestly insufficient in dealing with a known
14 severe threat level against high-density crowds and
15 crowded spaces, in particular where they arise from
16 specific activities involving thousands of people.

17 Our proposals address three things: the codification
18 of the Protect duty, measures to require stakeholders to
19 recognise their responsibilities , and provisions to
20 require compliance and enforcement where necessary. It
21 does not appear that the need for codification of
22 a Protect duty is controversial. In our view, it needs
23 to be set widely, in sufficiently prescriptive terms, to
24 be capable of making a real difference. It should set
25 a requirement that those responsible for publicly

1 accessible spaces above a certain capacity for footfall
2 are required to do everything reasonably practicable to
3 minimise the threat of a terrorist attack. This would
4 import a standard which is concordant with that in
5 health and safety provisions and it would be compliant
6 with Article 2 so long as it was practically enforced.
7 In that sense it would not seek to re-invent the wheel.

8 Our second proposal follows from the evidence that
9 responsibilities are not always clear and understood and
10 from the Parliamentary Intelligence and Security
11 Committee report, recommendation LL, which called for
12 clarity concerning who must do what.

13 In our view, the evidence has shown that there is
14 a need for two levels of responsibility to be defined.
15 Firstly, there is responsibility arising from ownership,
16 control or contractual duty, as in the arena and
17 City Room, but there's also a need to extend
18 responsibility to risks created or arising from the
19 activities of a publicly accessible space but occurring
20 outside its actual footprint. The ownership
21 responsibility should be set high with requirements to
22 put physical measures and human systems in place to
23 ensure security. The secondary responsibility should be
24 less onerous, for example requiring operators to engage
25 and work with the police and other agencies to ensure

1 public security for those arriving at and leaving
2 a venue.

3 The problem identified by the ISC and from the
4 evidence heard in the inquiry is that those who would
5 fall within those two areas of responsibility do not
6 always recognise the extent of their security
7 responsibilities and assume that others are responsible.

8 A requirement that all who hold primary
9 responsibility for security should maintain
10 a certificate setting out their security
11 responsibilities and that it be mandatory for that
12 document to be provided to all identified stakeholders,
13 including insurers, would go far in resolving grey areas
14 between them and prompting companies and authorities to
15 work together.

16 We have set out in writing how this proposal would
17 work with respect to the arena. SMG would prepare the
18 certificate and provide it to all those it recognises as
19 stakeholders, the freeholders, head lessors, other
20 leaseholders and tenants of the complex, its insurers
21 and the police force with operational responsibility .
22 Others, such as Northern Rail and GMP and the Highways
23 Authority, would also be provided with the document
24 because of secondary responsibility .

25 In terms of the discharge of responsibilities , we

1 recognise the strengths of the CTSA system and the need
2 for reasonably practical steps to have regard to
3 resources. If the CTSA system is to continue in some
4 form, and we think it should, we propose it should be
5 significantly modified. Firstly, as already argued, the
6 advisory and guidance system is manifestly inadequate
7 for larger or higher-risk or complex venues. Those
8 responsible for publicly accessible places of this
9 nature, such as the arena, should be required to
10 contract in or employ CT expertise, such as described by
11 Colonel Latham, and, as we understand, similar to that
12 which SMG has taken on subsequent to the bombing,
13 a director responsible for CT measures and provision.
14 Practically, the requirement would be apparent to most
15 responsible owners and operators, but if necessary
16 enforced by a CTSA certifying that the venue is beyond
17 their capacity or resources. Clear criteria would have
18 to be set for this determination and accreditation for
19 experts would have to be considered in line with the
20 evidence of Colonel Latham and Dr BaMaung.

21 Beyond this top tier, the CTSA system should
22 continue but with CTSAs making proper assessments,
23 consideration not being limited to the demise of the
24 premises, and with CTSAs having mandatory powers to
25 require owners and operators to take particular

1 measures. These changes would improve the understanding
2 of CTSA's and move from a voluntary to a mandatory system
3 where change is based upon risk rather than commercial
4 interest or appetite. Such change would ensure more
5 uniform standards and protection for the public.

6 As various informed witnesses and the experts have
7 fully acknowledged, the current framework is voluntary.
8 Some witnesses have described it as discretionary. If
9 neither engagement with the CTSA system nor following
10 recommendations is mandatory, there is no requirement on
11 private corporations or public authorities to engage CT
12 experts. There is no standard set to which anyone must
13 comply. Because there are no requirements, there is no
14 hint of a compliance or enforcement mechanism. Our
15 proposals would go a long way in dealing with those
16 shortcomings, make publicly accessible places safer and
17 bring our laws into compliance with Article 2.

18 We have also added a proposal for a third tier
19 requiring mandatory self-assessment on smaller venues
20 and spaces below the level at which it is possible to
21 resource the CTSA system, a suggestion driven by already
22 available online self-assessment tools. Given that
23 there are no requirements that these spaces currently,
24 the proposed system would be light touch with emphasis
25 on promoting staff awareness and basic protective

1 measures. The carrot rather than the stick.

2 For all levels weighted(?) to the higher-risk sites,
3 there must be a compliance and enforcement mechanism.
4 In our view, this should be an inspectorate linked to
5 the CTSA system, empowered to issue enforcement notices
6 and prosecute in extreme cases.

7 We have set out these proposals in greater detail in
8 the written submissions. We recognise that there is no
9 single way of ensuring that everything reasonably
10 practicable is done to protect innocent members of the
11 public from extreme threats. However, what we have put
12 forward would create mechanisms which would have
13 thwarted this attack.

14 This approach, or one similar, would ensure that the
15 UK has an Article 2 compliant framework. It would load
16 the financial burden on those who have the most
17 resources without imposing a disproportionate burden on
18 others or the public purse. It would meet
19 recommendations of the ISC regarding the identification
20 and recognition of who has responsibility for security
21 in various scenarios and it would harness the best parts
22 of the system which currently exist whilst moving from
23 a hopelessly voluntary scheme to one which takes
24 compliance seriously and allows for enforcement where
25 necessary. It would impose a simple, understandable and

1 enforceable standard and it would compel all those with
2 responsibilities to work together, whether corporations
3 or police forces.

4 The loss of 22 innocent lives and the injury and
5 trauma caused to countless others must lead to real
6 change without further delay. To pretend that the
7 position pertaining in 2017 and now is acceptable or
8 that systems in place were and are in any sense adequate
9 is to accept that the same can be allowed to happen
10 again. We can do better than that. But only if there
11 is a genuine intention in Government to make things
12 better. This inquiry has a crucial role to play in
13 ensuring that there is meaningful and tangible change
14 and not mere tea and sympathy, platitudes and
15 aspirations. The families I represent have had enough
16 of condolences; they want change.

17 We make two further points regarding
18 recommendations. Firstly, regarding policing primacy
19 at the arena. If BTP had properly engaged with SMG,
20 ShowSec and the GMP CTSA's and if BTP had properly
21 policed the City Room on the night, then the issue of
22 which force polices the arena may not be an issue, but
23 the evidence indicates otherwise.

24 We understand the starting point that the arena
25 complex is owned by Network Rail, but we fail to see why

1 that should require that a police force which exists to
2 police railways is left to police a major entertainment
3 arena.

4 The fact that the arrangement at the
5 Manchester Arena may not be unique is nothing to the
6 point. It may be that it is sensible for BTP to police
7 the whole complex and station when events are not on.
8 But on event days there is a compelling case for the
9 local force to have policing responsibility, not only
10 does it have greater resources but it has multiple other
11 entertainment venues which it also polices and therefore
12 much greater experience. At the very least, there must
13 be a memorandum of understanding between the forces as
14 to who is responsible for what and the level of policing
15 that will be provided.

16 Finally, we have heard much evidence regarding SIA
17 qualifications and training. There is a compelling case
18 to require an adequate level of CCTV monitoring at
19 a venue such as the arena and for those tasked with
20 monitoring CCTV systems for suspicious behaviour to be
21 properly SIA trained. Further, we note that some
22 SIA-accredited students were very young and poorly
23 trained and supervised. In our view, there should be
24 far better compliance and enforcement of training,
25 greater requirements for classroom-based training and

1 annual refreshers, and there is a strong case for
 2 requiring closer supervision and a probationary period
 3 for those recently accredited.
 4 In conclusion we ask: why would anyone think that
 5 a voluntary framework was sufficient or appropriate or
 6 continue to argue that it was adequate? Essentially,
 7 this meant that security and the counter-terrorism
 8 aspect of public safety was and remains entirely
 9 unregulated.
 10 I use strong terms here with care. It was
 11 a flagrant disregard for the safety of those attending
 12 or picking up children from the Ariana Grande concert to
 13 fail to have a director or senior manager with expertise
 14 and experience in protective security against terrorism.
 15 It was a flagrant disregard for the safety of all those
 16 people to fail to have any system which would have
 17 prevented Salman Abedi with his bomb from entering the
 18 City Room without being noticed, to skulk on the raised
 19 platform of the City Room for two periods totalling
 20 nearly 80 minutes, all without detection.
 21 More than 3.5 years after the arena outrage, we
 22 still have no change despite all the campaigning of
 23 families and others, including police officers and
 24 others behind Martyn's Law, the Government has not even
 25 launched the promised consultation. Indeed, the

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1 carefully drafted response to the inquiry regarding the
 2 consultation did not even set out a timetable for when
 3 that consultation will happen. Again, we ask why.
 4 We are told the delay is COVID-related. No one had
 5 heard of COVID for more than 2.5 years after the
 6 bombing; why was no progress made during that time?
 7 We are told the Government is sympathetic to the
 8 concept of a Protect duty and contemplating legislation.
 9 What's the delay?
 10 We all know the devastating impact COVID has taken
 11 on our society and many aspects of our lives, but it has
 12 not made the threat of terrorist attacks less likely.
 13 Is it really contended that policymakers and those with
 14 an understanding of counter-terrorism in Government
 15 departments or indeed industry have not had the time to
 16 consider and reply to a consultation since the spring?
 17 Whilst the Government dithers, Rome does not only
 18 continue to burn with the ever-present threat of further
 19 outrages, but this country continues to fail to have an
 20 Article 2 compliant framework for CT protection. The
 21 rule of law requires this country to comply with its
 22 domestic and international law obligations. This
 23 inquiry should make clear that it is not doing so
 24 because that would be a major driver for change.
 25 Thank you.

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1 SIR JOHN SAUNDERS: Mr Weatherby, I am extremely grateful.
 2 I have read part of your submissions on recommendations
 3 before you made your submissions and I am especially
 4 grateful for them. One of the matters that it occurred
 5 to me during your submissions which might be of interest
 6 to the inquiry is whether there is any similar type of
 7 duty imposed by any other country which would be
 8 Article 2 compliant as well or subject to Article 2. If
 9 anyone happened to know as a result of the answer to
 10 that then it might be of help to the inquiry in making
 11 recommendations which, as you will appreciate, are not
 12 necessarily straightforward if they're going to be
 13 detailed recommendations in relation to the Protect
 14 duty.
 15 It may be necessary at some time for me to come back
 16 to CPs to ask for any submissions they may have on how
 17 one should look at the word "proportionate" in this
 18 context, which will undoubtedly be used and always is
 19 used, but may have different meanings in different
 20 situations. So as I say, I am grateful for your help so
 21 far, but we may well be looking for more in the future.
 22 MR WEATHERBY: Indeed. Thank you.
 23 SIR JOHN SAUNDERS: Mr Greaney.
 24 MR GREANEY: Could we break for lunch now and resume at
 25 1.50, please, when we'll hear from Mr Welch on behalf of

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1 the families represented by Addleshaw Goddard.
 2 SIR JOHN SAUNDERS: Right. 1.50. Thank you very much.
 3 (12.56 pm)
 4 (The lunch adjournment)
 5 (1.50 pm)
 6 SIR JOHN SAUNDERS: Mr Welch.
 7 MR WELCH: Thank you, sir. Can you see and hear me
 8 sufficiently?
 9 SIR JOHN SAUNDERS: Both, thank you, and I'm grateful for
 10 your speaking note as well, which I have up in front of
 11 me.
 12 Submissions by MR WELCH
 13 MR WELCH: Thank you, sir.
 14 These submissions are made on behalf of Paul Hett,
 15 Paul Price and Robert Boyle. For a number of years,
 16 Paul Hett believed that his son Martyn had died on
 17 22 May 2017 because he happened to be in the wrong place
 18 at the wrong time. He had concluded that Martyn's death
 19 was unavoidable, caused as it was by the evil actions of
 20 the Abedi brothers, and that Martyn was just unlucky to
 21 have been in the City Room at 10.31 on 22 May.
 22 The evidence that has been presented in chapter 7
 23 has upset, shocked and angered Mr Hett as it has shown
 24 him that, tragically, his initial conclusion was
 25 mistaken. He is not alone among our clients in feeling

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1 this way. The truth is much, much more uncomfortable.
 2 Three organisations had responsibility for ensuring
 3 safety and security in the City Room: BTP, ShowSec and
 4 SMG. Each of those organisations failed. They failed
 5 on the night of 22 May and had engaged in failure for
 6 months, even years, beforehand. Their failures
 7 contributed to the City Room being unsafe. Their
 8 failures enabled Salman Abedi to carry out his murderous
 9 plans, unchecked, until he detonated his bomb, causing
 10 the maximum loss of life possible. Their failures
 11 contributed to the deaths on 22 May 2017.

12 There are eight stark and shocking facts in relation
 13 to the events that occurred at the Manchester Arena on
 14 the 22nd. First, as you have heard, the attack occurred
 15 at a time when the terrorist threat level was severe and
 16 less than 2 months after the Westminster attack. The
 17 threat to the UK from Islamist terrorism and the threat
 18 to crowded places was well-known.

19 Secondly, Salman Abedi first went to the City Room
 20 at 6.34 pm. He spent only a few seconds in there before
 21 turning around and leaving. At that time, two police
 22 officers were stationed within the City Room.

23 Thirdly, Salman Abedi then returned to
 24 Victoria Station complex at 8.30 pm with an improvised
 25 explosive device in a bag on his back. He spent the

1 next 2 hours in the complex with that device on his
 2 back.
 3 Fourth, during his second visit, he wandered back
 4 and forth throughout the complex. Between 8.30 and
 5 round about 10 pm, neither Victoria Station or the
 6 City Room were particularly busy. The Ariana Grande
 7 concert was underway and it was a Monday evening, well
 8 after the commuter rush had ended. Abedi travelled back
 9 and forth between the Metrolink platform, the main
 10 concourse of the station, the toilets, the overhead
 11 bridge and the City Room. All the while captured on
 12 CCTV, all the while weighed down by the murderous device
 13 he was carrying, hunched over, struggling at times to
 14 walk in a straight line.

15 Fifth, Abedi was never identified as suspicious on
 16 any of the CCTV systems that operated at the arena and
 17 its surrounds.

18 Sixth, he spent just short of one hour and
 19 20 minutes sitting in the City Room, firstly about
 20 20 minutes between 20.51 and 21.10, and secondly, about
 21 an hour, between 21.33 and 22.30, the City Room
 22 of course being the same room where he was to detonate
 23 the explosive device.

24 Seventh, no member of the ShowSec staff, SMG staff
 25 or the BTP ever identified him as suspicious.

1 Eighth, no member of the ShowSec or SMG staff or any
 2 BTP officer ever challenged Abedi.

3 For those facts to have come to pass it is quite
 4 obvious that something went very badly wrong with the
 5 provision of security in the City Room and
 6 Victoria Station complex.

7 However, the evidence presented in chapter 7 goes
 8 further. It clearly demonstrates that there were
 9 a number of missed opportunities. There were
 10 opportunities to deter Salman Abedi, to identify
 11 Salman Abedi as suspicious, to engage with him and
 12 potentially to prevent him carrying out his murderous
 13 attack.

14 We have identified the following. First, the
 15 failure of Kyle Lawler and Mr Atkinson to observe,
 16 interact or report Salman Abedi when he was on the
 17 footbridge.

18 Second, the missed opportunity for someone to have
 19 engaged with him when he was in the City Room between
 20 8.51 pm and 9.10 pm, a time when it was relatively
 21 quiet.

22 Third, owing to the fact that they had engaged in
 23 extended breaks, BTP officers were not patrolling the
 24 complex for prolonged periods, including a period
 25 between 8.58 and 9.36 when nobody was patrolling the

1 station.

2 Fourth, Salman Abedi was not noticed during the
 3 pre-egress checks that were conducted.

4 Fifth, at 10.15 pm, Witness A approached ShowSec
 5 staff member Mohammed Agha. The evidence strongly
 6 suggests that Mohammed Agha did nothing in the next few
 7 minutes, yet it was 10.23 by the time he spoke to
 8 Kyle Lawler.

9 Sixth, Mohammed Agha held a discussion with
 10 Kyle Lawler regarding the concern that had been raised
 11 by Witness A and the presence of Salman Abedi in the
 12 City Room. The evidence strongly suggests that
 13 Mr Lawler did little or nothing in response to whatever
 14 information Mr Agha gave him.

15 Seventh, despite the presence of four BTP officers
 16 within the Victoria Station complex on 22 May 2017, and
 17 despite their instructions, none were in the City Room
 18 for egress. No BTP officer spent any time in the
 19 City Room after 10 pm before the detonation of the
 20 device.

21 Eight, PC Corke, who had also been instructed to
 22 attend Victoria Station, chose to engage himself in
 23 duties elsewhere. He did not attend until after the
 24 detonation. In their written submissions, some core
 25 participants have suggested that it is impossible to

1 know what effect an intervention on any of these
 2 occasions might have had. It has been suggested that
 3 Salman Abedi would simply have detonated the device
 4 he was carrying whatever happened, even if he had been
 5 approached.
 6 We would suggest that there is no way of knowing
 7 with any certainty what Salman Abedi might have done.
 8 What is certain is that, save for Witness A, there was
 9 no intervention because all of these opportunities were
 10 missed. Consequently, Abedi was left to carry out his
 11 plan unchecked. He was able to wait until the City Room
 12 was at its fullest at egress. He was able to walk into
 13 the middle of a crowd of people. He was able to cause
 14 as much harm as he possibly could. It could not have
 15 been any worse.
 16 Had any of those missed opportunities been taken,
 17 there is a range of possible outcomes, any of which
 18 could have substantially reduced the impact of his
 19 actions.
 20 (1). He might not have detonated his device at all.
 21 (2). Other security personnel and other members of
 22 the police could have been contacted.
 23 (3). The room could have been sealed off to prevent
 24 further people entering.
 25 (4). The City Room could have been evacuated.

1 (5). He might have detonated the device at a time
 2 when there were fewer people in the room.
 3 (6). He might have detonated the device in the more
 4 enclosed area of the room where he had been hiding.
 5 (7). Fewer people were likely to have been in the
 6 blast radius if he had detonated the bomb earlier on.
 7 However you get there, the inevitable conclusion
 8 is that if any of those missed opportunities had been
 9 acted upon, the loss of life would have been less, and
 10 we say in all likelihood far less, than actually
 11 occurred on 22 May.
 12 Sir, as you are aware, the family teams agreed to
 13 divide the work between them in chapter 7.
 14 Consequently, our oral submissions, like our earlier
 15 written submissions, will focus in the main on BTP.
 16 We will today seek to explore some of the failures and
 17 other wider issues relating to BTP. We will also seek
 18 to address the root causes of those failures and issues
 19 and we will respond to some of the matters raised in the
 20 BTP written submissions.
 21 But first we address in greater detail the three
 22 missed opportunities as they relate to BTP.
 23 Missed opportunity 1, patrols and breaks. BTP had
 24 primacy for the policing of Victoria Station.
 25 Five officers were due to attend the station for the

1 Ariana Grande concert, albeit only four attended. Their
 2 role was to provide high—visibility assurance to members
 3 of the public and, as PCSO Morrey said, to look out for
 4 things.
 5 In his email of instruction to the officers, Police
 6 Sergeant Wilson indicated that he wanted the officers'
 7 breaks to be staggered between 7.30 and 9 pm. His
 8 timings would ensure that their staggered breaks were
 9 taken after ingress and before egress.
 10 All of the officers who were on patrol were aware
 11 that they were entitled to a refreshment break in the
 12 region of 50—minutes long. However, all of the officers
 13 took substantially extended breaks.
 14 PC Bullough and PCSO Renshaw left the station at
 15 7.27 to get food and went to the Northern Rail office
 16 until 9.36 pm, meaning that they were away from patrol
 17 and effectively on a break for well over 2 hours.
 18 PCSO Brown accepted that he and PCSO Morrey went for
 19 their break just before 9 pm, whilst PC Bullough and
 20 PCSO Renshaw were still on their break, and did not
 21 return until just before 10.30 pm, thus taking
 22 a 90—minute break.
 23 There was a period of nearly 40 minutes between 9.00
 24 and 9.35 when there were no BTP officers patrolling the
 25 station. This period was crucially important.

1 Between 9.29 and 9.33, Salman Abedi walked from the
 2 Metrolink stop through the station over the walkway and
 3 into the City Room for the last time. PC Bullough
 4 frankly accepted that had she come back on patrol sooner
 5 and seen Salman Abedi walking towards the City Room
 6 in that period, given how he was walking with the weight
 7 of his backpack, hunched quite low, she would probably
 8 have asked him what was in it.
 9 A real and significant opportunity to prevent
 10 Salman Abedi detonating his device was lost because of
 11 the lack of BTP patrols caused, at least in part, by the
 12 extended breaks taken.
 13 Missed opportunity 2, the presence of BTP officers
 14 in the City Room for egress. Some of the BTP officers
 15 from whom you heard evidence appreciated that the
 16 City Room was an attractive target for terrorists and
 17 that egress presented a particularly vulnerable time.
 18 Sergeant Wilson and PC Corke both considered that
 19 a BTP presence was necessary in the City Room for egress
 20 and Sergeant Wilson directed in his email that there
 21 would be one officer in the City Room for ingress and
 22 egress.
 23 His hope, though he didn't spell it out in his
 24 emailed instruction, was that officers would have
 25 attended at the City Room prior to the start of egress

1 and "up to 30 minutes before, 22.00 to 22.15".
 2 The understanding that the period during which
 3 officers should have patrolled the City Room preceded
 4 the scheduled end of the concert by some considerable
 5 time was one held by all of the junior and inexperienced
 6 officers who were at Victoria Station. Constable Corke
 7 gave evidence that if he was deployed to an event that
 8 had egress at 22.30, he would usually go to the
 9 City Room at about 10 o'clock.

10 However, none of the officers were in the City Room
 11 from 9.59 onwards. Instead, the four who were at
 12 Victoria located themselves at and around the entrance
 13 to the station by the war memorial from 10.01 until
 14 Salman Abedi had detonated his device.

15 On finishing their break, PCSOs Morrey and Brown
 16 joined them at the war memorial at 10.29. According to
 17 PC Bullough, the four officers were located at the war
 18 memorial "nattering away". This resulted in nobody
 19 being in the City Room during the egress period,
 20 contrary to Sergeant Wilson's instructions.

21 No explanation has been proffered by any of the
 22 officers as to why they were not in the City Room for
 23 egress from 10 pm.

24 The failure of any of the officers to be in the
 25 City Room meant that there were actually three missed

1 opportunities by BTP to disrupt Salman Abedi's attack.

2 Firstly, no officer was in the City Room to provide
 3 the visual deterrent that may have influenced or even
 4 deterred Abedi from committing the attack.

5 Secondly, the absence of an officer in the City Room
 6 meant that no officer had a chance to see Abedi hiding.

7 Thirdly, and crucially, is the question of what
 8 impact the presence of an officer in the City Room may
 9 have had upon the actions of Witness A. He had
 10 identified Salman Abedi as being a suspicious individual
 11 who caused him concern and had raised his concern with
 12 the ShowSec steward Mohammed Agha. The evidence of
 13 Witness A was that if he had seen a police officer in
 14 the City Room, he would definitely have approached the
 15 officer regarding his concerns. PC Bullough confirmed
 16 that if she had been approached by someone raising
 17 a concern about a suspicious character with a rucksack,
 18 she definitely would have taken action by approaching
 19 the person.

20 There can be no real doubt therefore that the
 21 absence of a BTP officer in the City Room for egress
 22 meant that a real and significant opportunity was missed
 23 to prevent Salman Abedi detonating the device at all or,
 24 at the very least, significantly to reduce the impact of
 25 such detonation.

1 Missed opportunity 3., the absence of PC Corke.
 2 PC Corke was the most experienced of the officers due to
 3 be on duty at the arena on 22 May 2017. At the time of
 4 the attack, he had served for 30 years as a police
 5 constable and had policed in the region of 100 events at
 6 the arena over many years. During events at the arena,
 7 PC Corke tended to locate himself in the City Room and,
 8 unless directed otherwise, during egress would locate
 9 himself on the mezzanine level in order to keep
 10 a lookout for what was happening in the City Room.

11 In the email briefing, PC Corke was instructed to
 12 assist with the handover of a suspect arrested for
 13 a burglary that had occurred at Piccadilly Station.
 14 Sergeant Wilson anticipated that Constable Corke would
 15 deal with the matter and then go to Victoria to be
 16 present during the concert.

17 At 9 pm Sergeant Wilson had a conversation with
 18 Constable Corke in which Constable Corke stated that
 19 he was running late as he was finishing some paperwork
 20 and was going to get a quick bite to eat. He would then
 21 be over at the arena for egress.

22 PC Corke was aware that the end of the concert was
 23 scheduled for 10.30 pm and agreed that it was important
 24 that he should be at the arena for egress because of his
 25 experience. He was aware that the other officers who

1 were on duty at the arena were inexperienced. However,
 2 PC Corke did not go to the arena until after
 3 Salman Abedi had detonated the explosive device in the
 4 City Room.

5 PC Corke said that after dealing with the burglary,
 6 he realised he was running late and could not make it to
 7 the arena in time by foot or any tram. He therefore
 8 decided to, in his words, scrounge a lift from
 9 PC Martin. Instead of going the direct route to the
 10 arena via Ancoats, which he says was subject to
 11 roadworks, they went via Deansgate and on the way
 12 decided to "pop into a vulnerable point" at that
 13 location.

14 PC Corke's explanation for his movements are
 15 surprising. Firstly, he recorded that the action of
 16 reporting the burglar for a summons had been completed
 17 at 8.27. According to Sergeant Wilson, the only other
 18 work that PC Corke would have been required to complete
 19 in relation to this task would have taken up to an hour.
 20 At the latest, therefore, PC Corke should ordinarily
 21 have completed the task by 9.30 pm, giving him plenty of
 22 time to get to the arena for egress.

23 Secondly, in his evidence PC Corke said that he left
 24 Piccadilly at 10 pm. PC Martin's statement said that he
 25 paired up with PC Corke at 10 pm, then went to

1 Oxford Road, then on to Deansgate where what they were
2 actually doing was, his words, "watching the trains
3 going out to provide reassurance to the public".

4 Finally, PC Corke suggested that he mistimed his
5 arrival by a couple of minutes. However, at the time he
6 heard the call for assistance over his radio at 10.32,
7 he was still on Deansgate. PC Corke stated that his
8 ordinary practice would have been to locate himself in
9 the City Room from 10 pm onwards. He was therefore over
10 half an hour late before he received the call on the
11 radio.

12 Despite his continued absence, and the knowledge
13 that the officers who were on duty were inexperienced,
14 PC Corke did not communicate to them or anybody else the
15 fact of his absence or give any directions to the junior
16 officers as to what they should do.

17 It is our submission that had PC Corke attended
18 Victoria Station as instructed, he would have located
19 himself in the City Room from 10 pm onwards, in uniform
20 and in possession of a radio, would have been on the
21 mezzanine, as was his normal practice, not far from
22 where Salman Abedi was located.

23 PC Corke has said that whilst he would not have
24 conducted a search of the City Room had he been there
25 for egress, he would have provided "a general

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1 high-visibility patrol showing that there is a police
2 presence within the City Room to all of the security
3 staff in the arena, the merchandise people and any of
4 the waiting parents".

5 Whilst PC Corke cannot say whether he would have
6 seen Salman Abedi from where he was, he recognised that
7 Abedi did not fit the audience demographic and that if
8 he had seen him for a period of time, he would have
9 approached him and challenged him. It is probable that
10 had PC Corke been on high-visibility patrol,
11 Salman Abedi would have seen him and Witness A would
12 certainly have seen Constable Corke and definitely would
13 have approached him regarding his concerns.

14 The absence of PC Corke from Victoria Station and
15 the City Room meant that further opportunities to
16 prevent or deter Salman Abedi from detonating the device
17 were missed.

18 There can be little, if any, doubt that BTP failed
19 in its duties to ensure the safety of the City Room on
20 22 May 2017 and that such failures amounted to missed
21 opportunities to prevent the attack or significantly
22 reduce its impact.

23 In response to the question of whether BTP had let
24 down the public in their policing of the City Room,
25 Assistant Chief Constable O'Callaghan has accepted that:

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1 "It was our responsibility to police that area and
2 that attack happened when we were policing it and there
3 were police officers deployed to the site of the attack
4 and they were not there. So in that term, yes."

5 But this is not simply a case of individual failings
6 by the officers concerned. This, we submit, was an
7 organisational failure. BTP's failings on the night of
8 22 May 2017 have their roots in events that occurred
9 long before, even years before, that night. There were
10 a number of wider and deep-seated failings within BTP
11 and its approach to policing of events at the
12 Manchester Arena that combined to produce a series of
13 blunders at the Ariana Grande concert. We suggest that
14 there were at least six readily identifiable underlying
15 reasons that led to BTP's failings on 22 May.

16 Reason 1, the relationship and liaison between BTP,
17 ShowSec and SMG. The evidence that you have heard, sir,
18 suggests that the relationship between BTP and SMG was
19 a good one. Clearly the two organisations would
20 communicate with one another. Individuals within the
21 two organisations were on friendly terms and that is to
22 be commended. But it is of little use unless it
23 translates into joint planning and coordination. But
24 joint planning and joint coordination between the two
25 organisations did not exist to any degree that can be

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1 considered close to satisfactory. There was no formal
2 system of agreement or liaison between BTP, ShowSec and
3 SMG prior to or during events. There were no operating
4 protocols between BTP and SMG.

5 At paragraph 53 of his written submissions,
6 Mr O'Connor Queen's Counsel on behalf of SMG stated
7 that:

8 "It is accepted that there should have been better
9 liaison at the planning level between SMG and BTP."

10 In our submission, it goes further. The extent of
11 the coordination and planning between the two
12 organisations was that once every 6 months, SMG arranged
13 a multi-agency planning meeting to which BTP were
14 usually invited, to review past events and consider
15 security and safety for future events. However,
16 according to Ms Stone, there was never a conversation
17 with BTP concerning fans leaving a concert and officers
18 being present in the City Room.

19 Nor was there any planning between ShowSec and BTP.
20 The ShowSec head of security, Tom Bailey, (a) never knew
21 how many BTP officers were on duty at Victoria Station,
22 (b) never enquired, (c) cannot recall any conversation
23 with BTP regarding a police presence in the City Room at
24 times of ingress and egress, and (d) had no routine
25 contact with BTP on the night of an event.

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1 This lack of planning and coordination at a senior
 2 level led to a complete lack of coordination and
 3 understanding of roles at an operational level. The BTP
 4 officers had no understanding of the deployment of
 5 ShowSec staff at events and there was no liaison
 6 allowing ShowSec to learn where the BTP officers would
 7 be for ingress and egress.

8 At best, BTP officers introduced themselves to some
 9 of the ShowSec staff and had informal discussions about
 10 issues other than security at the arena. BTP officers
 11 may have been approached as and when an incident
 12 occurred, such as a member of the public causing
 13 trouble. If SMG were to require the assistance of BTP,
 14 they would have to try and send someone to find an
 15 officer or, alternatively, telephone the BTP call centre
 16 who would themselves try and contact a BTP officer
 17 at the arena.

18 Furthermore, no BTP officer appears to have been
 19 aware of the CCTV blind spot. PC Corke stated that
 20 he had never been told of the existence of this, nor had
 21 PC Bullough.

22 The effect of this is that none of the organisations
 23 really knew what the others were doing. The absence of
 24 BTP officers on patrol on 22 May 2017 would not have
 25 come as a surprise or cause of concern to anyone from

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1 ShowSec or SMG because, quite simply, nobody from those
 2 organisations knew who the officers were, how many were
 3 meant to be there or where they were meant to be
 4 patrolling at any particular time.

5 Consequently, the absence of BTP officers in the
 6 City Room for egress was not apparently a cause of
 7 concern for anyone at ShowSec or BTP because they didn't
 8 know who, if anyone, was meant to be there.

9 The three organisations appear to accept shared
 10 responsibility for security in the City Room. It is
 11 therefore remarkable that there was never even
 12 a discussion between them as to how that responsibility
 13 should have been fulfilled, including who would be doing
 14 what, where and when in order that they could work
 15 together to best protect the public and to discharge
 16 that responsibility.

17 Reason 2, planning within BTP. Organisations
 18 involved in the provision of security and ensuring
 19 safety at events that are attended by tens of thousands
 20 of members of the public need to plan properly in
 21 advance. So much may seem obvious. It may be thought
 22 to be equally obvious that such planning should take
 23 account of events at the arena generally but should also
 24 include bespoke planning for specific events. Proper
 25 planning is the foundation stone of ensuring health and

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1 safety in any environment, and policing is certainly no
 2 exception. As has been observed in the past, if you
 3 fail to plan, you are planning to fail.

4 It is therefore a source of surprise and concern,
 5 but a sad fact, that BTP engaged in no meaningful
 6 planning in relation to the policing of the
 7 Ariana Grande concert. BTP's tactical plan for the
 8 policing of the arena was prepared on 13 June 2014.
 9 Remarkably, and shockingly, nobody involved in the
 10 planning or preparation of the operational policing of
 11 the Ariana Grande concert was even aware of its
 12 existence.

13 You may feel, sir, that in evidence, and
 14 particularly that of Inspector Wedderburn, BTP had been
 15 very keen to distance themselves from that plan.
 16 Inspector Wedderburn said that it was created at a time
 17 before the structural changes to Victoria Station. But
 18 that plan was never cancelled, it was never reviewed,
 19 and it was certainly never superseded by a new and
 20 revised plan.

21 You may feel, sir, that the reason BTP have been so
 22 keen to distance themselves from that plan is because
 23 had it been followed there would have been more officers
 24 at the arena. There would have been more senior
 25 officers. There would have been a proper degree of

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1 supervision. That plan established the benchmark that
 2 BTP sets itself and recognised as appropriate. BTP's
 3 failure to follow its own plan shows how badly it failed
 4 at an organisational level in 2017.

5 The failure even to know of the existence of the
 6 plan, let alone to follow it, meant that there was no
 7 planning for the Ariana Grande concert at a tactical
 8 level or any meaningful planning. The decision as to
 9 how many officers should be posted on a concert based
 10 simply on attendance at a six-monthly meeting organised
 11 by SMG, in our submission, cannot properly be described
 12 as planning.

13 Whilst operational orders were put in place for
 14 specific events that had a high risk of crime or public
 15 disorder, no operational order was put in place for the
 16 Ariana Grande concert. In the absence of such an order,
 17 there was no event commander or supervisor.

18 In terms of planning, BTP will point to the risk
 19 assessment conducted by Inspector Wedderburn and the
 20 briefing conducted by Sergeant Wilson, but both were
 21 grossly deficient and we shall deal with each in turn as
 22 separate topics.

23 Reason 3, risk assessment. Risk assessments are
 24 hardly a new or novel concept. Employers are legally
 25 obliged to prepare them. They are created, reviewed and

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1 used on a daily basis across all industries, businesses
2 and public services. They are important because they
3 force an organisation to do three things: (1), identify
4 potential risks; (2), decide how likely it is that
5 someone might be harmed by those risks; (3), take action
6 to eliminate or control that risk.

7 BTP originally suggested that the force, and
8 I quote:
9 "... conducted its own risk assessment based on
10 information provided by SMG and any intelligence
11 disseminated by the force's Manchester or London-based
12 intelligence bureau."

13 It appeared that BTP were suggesting that the only
14 failing related to the risk assessment was the fact that
15 it wasn't documented.

16 But Inspector Wedderburn did not conduct a risk
17 assessment. On the basis of what she had been told by
18 SMG as to what they considered the risk to be, she
19 decided how many officers would be deployed to the
20 event, but that, in our submission, is not a risk
21 assessment. It did not identify potential risks, it did
22 not identify the likelihood of someone being harmed by
23 such risks, and it did not consider what action was
24 necessary to eliminate or control those risks.

25 The risk posed by terrorism was completely ignored

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1 because the SMG risk assessments did not adequately
2 consider that risk. BTP made a flawed decision based on
3 a flawed risk assessment by SMG. This meant that there
4 were no specific measures considered, far less
5 introduced, by BTP to mitigate the risk posed by
6 terrorism.

7 The BTP written submissions suggest that there was
8 a lot of thinking about risks. That is said to have
9 included thinking about the terrorist threat by
10 reminding themselves of the threat level and providing
11 training to its officers, and the suggestion is that
12 such thinking, combined with training, was sufficient.
13 Such a submission is, with respect, quite clearly wrong.
14 We say it is wrong for the following reasons.

15 Firstly, training may mitigate a risk or some risks,
16 but it is only one measure of mitigation. Training
17 alone cannot displace the need for a proper risk
18 assessment, neither can it diminish the importance of
19 a proper risk assessment. If it were otherwise, the
20 universally understood and accepted concept of a risk
21 assessment would be redundant. It is entirely
22 insufficient for an organisation to simply say that it
23 has trained its staff and that is enough. That is
24 clearly wrong.

25 Secondly, it is plainly insufficient to identify

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1 a risk generally, in the abstract, and think about it.
2 You must identify specific potential risks as they
3 relate to what you are doing and where you are doing it.
4 A broad-brush approach of thinking about terrorism
5 generally at a national level will not identify what
6 needs to be done to mitigate the risk or threat in the
7 individual circumstances of the event that is being
8 policed. Clearly, the risk assessment that BTP carried
9 out in relation to the Ariana Grande concert should have
10 considered the risks posed by that concert at the
11 Manchester Arena. Each venue presents different risks
12 and therefore different ways to mitigate them, just as
13 each individual event at a venue presents different
14 risks.

15 Thirdly, in their written submissions BTP suggest
16 that what is important is the quality of thought given
17 to the risks, including the risk of terrorism, and that
18 such thinking should be "refreshed intelligently and
19 regularly".

20 However, nobody within BTP gave any consideration to
21 the threat posed by terrorism at the Ariana Grande
22 concert. It was not one of the matters that
23 Inspector Wedderburn took into consideration when she
24 was deciding on the appropriate number of officers to
25 deploy to the concert as she freely told us. She said

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1 that she considered the audience number and the sort of
2 audience they are to determine how to make sure that
3 they can get out safely without crushing points and
4 things like that.

5 In conclusion, there was no risk assessment, no
6 independent consideration of the risks that existed, no
7 thought given as to how likely they were to occur and
8 therefore no consideration of what measures were needed
9 to reduce those risks, including the risk of terrorism
10 at a time when the threat level was severe. Absent any
11 real control measures, the minimum number of extremely
12 inexperienced officers were deployed without any
13 supervision. BTP demonstrated no sense of awareness at
14 early senior or operational level as to what could go
15 wrong or how best to prevent it.

16 Reason 4, briefings. BTP's briefings of its
17 officers for events at the arena were, in our
18 submission, haphazard. The briefings were vitally
19 important because they should provide the officers who
20 attend the arena with clear instruction, understanding
21 and direction.

22 In the light of the evidence presented to the
23 inquiry, it needed to be spelt out to them, the
24 officers, that they were being deployed to protect the
25 public from the real threat of a terrorist attack and

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1 that required much more of them than acting like cinema
2 ushers. The more junior and inexperienced the officers,
3 the more important the briefings became, and the more
4 important it is that those briefings were specific,
5 detailed and clear.

6 BTP's system of briefings allowed for face-to-face
7 briefings, briefings via a telephone call or simply via
8 an email. Of greater concern than the method of
9 delivery is the content, particularly in relation to
10 counter-terrorism. Sergeant Wilson suggested that, in
11 his words:

12 "Every single briefing that I would give would have
13 an element of counter-terrorism and that every briefing
14 would mention the threat level."

15 However, the evidence suggests that this was not
16 correct. BTP as an organisation accepted in its lessons
17 learned document that no reference was made to
18 counter-terrorism when briefing officers.

19 Some officers have said that the threat level was
20 mentioned in briefings, others have no recollection of
21 counter-terrorism or the threat level ever being
22 mentioned. Some recalled that the threat level was
23 mentioned some of the time, but that was in the context
24 of officer safety, while yet others have said that it
25 depended which sergeant conducted the briefing and that

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1 it would be hit and miss at best.

2 Of the four officers who attended the arena, only
3 PCSO Renshaw recalls receiving a verbal briefing. He
4 cannot remember the detail of it and has no memory of
5 being told anything about the terrorist threat level
6 in the briefing. PCSO Brown, a probationer at the time
7 under PCSO Morrey, said that he was certain that there
8 was no briefing on 22 May. PCSO Morrey himself could
9 not remember being briefed. PC Bullough did not receive
10 any verbal briefing but simply read the email that had
11 been sent to her.

12 All four officers were sent Sergeant Wilson's email,
13 but, as you have seen, it made no mention of either the
14 terrorist threat level or any counter-terrorism measures
15 or awareness.

16 Despite Sergeant Wilson's assertion that every
17 single one of his briefings would reference both the
18 threat level and counter-terrorism, none of the officers
19 who attended the arena has given evidence that they
20 recalled being briefed about terrorism on 22 May 2017
21 and the only other evidence of the content of the
22 briefing, the email, did not mention terrorism at all.

23 This state of affairs points strongly to a briefing
24 utterly lacking in detail or direction to particularly
25 junior and inexperienced officers. They and the public

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1 deserve better to enable the officers to carry out their
2 duties effectively.

3 The direction given to the officers amounted to only
4 three lines of text in the email, stating, and I quote:

5 "You will be deployed for the in and out. I would
6 like one officer on the concourse, close to the barrier,
7 one patrolling the City Rooms, and one patrolling
8 [another area]. Please can breaks be staggered between
9 7.30 and 9 pm so we have someone at Victoria."

10 The briefing should have been face-to-face. It
11 should have allocated specific responsibilities to each
12 officer, detailing their locations and patrols,
13 including where and when to go into the City Room. Most
14 importantly, it should have contained a clear and
15 explicit counter-terrorism element that was specific to
16 the event.

17 The briefing was inadequate and unacceptable. It
18 certainly was not, as appears to have been suggested,
19 a model briefing. Its consequence was that the officers
20 had no focus on any potential problems that might occur,
21 no alertness to any potential threats, and only the very
22 minimum direction and instruction. It was effectively
23 left entirely to them to interpret. They were given no
24 focus on how to ensure the safety of the public beyond
25 guiding them in and out of the concert and being seen.

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1 A more formal briefing with clearer instructions and
2 a proper focus on counter-terrorism might have made it
3 more likely that the officers would have followed
4 Sergeant Wilson's directions and more likely that
5 Salman Abedi might have been either deterred or detected
6 by them.

7 Reason 5, supervision. The officers who were
8 deployed to and attended the arena were woefully lacking
9 in both seniority and experience. The most senior was
10 PC Bullough who was still in her probationary period,
11 having only been a constable for 8 months. She was
12 accompanied by three PCSOs, one of whom was himself
13 a probationer. In effect therefore there were two PCSOs
14 and a PC in her probationary period.

15 It should have been quite clear that such a group
16 would require a level of supervision. Sergeant Wilson
17 said that he considered that although the officers were
18 inexperienced, they were all very capable, and so he
19 chose not to attend the arena to supervise them. What
20 happened on 22 May — extended breaks, joint patrols and
21 failures to follow his instructions in relation to
22 egress — all these failings point to the conclusion
23 that they were junior officers who clearly needed
24 guidance and supervision.

25 Further, the evidence that you have heard suggests

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1 that such failings were not unique to 22 May 2017, they
 2 had become commonplace and were entrenched. For
 3 example, PCSO Renshaw stated that it was not unusual for
 4 him to be away from patrol for such an extended period
 5 of time as he was on 22 May 2017. PC Bullough accepted
 6 that she probably would not have taken an extended break
 7 if she had been supervised. She also suggested that
 8 senior officers knew about and turned a blind eye to the
 9 practice of taking extended breaks.

10 Constable Corke should have been there, but the
 11 plain fact is that he failed to attend the arena until
 12 after the explosion. Neither he nor anybody else
 13 appears to have given any thought to the effect of not
 14 having an officer of any seniority or experience at the
 15 arena.

16 No attempt was made to ensure that anyone of
 17 seniority or experience replaced him there. This meant
 18 that the police presence at the arena was being run by
 19 a very junior officer, as accepted by Sergeant Wilson.

20 Was she in charge? If not, who was? PCSO Morrey
 21 considered that PC Bullough, as the only PC present,
 22 would have been in charge, but that the officers would
 23 have discussed between themselves as to who went where.
 24 In contrast, PCSO Brown did not consider PC Bullough to
 25 be in charge, despite the fact that she was the most

1 senior officer. Whilst PC Bullough herself did not
 2 think that she was in charge of the other officers, she
 3 thought it was Sergeant Wilson who was in charge,
 4 despite the fact that he wasn't there and had actually
 5 gone off duty at 9 pm.

6 The reality is that this was a shambolic
 7 arrangement. Nobody was in any way in charge, as
 8 ACC O'Callaghan accepted. The absence of an experienced
 9 officer led to a total failure of leadership at the
 10 arena, there being nobody in authority to direct or
 11 supervise the junior officers who were there. This
 12 failure led to many other issues arising that night,
 13 including no officers attending at the City Room for
 14 egress.

15 In its written submissions, BTP appears to suggest
 16 that it was sufficient for Sergeant Wilson to have made
 17 a telephone call, described as authoritative, to the
 18 officers. There are two issues with this.
 19 Sergeant Wilson's evidence was not that he did speak to
 20 the officers, his words were, you may think, chosen
 21 quite carefully. He said he believed that he spoke to
 22 one of the officers who was on duty at the arena, albeit
 23 he cannot remember who, because that is what he normally
 24 does on every occasion.

25 Secondly, none of the officers who were on duty

1 at the arena gave any evidence of speaking with
 2 Sergeant Wilson.

3 A number of the BTP officers who gave evidence
 4 before you, sir, accepted that there should have been
 5 a more senior officer supervising them, which rather
 6 runs contrary to what is suggested in the BTP written
 7 submission on this topic. For instance, PC Bullough
 8 felt that there should have been a more senior officer
 9 present at the arena on 22 May.

10 Inspector Wedderburn accepted that in hindsight the
 11 officers in attendance at the arena on 22 May 2017
 12 should have been supervised by a sergeant. However,
 13 this ought not to have been a matter of hindsight. The
 14 BTP tactical plan specifically provided for the presence
 15 of a supervising sergeant at an event such as the
 16 Ariana Grande concert, and the inexperience of the
 17 officers actually deployed should have made supervision
 18 a glaringly obvious requirement at the planning stage.

19 We are concerned that both at a senior level within
 20 BTP and in submissions made on their behalf, there
 21 appears to be little by way of recognition or
 22 acknowledgement that BTP's failure to recognise the need
 23 for or to provide any supervision was a serious flaw
 24 which may well have contributed significantly to the
 25 various missed opportunities.

1 Reason 6, the attitude and approach to the concert.
 2 Why was, at both senior and junior level, the approach
 3 of BTP to the Ariana Grande concert so poor? At
 4 a senior level, why were basic principles such as
 5 planning, risk assessment, providing adequate
 6 instruction and supervision given so little attention or
 7 focus or even thought? Why did the officers on the
 8 ground simply ignore the instructions regarding egress?
 9 Why did they choose to have such extended breaks? Why
 10 did PC Corke feel able not to go to the arena at all but
 11 instead to go to Deansgate station to effectively watch
 12 the trains coming in and out?

13 BTP's written submissions suggest that following
 14 Sergeant Wilson's instructions is "pretty basic stuff in
 15 a hierarchical organisation". But those submissions
 16 provide no explanation as to why those basic
 17 instructions were not followed by any of the officers in
 18 attendance.

19 We suggest that the answer may lie in what can be
 20 discerned from the evidence generally about BTP's
 21 attitude over preceding years, which came through the
 22 approach of all the senior officers to the policing of
 23 the Ariana Grande concert and which consequently came to
 24 affect the attitude of the junior officers. In short,
 25 from top to bottom, BTP had become institutionally

1 complacent.
 2 The Ariana Grande concert was considered by BTP to
 3 be a normal, business as usual event. The role of BTP,
 4 as understood by the officers who patrolled the station,
 5 was extremely limited. PC Bullough said that her role
 6 was to see fans in and out of the concert, to provide
 7 high-visibility reassurance for the public and to assist
 8 if they had any issues or required any advice.
 9 PCSO Morrey said that the role of the BTP officers was
 10 to provide a high-visibility presence and reassurance
 11 but also to look out for things.
 12 Even PC Corke, the BTP officer with the most
 13 experience of policing events at the arena, said that
 14 the focus was:
 15 "To ensure that people leave the arena in a safe
 16 fashion, getting on the trains and leaving the area."
 17 The severe terrorist threat level, the tidal wave of
 18 Islamist terrorist attacks throughout Europe in the
 19 previous 18 months, a number of which occurred at
 20 crowded places, a number at entertainment venues and
 21 a number within the UK, appear not to have crossed any
 22 BTP minds at any level or to have informed their
 23 preparation for policing the concert.
 24 Three BTP officers made clear in their three
 25 slightly different ways, from Assistant Chief

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1 Constable O'Callaghan at the top through
 2 Inspector Wedderburn and down to PC Corke that absent
 3 notification of a specific threat, there was either,
 4 (1), nothing that could be done or, (2), nothing that
 5 needed to be done or, (3), nothing would happen because
 6 there was no specific threat --
 7 SIR JOHN SAUNDERS: Mr Welch, I'm sorry to interrupt you.
 8 Do you mind if I interrupt you just for 2 minutes?
 9 I have a phone in the house which is making an alarming
 10 noise, which is rather distracting. If you give me
 11 2 minutes, I'll be back. Thank you.
 12 (Pause)
 13 Mr Welch, I'm really sorry about that. You may have
 14 noticed it took me rather longer to stop the noise than
 15 I expected it would do. I'm sorry for the interruption.
 16 MR WELCH: Not at all, sir. I have not got much further to
 17 go.
 18 SIR JOHN SAUNDERS: That's fine. These things don't happen
 19 in court!
 20 MR WELCH: Sir, the attitude that in the absence of
 21 a specific threat nothing could be done or needed to be
 22 done, that sort of thinking, in our respectful
 23 submission, appears to have become institutionalised
 24 within BTP. It may well explain why the junior officers
 25 regarded their role as being largely peripheral rather

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1 than essential to public protection.
 2 Counter-terrorism and the protection of the public
 3 against a terrorist threat appears to have played
 4 little, if any, part in the minds of the officers'
 5 performance on 22 May or in their understanding of what
 6 as police officers they should be alert to when policing
 7 the Victoria complex during an event.
 8 PCSO Brown said in respect of the purpose of BTP
 9 policing station:
 10 "I don't believe there was such an emphasis on the
 11 counter-terrorism element. I believe it was just more
 12 of a public safety thing, watching people coming in and
 13 out of the arena itself, and if any issues came to light
 14 as a result of that."
 15 PC Bullough said that the role of the BTP officers
 16 in getting people in and out of the concert did not
 17 involve any counter-terrorism element. Then there was
 18 PC Corke, who viewed the role as:
 19 "To ensure that people leave the arena in a safe
 20 fashion, getting on to the trains and leaving the
 21 arena."
 22 He said that looking for suspicious people at an
 23 event such as the Ariana Grande concert would have
 24 involved looking at potential paedophiles rather than
 25 potential terrorists. He said that it never came into

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1 his mind that an attack might occur that night. He had
 2 concluded that an attack would not happen as there had
 3 been no indication of a specific threat to the arena
 4 that evening.
 5 We suggest that these attitudes are to be found
 6 among the junior ranks for an obvious reason. Among
 7 senior BTP officers, there was a lack of real focus on
 8 or concern about the potential of a terrorist threat to
 9 events at the arena.
 10 On the other hand, the training provided to the BTP
 11 officers in relation to counter-terrorism was of a high
 12 standard. The Hydra Minerva training product the
 13 officers were provided with was described as being one
 14 of the best that's available. But that alone was not,
 15 and is not, enough.
 16 To be effective, it requires application. It is the
 17 role of senior officers to ensure that the officers on
 18 the ground apply their training appropriately. To
 19 ensure that they understand, not at least through the
 20 briefings: (1), the central role they play in the vital
 21 task of public protection; (2), the relevance of the
 22 threat level; (3), that as each day passes, with the
 23 threat level set at severe, the likelihood of an attack
 24 does not diminish simply because there hasn't yet been
 25 an attack; (4), that the absence of any specific

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1 intelligence does not make an attack any less likely;
 2 (5), that these things are quite literally a matter of
 3 life and death.
 4 During Assistant Chief Constable O'Callaghan's
 5 evidence he was asked about the issue of
 6 counter-terrorism in briefings and he drew a parallel
 7 with boarding an aircraft, and the following exchange
 8 took place with you, sir. ACC O'Callaghan said this:
 9 "Answer: It's like with aviation and the safety
 10 briefing for people getting onto an aircraft. Is there
 11 any new information? It's the same information you're
 12 giving people time in and time out.
 13 You, sir, said:
 14 "Question: Okay, but no one suggests you shouldn't
 15 give it, do they?
 16 "Answer: No, sir, I accept that. However, I would
 17 say acknowledging that a lot of people do not listen to
 18 it.
 19 "Question: You have to make it somehow relevant so
 20 that each time you do it people pay attention and take
 21 notice and it affects the way they do their jobs."
 22 And he agreed. And you went on to say:
 23 "Question: And that's your job, to make them do
 24 that, isn't it?"
 25 And ACC O'Callaghan said:

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1 "Answer: That is extremely difficult if there is no
 2 information to base that new alive briefing to your
 3 officers, especially 2.5 years on from the level of that
 4 risk assessment or threat level."
 5 Sir, it may be that it is extremely difficult, but
 6 difficult or not, it must be right to say that it is the
 7 task of senior officers to find a way of getting the
 8 message across and of creating an outlook and attitude
 9 entirely different to the "business as usual, nothing
 10 will happen" approach that held sway on 22 May.
 11 Senior BTP officers needed to lead by example.
 12 Their attitude to counter-terrorism, when the threat
 13 level was severe, and the policing of the arena, was not
 14 a failure on a single day: they had allowed an attitude
 15 to develop in their force that simply being there was
 16 enough. This poor attitude ran from the top to the
 17 bottom of the force.
 18 By 22 May 2017, they had become institutionally
 19 complacent, almost to the point of apathy, and there
 20 seems to be very little acceptance of that reality.
 21 Everything was business as usual because that had seen
 22 them through until 22 May.
 23 We submit that it was this state of affairs, this
 24 attitude, this lack of any consideration of potential
 25 threats, far less of a terrorist threat, that fed into

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1 the conduct of junior officers and was a major cause of
 2 all the failures on the part of BTP.
 3 In conclusion, the individual errors by the junior
 4 BTP officers on 22 May in taking extended breaks, not
 5 patrolling the complex because of those breaks, and not
 6 attending at the City Room for egress, did mean that
 7 a number of real and significant opportunities to
 8 identify Salman Abedi and prevent him detonating the IED
 9 in the way in which he did were lost.
 10 However, it would be quite wrong and unfair to
 11 suggest that the errors lie solely with those officers.
 12 There is clearly a much wider failure on the part of
 13 BTP. The lack of planning for the Ariana Grande
 14 concert, the lack of any risk assessment, the lack of
 15 any real briefing, the lack of supervision, and the
 16 complete absence of any consideration of
 17 counter-terrorism and the terror threat level do reflect
 18 a culture of complacency within BTP.
 19 This institutional complacency meant that the
 20 officers who were policing the arena were woefully
 21 lacking in experience, lacking in seniority, lacking in
 22 instruction and lacking in supervision. Absent any
 23 direction or instruction to them of potential risks,
 24 including the terrorist risk, that they should be
 25 mindful of, absent any information about a specific

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1 terrorist risk, their role was reduced to being present,
 2 amounting to really little more than directing people to
 3 the exits and trains at the end rather like ushers in
 4 a cinema.
 5 This same complacency meant that the officers felt
 6 entitled to take extended breaks and that PC Corke felt
 7 able to prioritise attending at Deansgate station
 8 instead of providing policing to an event with nearly
 9 14,500 people. The overall effect of this culture of
 10 complacency was that members of the public attending the
 11 concert were unsafe and were vulnerable to a terrorist
 12 attack.
 13 The evidence of ACC O'Callaghan and BTP's written
 14 submissions suggest to us that no significant lessons
 15 have been learnt. There does not appear to be a proper
 16 understanding of the need for planning, the need for
 17 risk assessment, the need for adequate direction and
 18 instruction or supervision. BTP do not appear to have
 19 really considered why the mistakes were made by them.
 20 ACC O'Callaghan suggested that this was a case of, his
 21 words, "a lack of application of task". That, we
 22 suggest, is not a fair conclusion but a rather
 23 simplistic and superficial one, which serves to absolve
 24 BTP and its senior officers from any responsibility by
 25 placing the blame elsewhere.

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1 We invite you to consider making two
 2 recommendations, sir. Firstly, in relation to training,
 3 a recommendation that where responsibility for security
 4 and public safety is shared between organisations, as
 5 was the case at the arena, those organisations engage in
 6 joint training and the training should be done on site
 7 at the venue. We see great and quite obvious advantages
 8 to each of BTP, ShowSec and SMG had they engaged in
 9 joint training at the Manchester Arena itself,
 10 particularly in relation to terrorism. This was not
 11 a small venue; it hosted events attracting tens of
 12 thousands of people.

13 Secondly, the failings of BTP on 22 May were so many
 14 and so significant that questions must be asked about
 15 that organisation's competence and suitability to police
 16 mass entertainment venues such as the Manchester Arena.
 17 BTP was established to police the railway network and
 18 the particular challenges that that brings. It does not
 19 have any particular experience or skill in policing
 20 entertainment events attended by the public or indeed
 21 large scale public order events. The only reason that
 22 it was involved in the policing of the arena was because
 23 the arena is situated on land owned by Network Rail.

24 The failures of BTP, and in particular their lack of
 25 recognition as to their own organisational failures,

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1 lead us to invite you to recommend that primacy for the
 2 policing of all large scale events attended by members
 3 of the public, including events at the Manchester Arena,
 4 be transferred to the local Home Office force. That
 5 does not prevent BTP policing railway stations or even
 6 Victoria Station. It does not prevent them being
 7 involved at the railway station on event night and
 8 coordinating with the local force, but it will place
 9 primacy firmly in the hands of the local force that has
 10 a great number of local assets and resources, that is
 11 familiar with challenges in the locality, and has
 12 experience of policing public order events in that
 13 locality.

14 BTP have already been invited by GMP to cede primacy
 15 to the local force for the Manchester Arena. The fact
 16 that BTP continues to resist this suggestion only serves
 17 to reinforce the importance of you, in our submission,
 18 making a recommendation in this regard.

19 Sir, unless I can assist further, those are the
 20 submissions.

21 SIR JOHN SAUNDERS: Thank you very much, Mr Welch,
 22 particularly your timekeeping, which was impeccable.
 23 Thank you.

24 Mr Greaney, if we start again at 3.20?
 25 MR GREANEY: Yes, please, and at that stage we'll hear

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1 finally, so far as today is concerned, from Mr Cooper on
 2 behalf of the families represented by Slater & Gordon.

3 SIR JOHN SAUNDERS: Thank you very much. Twenty past.
 4 (3.05 pm)

5 (A short break)

6 (3.38 pm)

7 MR COOPER: Can I say how grateful I am for the patience of
 8 the inquiry. I'm afraid it was one of those things that
 9 had to happen to someone, and unfortunately it happened
 10 to me.

11 SIR JOHN SAUNDERS: We can quite understand, thank you.
 12 Submissions by MR COOPER

13 MR COOPER: Thank you so much.

14 We address the inquiry on behalf of the 12 that we
 15 represent, submissions made on behalf of the families of
 16 John Atkinson, Kelly Brewster, Georgina Callander,
 17 Wendy Fawell, Megan Hurley, Nell Jones, Martyn Hett,
 18 Lisa Lees, Angelika Klis, Marcin Klis, Eilidh MacLeod
 19 and Elaine McIver. Names now that are very familiar to
 20 this inquiry since we've been sitting and hearing
 21 evidence since the beginning of September.

22 The families who we represent have sat in person or
 23 remotely, heard the evidence presented over the last few
 24 months, and for them none of the time taken by this
 25 inquiry to explore the evidence was wasted. It was all

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1 a necessary exercise by which I can say immediately they
 2 have gained as much catharsis and understanding and
 3 insight that could have been achieved.

4 Realising as I do that I address you, sir, fourth in
 5 the list of CPs, I am conscious of attempting to assist
 6 the inquiry with perhaps new issues or new approaches.
 7 But obviously, what comes with coming last is that
 8 sometimes one has to nuance perhaps all the able
 9 submissions that have been made on other families'
 10 behalves and try to assist you with an insight we
 11 particularly have on the issues raised.

12 Through chapter 7 it is right to say the families
 13 have obtained a much greater understanding of a number
 14 of parts and facets of this inquiry. The limits of the
 15 security regime that was in place on 22 May 2017. The
 16 level of protective security that ought to have been in
 17 place.

18 Thirdly, the systemic reasons why the provision for
 19 the Ariana Grande concert fell short of the standards at
 20 the time. And we emphasise "at the time", and I'll
 21 address you in due course, sir, a little about how
 22 that is an important aspect and one that, despite some
 23 of the submissions of the corporate CPs that we've seen
 24 in advance of our address to you, it does not get them
 25 off the hook.

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1 And fourth, the improvements that must be made now,
 2 guaranteed in order to give as much meaning as possible
 3 to the loss of those lives .
 4 We ask you, sir, as part of your process of
 5 consideration of this section of the inquiry to consider
 6 the evidence in those same four broad categories. And
 7 we know, sir, you have our written submissions in
 8 advance, whereby we put into place the arguments we make
 9 within those four categories.
 10 The families submit that at the close of the
 11 evidence in chapter 7, the inescapable truth is that
 12 there was a failure of security at the arena, singularly
 13 and cumulatively, which enabled the terrorist ,
 14 Salman Abedi, to succeed in his murderous activities.
 15 And whilst it is a matter for this inquiry to resolve
 16 whether he could have been prevented from detonating his
 17 evil bomb in the City Room, it is without doubt, we
 18 submit to you, sir , on the evidence, clear that but for
 19 the multiple failures that you've been addressed on and
 20 we'll continue to address you on a little this
 21 afternoon, the multiple failures of parties who are
 22 responsible for the arena and the protection of public
 23 in it , some lives could have been saved.
 24 Indeed, sir , it is our overall submission that these
 25 failures were not slight or marginal failures , they were

1 fundamental failures and they were chronic failures .
 2 There may be multiple reasons for these failures on
 3 behalf of those responsible to protect the public:
 4 ignorance, passivity , poor training, complacency,
 5 turning a wilful blind eye, a dereliction of duty,
 6 a lack of funding, a lack of communication, a lack of
 7 leadership, a failure of systems, a failure of
 8 equipment, a failure to take responsibility and an
 9 overriding drive to penny—pinch. A virulent and, we
 10 submit, ultimately fatal cocktail .
 11 Of course, sir , you' ll be hearing from other core
 12 participants in the days ahead and we've had the
 13 advantage of reading their written arguments. In
 14 particular , we have read carefully the arguments of SMG,
 15 ShowSec and the British Transport Police, and we have
 16 read their written submissions not only with great care
 17 but not a little disappointment.
 18 During the course of my address to you, sir , this
 19 afternoon, we'll look a little more closely at those
 20 submissions, but we must mark now, with profound
 21 anxiety, if not, on behalf of those we represent, anger,
 22 as to the various failures of SMG, ShowSec, British
 23 Transport Police in particular , those three, the
 24 failures of them to accept responsibility and the sheer
 25 distasteful spectacle of them blaming each other for

1 this tragedy. It is demonstrative, we submit, of their
 2 dysfunctional nature, the dysfunctional nature of all
 3 three, the dysfunctional nature of their relationships ,
 4 which existed in 2017 and from reading their
 5 submissions, still exists now.
 6 It is our submission to you, sir , overall that the
 7 families deserve a better spectacle than they're about
 8 to receive this week from them. This is a matter, sir ,
 9 of them passing the buck or trying to save a buck. It
 10 might be one or the other, but for the families who seek
 11 accountability we submit it is not a very pleasant
 12 spectacle.
 13 We ask you first to consider , as we have laid out in
 14 our document, the protective security provision on the
 15 actual day, on 22 May 2017, and the limits of it. This
 16 is our paragraph 1 onwards.
 17 It should be marked that Manchester Arena, which
 18 opened in 1995, was a significant venue. It was one of
 19 the largest arenas, and still is , in Europe, with
 20 a capacity of 21,000. Indeed, on the tragic night of
 21 the 22nd, there were about 14,000 young people, along
 22 with their families who were waiting to pick them up and
 23 take them to the safety of their homes on this
 24 particular night.
 25 Those charged with protecting those young people and

1 those charged with indeed protecting those who were
 2 coming to take them home failed miserably in their
 3 duties. When considering, as we do, the individual
 4 responsibilities and consequent dereliction of them, we
 5 also emphasise that the levels of communication and
 6 cooperation between different stakeholders failed to
 7 meet the standards required at such an interrelated
 8 venue.
 9 For all the alleged intimacy of the relationship
 10 between SMG and ShowSec, that piece of evidence is
 11 perhaps in the same category as much of the evidence
 12 we've heard from them: fine words and fine talk, with
 13 little substance.
 14 Dr BaMaung made it crystal clear. He said this:
 15 "The security operation at the arena would have been
 16 greatly improved if there had been closer liaison and
 17 planning between all the organisations involved on event
 18 days including SMG, ShowSec and British Transport
 19 Police, but also the Greater Manchester Police."
 20 Your expert said this:
 21 "That as far as Greater Manchester Police were
 22 concerned, although not involved in events, they should
 23 have been made aware of the dynamics to be able to make
 24 an appropriate response if required to assist British
 25 Transport Police."

1 These are not the words of any partial witness,
 2 these are the words of your experts, and we echo the
 3 observations made, and we need repeat them, by
 4 Mr Weatherby concerning what we would submit was the
 5 disgraceful treatment of those witnesses, who were
 6 independent individuals appointed by you to assist this
 7 inquiry, who were needlessly vilified by certain parties
 8 during the course of examination.

9 We accept that by virtue of the structure, the
 10 ownership and the interrelationship between a number of
 11 people and a number of organisations in and around the
 12 arena, that relationship was complex and that indeed
 13 a level of cooperation, understanding and willingness
 14 was required to keep the City Room safe. We say that
 15 particularly having in mind issues relating to the
 16 security perimeter, which of course you've been
 17 addressed on already.

18 SMG, though, bear a fundamental responsibility, we
 19 submit, and they cannot shirk from it, for providing the
 20 safety to young people and those attending in the
 21 City Room and at the arena. In many respects, the
 22 forthcoming submissions to be made on behalf of SMG come
 23 as no surprise to those we represent. Astoundingly, on
 24 the face of the evidence, and despite the fact that
 25 we have all heard it and sat in the same room with them,

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1 they continue to deny and to shift blame, a trait not
 2 exclusive to them but again profoundly disappointing.

3 We précis that with the evidence that SMG will now
 4 have to deal with, to put into clear focus, and to
 5 question themselves before they make their final address
 6 to you, sir, later on this week whether that
 7 prevarication, finger-pointing and blaming other parties
 8 is really appropriate in the context of what you and the
 9 families require.

10 Because so it is that SMG were at all times
 11 responsible for security and safety of all those within
 12 the complex, neither SMG or ShowSec's documented risk
 13 assessment process took any sufficient account of the
 14 subsisting threat of terrorism, despite, as you know
 15 well by now, and many people have heard it said on
 16 a number of occasions, despite the level, the national
 17 threat level as being severe.

18 Let's remind ourselves, if we may, that severe means
 19 that an attack was highly likely. ShowSec were not
 20 provided with the SMG risk assessment, an example of
 21 that breakdown of communication between this so-called
 22 intimate set of corporate bodies.

23 Furthermore, the minutes of the multi-agency
 24 planning meeting betray a complete lack of appreciation
 25 of the particular and distinct requirements to protect

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1 the demographic which made up the audience for an
 2 Ariana Grande concert.

3 At SMG, no one individual appears to have been
 4 seized of responsibility for coordinating protective
 5 security provision at the arena. And as you heard, SMG
 6 neither employed nor commercially contracted for
 7 specialist counter-terrorism advice.

8 Again, sir, we're acutely conscious that you've been
 9 addressed all of the day on these particular issues, but
 10 it is worthy of repeating just a few of the highlights,
 11 knowing full well that the defence, if one can call it
 12 that, of SMG and ShowSec to all this is effectively
 13 passing the buck or arguing, "Well, we go by
 14 contemporary standards". We'll meet that in a moment.

15 They appear, SMG, to have expected the CTSA,
 16 Ken Upham, to audit or sign off their protective
 17 security provision, but that was a misunderstanding of
 18 his role and, we submit, an abdication of their ultimate
 19 responsibility to determine sufficiency and
 20 effectiveness. One of the words which, we submit,
 21 pervades the whole of the attitude of either SMG,
 22 ShowSec or even British Transport Police is the word
 23 "passive".

24 Time and time again when you were hearing the
 25 evidence, sir, we submit that that was an element of the

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1 attitude by all parties at certain different stages of
 2 this process to their duties: passive and reactive. And
 3 perhaps it's indicative of that passive and reactive
 4 approach that they continue to try and pass the buck and
 5 finger-point at each other.

6 But they cannot have been unaware of the risks of
 7 the day. SMG were acutely aware of the European
 8 terrorist attacks that had preceded May 2017 and
 9 discussed them. At no stage did they structurally
 10 review their security operation as they had been advised
 11 to do by NaCTSO. It's sometimes, with all the evidence
 12 that we've heard, some complex evidence, and some
 13 evidence given astutely by experts or other leading
 14 figures in the field, to actually stand back and
 15 appreciate the crass misunderstanding of these
 16 individuals who were supposed to protect the public.

17 We perhaps can get lost at times, we submit, in the
 18 detail. When we hear from SMG and ShowSec, as we no
 19 doubt will, dealing with contemporary positions, well,
 20 things have changed, we've learned our lessons, it's all
 21 hindsight -- those, as it were, sprigs of garlic against
 22 having to take accountability. It is important, sir,
 23 for us to get back to the basics, in our submission.

24 What was happening in Europe? What was happening in
 25 the world at the time that Ariana Grande sang her first

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1 song on 22 May 2017? It is not necessarily something
 2 which required these individuals , who were supposed to
 3 protect young people, to grapple with in any great
 4 detail or in any great book or in any great report.
 5 Most people sitting in their front rooms watching the
 6 news would have told you, sir, at the time, "We live in
 7 dangerous times", and it is utterly incredulous and
 8 dismissive of those we represent, in our submission,
 9 that in some way the decision—making process by SMG,
 10 ShowSec and British Transport Police at the time in
 11 particular , in some way needed specialist advice in the
 12 world that they were living in at the time.

13 The only analysis of stewarding undertaken at the
 14 arena in the years before the attack was commissioned as
 15 an efficiency or cost—saving exercise, which again hits
 16 the tone that we have been attempting to assist you with
 17 over the last few months of penny—pinching. This is
 18 what these corporate institutions , in our respectful
 19 submission, were about: making a buck, penny—pinching.

20 This is what drove them and this is what, in our
 21 submission, led to a situation where young people were
 22 not protected at the arena.

23 A subsequent review of that exercise sought to fend
 24 off further proposed staff reductions by pointing out
 25 that many industry peers that had then increased their

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1 staff numbers in the light of the national security
 2 climate was a relevant matter to be considered, neither
 3 exercise resulted in any uplift to the protective
 4 security regime in place at the arena on 22 May.

5 SMG executives even attended these seminars, one for
 6 instance at the Accor hotel, to listen to presentations.
 7 One asks oneself rhetorically , what were they doing when
 8 they were there, what were they hearing? Were they
 9 listening to the importance at those seminars expressed
 10 of effective grey space security?

11 The presentation acknowledged the consequences of
 12 the increased security which they proposed would
 13 correspond with an increase in cost of about 20% above
 14 the regular. Was that one of the reasons why perhaps,
 15 when these corporations were attending these warning
 16 signal conferences that it was perhaps not necessary to
 17 their tastes to provide that protection to young people
 18 and members of the public who were attending at the
 19 arena?

20 As Miriam Stone said:
 21 "SMG was a commercial organisation which was
 22 resistant to spending more money than was needed. They
 23 also did not want to look like Fort Knox."

24 We are here to submit to you now, sir, Fort Knox SMG
 25 and the arena certainly were not.

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1 SMG executives who attended the Accor hotel
 2 presentation quickly dismissed applying its teachings to
 3 the arena. There's no minute or other record of any
 4 subsequent formal or informal discussion , and neither
 5 was the matter raised with SMG's landlords or
 6 co—tenants.

7 Approximately 6 months before the attack on the
 8 Ariana Grande concert, the McDonald's outlet in the
 9 City Room closed, materially altering the make—up and
 10 use of the City Room mezzanine, an area which remained
 11 part of one of the busiest entrances and exits to the
 12 arena bowl. In the months that preceded the attack,
 13 there had been no consideration or review by SMG or its
 14 agents as to how this change might impact the security
 15 challenges presented by the City Room, challenges that
 16 they all appear to be aware of that were complex.

17 CCTV, a protective security system, CCTV system, was
 18 in place across the arena site , with cameras covering
 19 internal and external locations. And as you know, sir,
 20 the system had a substantial and ultimately significant
 21 blind spot within the City Room along much of the
 22 mezzanine. It bears repetition : a blind spot that
 23 Salman Abedi certainly spotted. And if someone like
 24 Salman Abedi could spot it, a man that doesn't even have
 25 the intellect to open a toilet door without getting into

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1 trouble, one wonders what on earth SMG and ShowSec were
 2 doing when attending to that blind spot.

3 Why was it such a revelation? Despite this, the
 4 existence of the mezzanine blind spot was not recorded
 5 in any document or plan, and nor were any CCTV
 6 operatives or stewards trained that it existed. Few, if
 7 any, of the SMG executives, ShowSec senior officers or
 8 CCTV operatives themselves even knew of its existence.
 9 I emphasise again: a man who couldn't even open a toilet
 10 door did.

11 Of those who gave evidence, only Michael Edwards
 12 suggested he'd have been aware of the mezzanine blind
 13 spot before May 2017. Indeed some of the SMG executives
 14 seemed to learn of the existence of the blind spot only
 15 through this process.

16 Your expert, Colonel Latham, said that the mezzanine
 17 place was a significant position in the City Room as far
 18 as security was concerned. It was a significant hiding
 19 place, a CCTV blind spot. Given that there was a blind
 20 spot where the mezzanine was, or this particular part of
 21 the mezzanine, your expert, sir , said all the more
 22 reason that it needed to be checked on foot as there was
 23 no other way to check it.

24 So we have a proliferation of issues , again coming
 25 from and isolated by Colonel Latham. If there is

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1 a blind spot, there shouldn't be. If there is a blind
 2 spot, those responsible should know about it. And if
 3 they do know about it, they should put in other measures
 4 to check a very dangerous area. The fact was that was
 5 the area where a terrorist like Salman Abedi was most
 6 likely to hide. Indeed, again, this man, who certainly
 7 is not presented as being the greatest of intellects ,
 8 managed not only to know, for instance, that there was
 9 a blind spot, but also seems to know the precise
 10 position on the mezzanine to hide.

11 His reconnaissance work paid tragic and evil
 12 dividends for him. We ask again, rhetorically, on
 13 behalf of the families : if someone like him can work
 14 this out, why is it that those responsible for the
 15 protection of the families , those that died and indeed
 16 those that were going to collect them, why indeed did
 17 they not know this and take remedial steps? Because the
 18 things go together. If the blind spot had been known of
 19 and could not have been for whatever reason corrected,
 20 then it is more acute in our submission that your
 21 inquiry looks into the patrols on the mezzanine.

22 Sir, on 22 May 2017, as was typical, as egress
 23 approached, the one camera that could provide some
 24 limited coverage of the mezzanine was instead trained on
 25 the internal arena doors. It had been put in that

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1 position by those in the Sierra Control Room who had
 2 primary control at that time. The precise
 3 configuration, location and inherent difficulties in
 4 viewing of the monitor screens within that control room
 5 is well-known and you've had it addressed to you on
 6 a number of occasions.

7 As was their habit, none of those in Sierra Control
 8 on 22 May were in fact watching the footage proactively
 9 and nor were they looking at the footage for any purpose
 10 of detecting suspicious individuals . Instead, the focus
 11 of their limited attention on CCTV was crowd management,
 12 and they depended upon being alerted to other relevant
 13 incidences by messages to them by others.

14 On the contrary, those in Whiskey understood that
 15 during a show, the primary responsibility for monitoring
 16 the CCTV rested with Sierra and with it control of the
 17 moving cameras. A resting point was that no witness
 18 asserted that at any stage during the course of the
 19 concert had the camera with the view of the mezzanine
 20 steps been operated so to profile individuals or
 21 otherwise conduct protective security considerations of
 22 those within the City Room. It is, as it were, as far
 23 as the mezzanine is concerned, the perfect storm of
 24 incompetence when one traces it back from the blind spot
 25 to the activities in the control room.

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1 In any event, none of the staff who monitored the
 2 CCTV in either control room had received accredited
 3 external training on just how to find, detect or even
 4 notice individuals involved with hostile surveillance or
 5 suspicious behaviour that might indeed be identified
 6 through CCTV.

7 Despite repeated requests being made to senior
 8 executives of SMG, none had obtained the relevant SIA
 9 CCTV licence, which would have trained them in those
 10 very topics and, sir , let those who may submit, if they
 11 will , later this week that this is all hindsight or this
 12 is all practices of the day, let that be just one, and
 13 we'll come to many others, incident whereby on the day,
 14 on the day, repeated requests — I don't mean on the day
 15 of 22 May, but on the day, as it were, contemporaneously
 16 in 2017 — at the time, repeated requests being made to
 17 senior executives of SMG concerning SIA CCTV licences
 18 and nothing done.

19 We will not, if you'll excuse us from being so
 20 assertive , sit here on behalf of those we represent
 21 knowing full well what is coming from these individuals
 22 allow it to be asserted that it's all hindsight and it's
 23 all not judging by what was happening at the time. That
 24 is wrong and we submit that is misleading.

25 The camera operatives received on—the—job training

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1 from an internal trainer . The training received had
 2 focused simply on the locations of cameras and the
 3 functioning of the system itself and the trainer had
 4 last received external CCTV training in 2001 on a course
 5 that had covered only data protection issues that might
 6 arise in the monitoring of CCTV and not including any
 7 element of hostile reconnaissance or the identification
 8 of suspicious behaviour.

9 We read with great interest the submissions of
 10 ShowSec in particular when it was asserted that perhaps
 11 the appearance of Salman Abedi was only perhaps distinct
 12 by his headgear or by a rucksack that he was carrying.
 13 Unless of course these submissions change between now
 14 and whenever, that is what is being said.

15 We were surprised to hear those submissions,
 16 particularly in the light of what Colonel Latham has
 17 told you. Salman Abedi wasn't just a man wearing a cap
 18 with a rucksack. Colonel Latham gives you, sir, a list
 19 of identifying and concerning features that would have
 20 brought an individual like Salman Abedi, or should have
 21 brought an individual like Salman Abedi, to the
 22 attention of those properly trained to monitor either by
 23 camera or on the floor.

24 His headgear, yes. But not just that. That he was
 25 overdressed for the weather. You'll remember, sir,

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1 evidence that you received which indicated that the
 2 temperature was in the high 60s, and indeed other
 3 individuals reported Abedi as being overdressed for the
 4 weather. That Abedi was walking against the crowd.
 5 These are all issues that Colonel Latham has raised.
 6 That at times he was standing still and looking at the
 7 queue. That he didn't fit the demographic. That he was
 8 turning around and looking around. That he had two
 9 mobile telephones. That he looked nervous. And
 10 of course, yes, that he had a backpack.

11 But let's again, sir, if we may, just deal with
 12 that. As Colonel Latham tells you, not just a backpack,
 13 but one that was unusually large, heavy, and so heavy
 14 that it was affecting the gait of the terrorist, and
 15 despite all this it seems that you may hear submissions
 16 tomorrow, unless they're changed overnight, you may hear
 17 submissions tomorrow that the only worrying feature that
 18 Abedi presented at the time might have been some
 19 headgear and a backpack. When you, sir, and others hear
 20 that submission we submit it should be taken in the
 21 context of what we have just submitted to you.

22 And of course you'll hear the evidence, sir,
 23 repeated to you, no doubt, by those tasked with the
 24 safety of those we represent that: oh well, this is an
 25 area where a number of people may or may not at certain

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1 times carry backpacks. We again commend to you, sir,
 2 the evidence of Colonel Latham. He said this to you:

3 "Not many bags were seen in the City Room."
 4 And Colonel Latham graphically indicated to you,
 5 sir, that he played a game, if it can be call that in
 6 a crass way, of spot the bag, as he put it. He didn't
 7 see, said Colonel Latham, many. You'll remember, sir,
 8 that there was indeed an operation going on to prevent
 9 that anyway happening.

10 But Colonel Latham adds, if it be suggested to you,
 11 sir, at any stage during the course of the week that
 12 there was nothing extraordinary about someone being in
 13 that area with a bag, Colonel Latham adds that this bag
 14 was extraordinarily large and heavy.

15 The high point, it seems, of SMG's argument is that
 16 Salman Abedi looked suspicious on 22 May 2017 in that
 17 he was carrying a large rucksack and remained on the
 18 mezzanine floor for a period of time. Listen carefully
 19 tomorrow if that's what they're going to repeat and
 20 whether they also repeat the other catalogue of
 21 identifying features of a potential terrorist that were
 22 missed by SMG, ultimate responsibility, and by ShowSec,
 23 who were supposed to be doing their job.

24 SMG had all the advice, the knowledge, the
 25 experience and resources required to meet the threat

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1 which emerged on 22 May 2017. The problem was not the
 2 advice; the problem was failure to implement that
 3 advice. Apologies to Greater Manchester Police because
 4 those are their words, not mine. But we adopt that for
 5 the purposes of our arguments today. SMG had all the
 6 advice, the knowledge and experience and resources
 7 required to meet the threat; the problem was the failure
 8 to implement that advice.

9 We on behalf of the families we represent don't take
 10 sides. The concerns we have are quite simple: how it
 11 came that these people lost their lives and were put at
 12 risk. We simply put the competing arguments, which each
 13 and every time we look at them highlight the unseemly
 14 squabble between those who really should be protecting
 15 the public and accepting their accountability.

16 Again, on the issue of the mezzanine floor, which we
 17 could, and we won't, have gone into far more detail on
 18 but adopt the able submissions that have been made in
 19 advance of ours. As your expert again says, there were
 20 people on the mezzanine floor who also thought
 21 Salman Abedi was suspicious:

22 "If a uniform had gone up, it is likely that
 23 Salman Abedi would have been pointed out to them."

24 That again is Colonel Latham:
 25 "If a uniform had gone up, it is likely that

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1 Salman Abedi would have been pointed out to them."

2 There's really no getting round this, no getting
 3 round this that someone charged with the protective
 4 duties that they were charged with should have walked up
 5 those steps at the very least and done their job.

6 Patrols. SMG were contractually required on the
 7 position of doing their job to undertake regular foot
 8 patrols of the arena complex on a 24-hour basis, and
 9 ShowSec, as SMG's agents, had already been signatories
 10 to that agreement, establishing that obligation. These
 11 are the Deister patrols that you've heard much of and
 12 that, certainly as far as we are concerned on behalf of
 13 those we represent, has caused profound concern as to
 14 the way they were executed.

15 Those who undertook the patrols were trained to look
 16 out for people loitering or otherwise behaving
 17 suspiciously. Whilst it's recognised in evidence that
 18 such patrols ought to have augmented CCTV monitoring,
 19 and in particular taking into account the blind spots,
 20 the arena Deister patrol route had not been designed to
 21 do so. As it happened, the standard Deister patrol
 22 route did in fact include checking the City Room
 23 mezzanine and the very space behind the raised area
 24 where Salman Abedi secreted himself on 22 May.

25 How many opportunities, sir, we ask rhetorically,

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1 did the people charged with the protection of these
 2 young people and those waiting to see them and all of
 3 those attending the concert, and in particular those who
 4 tragically had their lives taken away from them -- how
 5 many more opportunities do SMG need, do ShowSec need, do
 6 British Transport Police need to do their jobs?

7 Whiskey Control staff were instructed to perform
 8 four Deister patrols per 12-hour shift and so eight in
 9 any 24-hour period. On 22 May 2017, the last Deister
 10 patrol took place at 12.12, only the third to have been
 11 conducted that day. From then, no other patrols with
 12 a counter-terrorism element were conducted in the
 13 City Room. We commend our analysis to you, sir, in our
 14 document beginning at paragraph 1.20 on, again, the
 15 complete dereliction of responsibility, which may -- may
 16 -- have detected, deterred Salman Abedi and, let me add
 17 my realistic submission to those that have already been
 18 made, it would have been my pleasure to have said that
 19 by detecting him, the bomb wouldn't have gone off, but
 20 maybe it would, and the point well made by others before
 21 me, which we emphasise now in our submissions, the point
 22 is: if this evil man was to detonate his bomb, it may
 23 have occurred not at the height of egress but on an
 24 occasion where tragically others may have been
 25 casualties, but fewer and less. Tragedies though they

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1 might be, but the level of this tragedy by people doing
 2 their jobs could have been curtailed.

3 In 2017, the Deister patrols were habitually not
 4 performed during the currency of an event. Indeed, SMG
 5 executives have stated that it was their expectation
 6 that ShowSec would discharge that responsibility on
 7 their behalf during the hours of an arena event, at
 8 least as much as within the City Room. On the other
 9 hand, ShowSec witnesses and representatives stated
 10 expressly and repeatedly that they did not accept that
 11 they'd been asked to discharge a contractual
 12 responsibility for Deister patrols.

13 Stepping away from that particular dispute, the
 14 simple position is that the contractually required
 15 site-wide counter-terrorism patrols were never performed
 16 during the hours of an event when the need was greatest.
 17 An absolute scandal. How it can be that two such close
 18 commercial partners, so intimate, we are told, together
 19 can have such a failure of communication has never been
 20 adequately explained. Your expert, Colonel Latham, says
 21 this:

22 "There's no logic to there being fewer patrols on an
 23 event day than on a dark day. It would amount to
 24 reducing security when you are busier."

25 It would amount to reducing security when you are

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1 busier.

2 Utterly illogical and that's the nicest thing, we
 3 submit, about it. The patrols ShowSec performed during
 4 the currency of an event, we know, pre-egress checks,
 5 and at times during the evidence it appears to be
 6 a matter of contention between SMG and ShowSec as to
 7 whether such checks should have a counter-terrorism
 8 element and whether it has been agreed that they would
 9 include a check on the City Room mezzanine. I hesitate
 10 for a moment to clumsily pray in aid the reasonable
 11 bystander test or the outdated man, person, on the
 12 Clapham omnibus, but that there should even be a debate
 13 between SMG and ShowSec about whether these patrols
 14 should contain a counter-terror element to them is
 15 astounding. It's astounding generally and it's
 16 astounding that in the context of what was going on in
 17 2017, and we remind your hearing, sir, that there had
 18 been most recently about four atrocities already around
 19 this period, terrorist atrocities. It is astounding
 20 that whether or not these patrols should have incurred
 21 a counter-terrorism element before 2017, why is it even
 22 a subject of discussion that it shouldn't then?

23 These are important matters, in our respectful
 24 submission, sir, that your inquiry should resolve. From
 25 the families' perspective, however, the truly important

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1 facts are not contentious. The pre-egress checks
 2 undertaken on 22 May 2017 did not have
 3 a counter-terrorism element to them and the mezzanine
 4 area was not checked at all, whether for suspicious
 5 behaviour or otherwise.

6 The person charged with undertaking the pre-egress
 7 checks was Jordan Beak, and Jordan Beak undertook those
 8 pre-egress checks at 20.00 hours and 22.09 hours. On
 9 neither occasion did he go to approach the mezzanine.
 10 His route across the City Room took him close to the
 11 wall on the opposite side on both occasions. Those
 12 times, sir, in our submission, as far as Mr Beak's
 13 patrols are concerned, are important. We emphasise them
 14 again. He undertook his pre-egress checks at
 15 20.00 hours and 22.09 hours. Back to your expert, if
 16 I may, Colonel Latham. He said this:

17 "The opportunities to disrupt Abedi on 22 May are
 18 those 20 minutes when he's in the City Room between
 19 20.51 hours and 21.10 hours, and during that hour when
 20 he's within the City Room, between about 21.30 and
 21 22.30, with the disruption either by the means of him
 22 being spotted by the CCTV or of being spotted by someone
 23 on the ground, either by ShowSec or British Transport
 24 Police."

25 So those times that Beak is undertaking pre-egress

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1 checks but not on the mezzanine are the times your
 2 expert says were critical to the detection of this
 3 terrorist .
 4 Mr Beak refused to accept during the course of his
 5 evidence that what he had done on 22 May was in breach
 6 of the requirements of the document that we refer to in
 7 our submission:
 8 "Entire City Room area, including McDonald's and
 9 JD Williams entrance."
 10 Mr Beak steadfastly refused that what he did was in
 11 breach of any description within the documents that he'd
 12 been referred to. He asserted that the mezzanine was
 13 outside his jurisdiction , that was his word, and that
 14 he'd been trained by ShowSec to do just as he had done
 15 for the pre-egress check. From his perspective, his
 16 only responsibility towards the mezzanine area was
 17 limited to the two short staircases and then his
 18 function extended only to asking those sitting to move.
 19 He maintained that he'd been able to fulfil his function
 20 on the opposite side of the room.
 21 When shown footage of himself going up to the
 22 mezzanine on that occasion, Mr Beak reiterated his
 23 understanding that it was not his responsibility to
 24 check the area for suspicious persons.
 25 It is of note to those we represent both that

1 Mr Beak's view of his pre-egress and mezzanine
 2 responsibilities seemed to be in accordance with the
 3 working practices of other long-standing and senior
 4 ShowSec colleagues, although seeming in flat
 5 contradiction, we submit, with the documentation setting
 6 out the scope of counter-terrorism mitigations ShowSec
 7 had agreed to provide in the area.
 8 This is an important observation we make, we submit,
 9 sir, in terms of the passing the buck attitude of
 10 ShowSec and SMG and particularly when it comes to
 11 picking on individuals. Of course we have our
 12 criticisms when it comes to Mr Lawler and Mr Agha and
 13 other individuals, but it does not get ShowSec and SMG
 14 out of the woods, if we may put it that way, by
 15 suggesting that Mr Beak's approach is in some way
 16 bespoke to him. We emphasise that what he was doing on
 17 the night is very similar to the working practices of
 18 other long-standing and senior ShowSec colleagues.
 19 We make our submissions in some depth within our
 20 document and we commend them to you. In short, the
 21 threat level at the time, as we've emphasised, was
 22 severe. The City Room during egress is going to contain
 23 many people, as your expert obviously concluded, and is
 24 attractive to the terrorist. The mezzanine is where
 25 a terrorist may hide. It is therefore somewhere which

1 should be visited on a pre-egress check. Detonation may
 2 not have been prevented, but as your expert,
 3 Colonel Latham, said, the loss of lives would have been
 4 reduced.
 5 We have addressed you in some depth on profiling,
 6 I won't repeat those, but all that should mesh with our
 7 submissions on the mezzanine. Should individuals have
 8 received training as to profiling? The detection and
 9 recognition of Salman Abedi would have been quicker and
 10 more efficient.
 11 The failure of pre-egress checks, yes, sometimes and
 12 to some degree can be put down to individual
 13 responsibility, but that is no way out. Because as
 14 you have been told by Colonel Latham, the failure of
 15 pre-egress checks is a lack of leadership and
 16 management.
 17 So lest again there be finger pointing in the next
 18 few days ahead, we urge you, sir, to remember the
 19 evidence of Colonel Latham. The failure of the
 20 pre-egress check, he tells you, was down to a lack of
 21 leadership and a lack of management. He says SMG have
 22 a responsibility to ensure sufficient management and
 23 supervision. Finger-pointing will not get them out of
 24 that one.
 25 We do not subscribe to the corporate scapegoating of

1 any individual and although we have criticisms, and
 2 others have echoed them and we won't repeat them, of the
 3 conduct and behaviour of Mr Lawler and Mr Agha, we keep
 4 a lot of our focus on the corporate enterprise. We
 5 agree that the conduct and behaviour and fulfilment of
 6 duties by Lawler and Agha were at times substandard.
 7 But equally, we agree with Colonel Latham when he urges
 8 you to conclude that it's all well and good to focus on
 9 the failures of individuals, but it would not be fair
 10 because they lacked direction and supervision.
 11 So again, we agree with your expert on this. Whilst
 12 it is right to apportion what accountability you feel is
 13 appropriate to individuals, be it Lawler, Agha or
 14 others, we echo again Colonel Latham when he says they
 15 lacked direction and they lacked supervision.
 16 You've been addressed on, for instance, Mr Agha
 17 receiving no briefing or explanation for his role on
 18 22 May. He didn't even know the location of the station
 19 to which he had been appointed. He was told the
 20 location was like any other event.
 21 The particular purpose, for instance, of the grey
 22 door position was not safety but revenue protection, we
 23 submit, and you'll remember the tranche of questions
 24 that I and others put to witnesses concerning the grey
 25 door imperatives.

1 The twin failures to provide Mr Agha with either
 2 a clear briefing of his role or written notes of
 3 instructions were each breaches, we submit, sir, of the
 4 arena licence. And whilst submissions can be made about
 5 individuals, sometimes young individuals with little
 6 training and experience, let alone of life or otherwise
 7 and where some of it may land and be appropriate, it
 8 will not in our submission and should not shift the
 9 blame from those who were ultimately responsible:
 10 leading corporations, SMG, ShowSec, who should take
 11 responsibility and not finger-point.

12 Kyle Lawler was deployed to other duties away from
 13 the bridge for more than an hour between 21.04 hours and
 14 22.23 hours. On his return journey to the City Room,
 15 he was intercepted by Mr Agha and had Christopher Wild's
 16 information relayed to him. This redeployment meant
 17 that Mr Lawler was in no position either to see Abedi
 18 leave the City Room at 21.10, nor his return for the
 19 final time at 21.36, on each occasion burdened with that
 20 heavy rucksack that we've described on previous
 21 occasions and we again repeat the description that
 22 existed at the time over and above a hat and a heavy
 23 rucksack.

24 Despite observing Abedi's appearance and behaviour,
 25 at no stage did Mr Agha seek to approach him or engage

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1 him in conversation and nor did he relay his observation
 2 to any colleague. And sir, you've been addressed on the
 3 level of training and the approach to training, not only
 4 of those corporate organisations but also of the
 5 individuals.

6 What you will be, in our submission, in no doubt
 7 about is that by the end of the evidence there's no
 8 dispute that Mr Wild had communicated to Mr Agha that he
 9 considered Abedi to be suspicious. Abedi had placed
 10 himself out of eyesight and was in possession of his
 11 large rucksack and he was being evasive and giving
 12 unsatisfactory answers when challenged by Mr Wild,
 13 something that chimed with what Agha described as his
 14 lingering impression of Abedi.

15 Agha asserted that he had reassured Mr Wild and told
 16 him that his concerns would be acted upon expeditiously.
 17 Mr Wild was also to say that had there been a police
 18 officer in the City Room at the time, he would have
 19 reported the matter to that officer.

20 Sir, the issue of training is important. ShowSec,
 21 rather than SMG, trained the stewards who worked at the
 22 arena, and in many respects that is their responsibility
 23 so far as that training is concerned, always
 24 remembering, as we do, that overall the contractual
 25 duties were with SMG. Those stewards were employed on

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1 zero hours at minimum wage and were expected to
 2 undertake the training online for commercial reasons in
 3 their own time, at their own expense and using whatever
 4 devices were available to them.

5 The independent experts considered that the
 6 counter-terrorism and identifying suspect behaviour
 7 training provided was inadequate. The gaps in the
 8 content of that training was too text based, say the
 9 experts, for young and inexperienced staff with poor
 10 educational attainment and some had been lifted verbatim
 11 from Wikipedia.

12 Most fundamentally, there was no checking of those
 13 who had undertaken the training, no monitoring, and
 14 you'll remember the evidence of how speedily some
 15 individuals went through their training.

16 On the back of that, ShowSec say, and will say, that
 17 their people were well-trained, an experienced workforce
 18 provided to SMG — this is what they say in their
 19 document — and in fact, a telling expression from
 20 ShowSec, they provided SMG with more than was being paid
 21 for. An interesting observation. Not sure where that
 22 lies, save it shows a mindset, we submit, in the way
 23 ShowSec express themselves in their written document.
 24 They say that their staff are well-trained and
 25 experienced, provided to SMG. In fact they were more

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1 than was being paid for.

2 One wonders, sir, looking at that written submission
 3 from ShowSec, what perhaps they had paid for. What
 4 perhaps deficient service, by noting ShowSec's
 5 observation there, might have even been provided if
 6 ShowSec had not provided a quality above that which was
 7 being paid for.

8 We indicated at the start of our submissions that
 9 the families find it, at the very least, distasteful
 10 that the passing of the buck, the pointing of the finger
 11 continues. And we ask you, sir, at the end of these
 12 submissions, as far as the protective element of the
 13 arena and the City Room is concerned, to look beyond
 14 that. Look beyond the suggestions being made by these
 15 parties that they are not responsible for things they
 16 clearly are responsible for.

17 Sir, that applies not only to ShowSec but, as
 18 we have indicated before, to British Transport Police.
 19 Of course it's said that it was for SMG, ShowSec say, to
 20 assess the risk of those attending at the venue and
 21 ShowSec accepted the inadequacy of that risk assessment.
 22 But ShowSec should not leave it there. They will submit
 23 tomorrow that there was little guidance in 2017 to
 24 a company like ShowSec as to how to complete
 25 counter-terrorism risk assessments.

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1 Sir, again, in our submission, that matters little .
 2 One of these organisations, if not both, are responsible
 3 for the protection of the public and the arguments
 4 between the two bodies are encapsulated, we submit, on
 5 the mezzanine issue.
 6 Policing. Again, touched upon by counsel who
 7 addressed you only recently and, of course, British
 8 Transport Police having primacy for those duties.
 9 Whilst it was suggested by British Transport Police in
 10 evidence that the 2017 changes in the design of the
 11 Victoria Station and the City Room overbridge somehow
 12 diminished the relevance of a previous 2014 plan, no
 13 evidence has been provided by them that there's ever
 14 been a review or re-evaluation of the context of that
 15 protective plan. The reasoning relied upon jars with
 16 that document.
 17 Had the current tactical plan been followed on
 18 22 May 2017, at least one sergeant, four constables and
 19 two PCSOs would have been deployed to police the
 20 Ariana Grande concert, with consideration being given to
 21 the deployment of additional resources, including
 22 explosive detection dogs. The resources that were, as
 23 you've heard, sir, in fact allocated were no sergeant,
 24 only two constables, and two PCSOs, with the addition of
 25 a PCSO in training.

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1 In the event, the senior constable allocated did not
 2 attend the arena until after egress and after the
 3 explosion as he had been caught up in other duties. The
 4 officers allocated to police the concert had been
 5 instructed by their sergeant. They were instructed to
 6 stagger their rest breaks and to take them between
 7 19.30 hours and 21.00 hours, being present for both
 8 egress and ingress, and at those times to patrol four
 9 separate locations, expressly including the City Room.
 10 What you've heard from others submitting to you on
 11 British Transport Police and what we present to you in
 12 summary form now again, we submit, is a dereliction of
 13 the duties that British Transport Police held or should
 14 have held towards those they were there to protect.
 15 Let me pause a moment before I reflect on the
 16 submissions which we submit, made on behalf of British
 17 Transport Police and in writing, which we find -- and
 18 there's no other word to use -- distasteful, and I'm
 19 going to read them to you. I'm going to indicate that
 20 the matters that counsel for British Transport Police
 21 urge upon you within these paragraphs, 80 to 81, should
 22 be completely expunged from your mind.
 23 In two paragraphs, which are some of the most
 24 condescending paragraphs that I've read for some time
 25 in relation to those we represent, British Transport

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1 Police say this:
 2 "The inquiry has deliberately indulged a certain
 3 amount of speculation, partly in an effort to encourage
 4 free expression of ideas and feelings, perhaps through
 5 therapeutic reasons..."
 6 How condescending:
 7 "... but that indulgence [says Mr Gibbs] was always
 8 contingent on the need at this stage in the process to
 9 return to a more judicial stand and analysis..."
 10 Says Mr Gibbs on behalf of his clients:
 11 "... requiring courtroom wisdom and judicial skill."
 12 He goes on:
 13 "It is natural to want to follow one's imagination
 14 out of the tangible misery of what actually happened
 15 into a sunnier, hypothetical scenery with less ghastly
 16 consequences. It is a comfort to be able to imagine the
 17 lesser of two evils and the brain longs to believe that
 18 the lesser might have been possible. It therefore
 19 requires great strength of mind and cold logic to resist
 20 a siren of 'if only'."
 21 It gives me no pleasure to make this submission that
 22 we submit on behalf of those we represent, those two
 23 paragraphs are completely and utterly inappropriate as
 24 far as those we represent. Let me make it very clear
 25 indeed: your indulgence in allowing questions to be

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1 asked by all counsel in this matter is nothing to do
 2 with therapeutic reasons, as my learned friend Mr Gibbs
 3 on behalf of British Transport Police seems to think,
 4 and one assumes his clients think, it is to do with
 5 getting to the root of the matter and finding the truth
 6 and allotting accountability where it is appropriate.
 7 As for "following one's imagination out of the
 8 tangible misery of what actually happened into a sunnier
 9 hypothetical scenery with less ghastly consequences", if
 10 it's being suggested that those who we represent, the
 11 bereaved, who lost loved ones during this process, are
 12 in some way trying to delude themselves into an approach
 13 which doesn't hold forensic substance, then we strongly
 14 condemn that approach and we would ask in due course
 15 whether the terminology at paragraphs 80 to 81, when
 16 Mr Gibbs does address you, is completely and utterly
 17 withdrawn.
 18 It is condescending and it is inappropriate. You do
 19 not allow questions for therapeutic reasons. Those we
 20 represent represent an intelligent -- a cohort of
 21 integrity and dignity who understand this process and
 22 have demonstrated that they understand this process and
 23 they understand what questions can be asked and they
 24 understand what questions can't be asked and at times
 25 have had to take painful positions, understanding the

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1 questions they would like to be asked cannot be asked.
 2 They find, and we find, the approach of British
 3 Transport Police here to them within those paragraphs
 4 condescending and unnecessary. But perhaps it does
 5 belie an attitude of condescension that still pertains
 6 here that how dare we perhaps criticise, as other
 7 counsel have, the behaviour and the guidance and the
 8 instructions given to British Transport Police as if
 9 we are in some way going off on a frolic of our own.

10 We submit to you, sir, that the evidence you have
 11 heard and which I am not going to repeat or exacerbate
 12 your patience about, late is the hour and others have
 13 dealt with it, but we submit there is a wealth of
 14 evidence before you about the inept behaviour of British
 15 Transport Police, either individually or indeed
 16 corporately.

17 You have been addressed, for instance, on issues
 18 relating to members of British Transport Police going to
 19 get their kebabs and disappearing for inordinate amounts
 20 of time in totally unacceptable ways and for totally
 21 unacceptable periods of time. We deal with it at
 22 page 32 of our submissions and I won't repeat them here.

23 But in those submissions, around page 31 and 32 and
 24 onwards leading into 33, you will see that we have
 25 highlighted, sir, the consequences of those derelictions

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1 of duty. And they were derelictions of duty. And
 2 whilst we recognise the heroics performed by at least
 3 one of those individuals after the detonation, and after
 4 the explosion, that does not take away in our submission
 5 accountability for what happened before it.

6 You have heard, sir, submissions about the
 7 possibility of Salman Abedi being detected or indeed
 8 being deterred from what he did. And from the way
 9 British Transport Police behaved on that night at that
 10 time, including the non-attendance of Corke, a man who
 11 probably would have walked upon the mezzanine floor and
 12 who probably would have spotted Salman Abedi, it is
 13 a significant lapse and dereliction of duty, in our
 14 submission, that British Transport Police cannot answer
 15 by suggesting that in some way the families are
 16 performing their duties in relation to therapeutic
 17 courses rather than what we are doing here: trying to
 18 get to the truth and trying to hold those accountable
 19 accountable. We do not take kindly to being patronised.
 20 Forget whether I do, the families don't. I'll move on.

21 I mentioned very briefly, and I'll --
 22 MR GREANEY: Sir, I can see that you're attempting to talk.
 23 Your microphone is on mute. The chairman was, I could
 24 see, attempting to address you, but his microphone is on
 25 mute.

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1 SIR JOHN SAUNDERS: It doesn't indicate it's on mute.

2 MR GREANEY: You've come off mute, sir.

3 SIR JOHN SAUNDERS: Mr Cooper, if I can see you again.

4 We've been listening to submissions now since 10 o'clock
 5 in the morning. They are detailed submissions, they're
 6 obviously matters I need to take very much into account.
 7 I think I want to call an end to it today. Can I just
 8 say this, and please don't take it the wrong way. If
 9 you had been addressing the United States Supreme Court,
 10 they would now have pulled the plug on you and would not
 11 allow you to say another word because I think you've
 12 probably reached your 1 hour and 15 minutes.

13 MR COOPER: Have I? I'll have to address that.

14 SIR JOHN SAUNDERS: I will allow you to go on tomorrow
 15 morning, but I have read every word you said in your
 16 written submissions and therefore if you could bear that
 17 in mind, otherwise we're going to get very behind on the
 18 timetable.

19 MR COOPER: I'm sorry, sir, I shall be brief. I lost my
 20 timetabling because when I started, my clock was out of
 21 sync because I started later than I thought. Forgive
 22 me.

23 SIR JOHN SAUNDERS: Anyway, for now I think it's a good idea
 24 for us to actually stop and we will continue with the
 25 rest of your submissions at 10.00 tomorrow morning, and

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1 it gives you time to relook at what you've got to say
 2 still, bearing in mind that, as I have said, I have read
 3 everything you have written.

4 MR COOPER: I hear what you say, sir, and I'll focus.

5 SIR JOHN SAUNDERS: I'm not saying what you have said isn't
 6 focused so far, but I want to try and keep within the
 7 time limit.

8 Mr Greaney, did you want to say anything else?

9 MR GREANEY: No, sir, I didn't want to say anything else.

10 We'll restart at 10 o'clock tomorrow morning, subject to
 11 your views.

12 SIR JOHN SAUNDERS: Yes. 10 o'clock. Thank you very much.
 13 (4.50 pm)

14 (The inquiry adjourned until 10.00 am
 15 on Tuesday, 26 January 2021)

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1 I N D E X

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3 Closing submissions on CHAPTER 72

4 Submissions by MR ATKINSON2

5 Submissions by MR WEATHERBY60

6 Submissions by MR WELCH108

7 Submissions by MR COOPER151

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