

OPUS2

Manchester Arena Inquiry

Day 57

January 27, 2021

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Wednesday, 27 January 2021

(10.00 am)

SIR JOHN SAUNDERS: Mr Greaney, good morning.
MR GREANEY: Good morning, sir. First this morning, we will hear from Mr Horwell on behalf of Greater Manchester Police.

SIR JOHN SAUNDERS: Thank you. Mr Horwell.
Closing submissions on CHAPTER 7 (continued)
Submissions by MR HORWELL

MR HORWELL: Good morning, sir.
SIR JOHN SAUNDERS: Thank you for the speaking note.
MR HORWELL: Not at all, sir, I'm glad to help.
Our closing submissions are set out in a 43--page document replete with 203 footnotes. I have no intention of diluting those submissions by summarising or repeating some of them today. They stand as our response to the relevant evidence in chapter 7. It is for that reason that these oral submissions will be short and, I hope, a good deal shorter than the time allocated.
This morning, my purpose is first to respond to some of the points raised by other core participants and, second, as this chapter is at its end, to make some general comments with a view to assisting this inquiry in its task to consider recommendations and improvements

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for the future.
Blame or criticism is commonplace in a public inquiry. Sometimes it is justified, but it can also be directed by a core participant at other organisations or individuals in order to mask its own inadequacies or deficiencies. Mr Upham has been criticised, and that is the correct word, for causing SMG to have a false sense of confidence in its protective security measures, for not advising SMG to extend the perimeter, and for not giving SMG documents.

In short, SMG claims it was misled and poorly advised. We do not accept that the evidence supports those contentions and we suggest that SMG simply did not devote enough time and the attention required to ensure that its protective security measures were properly and effectively applied.

Mr Upham was a police employee and had been trained by NaCTSO. But any suggestion that SMG as an organisation was vulnerable or inadequate or unable to understand its responsibilities and how to discharge them does not survive scrutiny.

On one side, Mr Upham, a single person who of course represented a large organisation, a trained and competent CTSA who delivered a free and limited service. It is worth noting what he did not have. First and

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foremost, time. Like every other CTSA, he did not have the time to spend days or weeks at this or any other site. The time he could devote to the arena was very limited and perhaps best exemplified by the fact that he was required to make just two formal visits each year, each visit lasted about 2 hours only, and we contend that the limited amount of time he had would have been obvious to SMG.

Of course his involvement was greater than that, but those meetings were fundamental to his relationship with the site and they were held to discuss the action plan, a document which Mr Upham brought with him on each occasion. Those discussions were directed at the progress, if any, which SMG had made since the last visit.

Second, he did not always receive accurate reporting. At each visit Mr Upham was reliant on what he was told. Any misunderstandings by SMG as to what was in fact happening at the arena became his misunderstandings, and the evidence has shown quite clearly that there were misunderstandings: misunderstandings between the different iterations of SMG as to their respective responsibilities and misunderstandings between SMG and ShowSec as to the precise service the latter was providing. None of this

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was Mr Upham's fault. He was not told the full facts because SMG did not know them.

Third, Mr Upham did not conduct an audit or an inspection of the protective security measures in operation and neither was he required to. His role was clear and could not have been misinterpreted. As someone who never witnessed the manner in which security was delivered, he was never in a position to give any assurance about its quality.

On the other side, however, was SMG, a global conglomerate, the size, history and experience of which we have set out in our written submissions. At every one of its arenas throughout the world, no doubt, it was responsible for the safety of its customers. Searching, patrolling, stewarding and checking were intrinsic to its core business. A company cannot be in the business of live mass entertainment without keeping the masses safe.

As such, SMG had a responsibility to ensure that those it put in charge of safety and security had an adequate knowledge of basic guidance and procedures, together with the time and appetite to expand that knowledge. Safety was not secondary to its business, it was central, and if employees did not have the necessary time or training, that was not their fault.

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1 SMG was entitled to have confidence in the arena
 2 itself . It had been well designed and constructed to
 3 protect those inside . The protective security measures
 4 were such that Salman Abedi would never have been able
 5 to enter the arena with his rucksack, but as to the
 6 surrounding areas, the City Room and of course
 7 elsewhere, security was only as good as the proficiency
 8 with which it was delivered and the degree to which
 9 plans and procedures were followed. None of that had
 10 anything to do with Mr Upham and nor should it have
 11 done.
 12 On the evidence you have heard, Mr Upham did discuss
 13 the City Room with SMG and had been told that SMG had
 14 queueing rights only . That can only have meant that it
 15 had no other rights or control over any other persons or
 16 businesses in that area . It is likely , therefore, that
 17 the concerns and limitations of the City Room had
 18 featured in their meetings. There is no reasonable
 19 basis, in our submission, for finding that Mr Upham
 20 should have taken this further . It was not for him to
 21 unravel the legal niceties or to embark upon a quest
 22 which, on the evidence, was bound to fail.
 23 SMG had considered extending the perimeter and had
 24 rejected the idea and, in any event, the security
 25 measures were in fact adequate and were sufficient to

1 have either deterred or mitigated this attack if only
 2 they had been implemented.
 3 As for the suggestion that it was Mr Upham's
 4 responsibility to tell SMG that they should employ an
 5 in-house security expert, we make four points.
 6 First , the need for such expertise may seem obvious
 7 now, but that is after 3 months of detailed and
 8 wide-ranging evidence. The inquiry has much more
 9 information than Mr Upham had. As I have said, the
 10 measures which were purportedly in place, sufficient
 11 CCTV coverage, patrols conducted by CT trained and
 12 briefed stewards, wall-to-wall pre-egress checks and so
 13 on, were adequate.
 14 Second, even if Mr Upham had told SMG they should
 15 employ a CT expert, the response, we submit, would
 16 likely have been that such a post was unnecessary as SMG
 17 employed ShowSec, an organisation with extensive CT
 18 experience and whose role included a CT element. This
 19 was the understanding of Ms Stone and Mr Allen at the
 20 time.
 21 Third, one must not lose sight of the context of the
 22 CTSA system as it operated in 2017. Proposing to a site
 23 that it should employ a CT expert was not an aspect of
 24 the PSIA process and there was no NaCTSO guidance on the
 25 matter. Indeed, for most sites, including charities

1 like the National Football Museum, employing such
 2 a person would not have been a financial possibility .
 3 If this is a flaw in the CTSA regime then it is not the
 4 fault of the CTSA working within that system.
 5 Fourth and finally on this point, any criticism of
 6 Mr Upham or the wider system in this regard ignores the
 7 responsibility of SMG. First and foremost it was for
 8 SMG to identify what expertise it needed in order to
 9 keep its concertgoers safe. Dr BaMaung noted that if
 10 Ms Stone and Mr Allen realised that they lacked
 11 expertise and felt that CT security measures were
 12 important then, to use his words, there was an onus on
 13 them to get that expertise.
 14 Responsibility is a straightforward concept, but the
 15 following examples demonstrate a tendency by SMG either
 16 to blame others for its inadequacies or to distance
 17 itself from taking an active role in matters concerning
 18 security . Even as late as yesterday, SMG has continued
 19 to criticise Mr Upham for not only failing to inform it
 20 of the existence of PAS127 but also for not sending it
 21 the PAS127 guide.
 22 PAS127 is the Government's guide to good practice
 23 for checkpoint security screening of people and their
 24 belongings at buildings and large events and is intended
 25 for those concerned in the delivery of security systems

1 and procedures for checkpoint security, and that
 2 includes manual searches.
 3 If we just pause there for a moment, SMG,
 4 responsible for the searching of every bag and some of
 5 its visitors on every event day at its multiple sites
 6 in the country, did not know about the Government's
 7 guidance for good searching practice. That might be
 8 thought surprising. SMG then criticises Mr Upham for
 9 not sending it the guide, a guide which Colonel Latham
 10 thought cost £250, and which an internet search has
 11 revealed costs, at least now, £90.
 12 There is not a police force in the country which
 13 would give such a guide to anyone, let alone a company
 14 the size of SMG. Responsibility implies being aware of
 15 such guidance and paying for it. In any event, PAS127
 16 appears twice on two drop-down boxes in the PSIA scoring
 17 tool, and for that reason alone it is more likely than
 18 not that the existence of this guide would have been the
 19 subject of discussion between the CTSA and SMG.
 20 Mr Upham is adamant that he took Ms Stone and
 21 Mr Sinnott through each section of the PSIA scoring tool
 22 on his first visit to the arena on 29 August 2014.
 23 A similar comment applies to another document, the
 24 NaCTSO publication, "Terrorism Protective Security
 25 Advice for Stadia and Arenas". This is a publicly

1 accessible guide of which surely an arena manager and
 2 specialist should have been aware, with or without
 3 Mr Upham. It was the practice of Mr Upham's predecessor
 4 to give a document with an identical title to each site
 5 and the NaCTSO process again introduced SMG to it a year
 6 before the attack.

7 Miriam Stone read that document and would have been
 8 aware of the content and the wholly unremarkable
 9 statement in it that stadia have the responsibility of
 10 seeking out advice and acting upon it. That is no more
 11 than a reflection of the duty of care which such
 12 organisations have to ensure the reasonable safety of
 13 everyone who visits their venues.

14 Then finally on this point, it has been suggested
 15 that SMG was passive and not active when it came to some
 16 aspects of security. Three examples immediately come to
 17 mind. First, the interminable saga of the distinction,
 18 if any, between a bag search and a bag check. This
 19 dispute could so easily have been resolved by contacting
 20 the SIA. SMG did not so.

21 Second, the monthly Bridge calls, a worthwhile and
 22 informative connection to other businesses to discuss
 23 their CT planning and practices and CT generally. SMG
 24 did not take part in a single call.

25 Third, the Business Sentinel newsletters,

1 a well-researched and helpful summary of current
 2 terrorist attacks and methodologies and how to deter
 3 them. They should have been more widely distributed
 4 at the arena but were not. The reason given was that it
 5 was thought that access was limited. The simple
 6 solution would have been to ask Mr Upham, but no request
 7 was made. Horses and water again and again come to
 8 mind.

9 As for what Mr Upham did and said, you have his
 10 evidence from his three witness statements, evidence
 11 from a man who has been commended in large measure by
 12 the experts and described by CTPHQ as being plainly
 13 a dedicated and hard-working police professional. You
 14 also have the evidence of Mr Scally. This is important
 15 because it provides an example of how a smaller
 16 organisation, a charity, responded with such enthusiasm
 17 to Mr Upham, who Mr Scally described as a helpful,
 18 though cautious, adviser. Why should his approach to
 19 SMG have been so different? I shall return to Mr Scally
 20 in a moment.

21 I now deal with some specific points raised by
 22 Mr O'Connor in his oral submissions yesterday. First,
 23 Mr O'Connor said that Mr Upham's advice went well beyond
 24 that which should have been given by a CTSA. This is
 25 a submission too far. You have heard no evidence that

1 Mr Upham went well beyond the advice which was proper in
 2 the circumstances. At most, you have the evidence from
 3 Miriam Stone that Mr Upham said that he was happy with
 4 the security arrangements. That is slightly
 5 contradicted by the evidence of Mr Upham, who states:

6 "I am confident I never advised the arena that SMG
 7 were doing all that it was being advised to do or that
 8 I was happy with the security procedures in place at the
 9 arena on both event days and dark days."

10 He was patently not happy with the security
 11 arrangements because there were outstanding actions on
 12 the PSIA action plan.

13 Importantly, Miriam Stone's characterisation of
 14 Mr Upham's approach is also at odds with the evidence of
 15 Mr Scally, one of those rare witnesses who has no
 16 interest in the proceedings and no axe to grind. As
 17 just stated, Mr Scally described to you the circumspect
 18 and caveated way in which Mr Upham gave advice.
 19 Mr O'Connor invites you to consider reasons why Mr Upham
 20 may have adopted a different approach to Mr Scally than
 21 he did to the arena, including the fact that Mr Upham
 22 had engaged with Mr Scally 7 months after he had done so
 23 with the arena.

24 There is nothing in these supposed differences and
 25 no reason to think that Mr Upham would have taken

1 a different approach with the arena than he did with the
 2 Football Museum. Yes, it is a sample of one, but
 3 a sample which is random, unbiased, and we would suggest
 4 worthy of consideration.

5 Second, Mr O'Connor conceded that there was some
 6 force in the point that Mr Upham was given incorrect
 7 information by SMG. We are grateful for that concession
 8 but note the understated way in which it was made.
 9 There is actually a great deal of force in the point.

10 A CTSA is wholly reliant on the information provided
 11 to him or her by a site. Where a site is itself
 12 ignorant of security problems, it will pass that
 13 ignorance on to the CTSA. Mr O'Connor reminded you of
 14 Miriam Stone's evidence and how she had discussed
 15 patrols and pre-egress checks in the City Room with
 16 Mr Upham before the attack.

17 In respect of these crucial aspects of security
 18 it is clear that Miriam Stone would have given Mr Upham
 19 incorrect information. She was under the impression
 20 that wall-to-wall checks of the City Room were being
 21 undertaken by ShowSec prior to egress, exactly the type
 22 of pre-egress check which would have discovered Abedi
 23 hiding in the blind spot.

24 It is also difficult to understand SMG's approach.
 25 On the one hand, it has failed to meet one of our

1 principal points, which is that Mr Upham could never
 2 have provided any form of assurance for security
 3 measures which he had never seen delivered. But then it
 4 suggests it was entitled to take confidence from
 5 whatever Mr Upham said about security in the City Room
 6 when it also accepts that Mr Upham had been provided
 7 with incorrect information.
 8 Third, Mr O'Connor said that the CCTV in the
 9 City Room was not taken into account by Mr Upham as part
 10 of the PSIA process, so whether he was told about the
 11 blind spot is neither here nor there. That is not
 12 correct. While it is right that the PSIA focuses on the
 13 site itself, scores can also be awarded for measures
 14 outside the venue which protect the crowd inside.
 15 In relation to the arena, this included the CCTV
 16 in the City Room. Mr Upham specifically addressed this
 17 in his first witness statement and said as follows:
 18 "The PSIA scoring took into consideration the CCTV
 19 and security staff deployed by the arena within the
 20 City Room."
 21 In this context, it is important to note that
 22 Mr Upham would not have been told about the CCTV blind
 23 spot in the City Room because Miriam Stone did not know
 24 of its existence. The existence of a CCTV blind spot
 25 may or may not have been unusual at a complex site but

1 what matters is that if a blind spot exists, it is
 2 discovered so that the deficiency can be mitigated by,
 3 for example, extra patrols.
 4 Fourth, Mr O'Connor submits that GMP's position can
 5 be characterised as follows: because SMG is a large
 6 international business, it did not need to approach
 7 a CTSA, let alone rely on the advice of a CTSA. That is
 8 clearly not GMP's position. Rather, we say that it does
 9 not become SMG, a global conglomerate, to suggest that
 10 engagement with Mr Upham fully or principally discharged
 11 its responsibilities for CT security and that because of
 12 that engagement it was not required to seek advice and
 13 to be aware of guidance from other sources. CTSA
 14 engagement was but one piece of the jigsaw of CT advice
 15 which SMG had at its disposal and which it should have
 16 utilised.
 17 Similarly, Mr O'Connor suggests that it was not
 18 necessary for SMG to employ an in-house CT security
 19 expert at the time because it was being advised by
 20 Mr Upham. The difference between a specialist employee
 21 whose sole focus would have been security at the arena
 22 and who would have been able to witness the operation in
 23 practice day in and day out and a CTSA who makes two
 24 short formal visits a year and does not attend any event
 25 is obvious. It is obvious now and it should have been

1 obvious then.
 2 In their written submissions core participants have
 3 sought to criticise Mr Upham for suggested failures in
 4 the system. He has been criticised for not involving
 5 ShowSec in his meetings with SMG and effectively for not
 6 performing an audit of the security measures in
 7 operation. Neither of those actions were NaCTSO
 8 requirements, nor do they represent practice at the
 9 time. Mr Upham did not set the policies; he worked in
 10 accordance with them.
 11 Our point is simply this: Mr Upham made mistakes,
 12 the limited impact of which we have analysed in our
 13 written submissions. He was not perfect, but the
 14 spectacle of SMG blaming him for its deficiencies and
 15 inadequacies has been as unattractive as it has been
 16 unfair.
 17 Public inquiries tend to polarise organisations and
 18 individuals. No doubt there is some common ground here,
 19 but the responsibility for the safety of visitors was
 20 that of SMG alone, and part of that responsibility
 21 involved being aware of relevant guidance and good
 22 industry practice. An even greater part comprised the
 23 central importance of vigilance, for which there was
 24 a plethora of advice.
 25 Patrols, checks and vigilance were under the control

1 of SMG and not Mr Upham and, as stated at some length in
 2 our written submissions, the problem was not the advice,
 3 the problem was the implementation of that advice.
 4 Now some general points. First, contrary to one
 5 suggestion, there is no competition or rivalry between
 6 GMP and BTP for policing primacy of the arena. It
 7 should be taken as read that both organisations want the
 8 same, namely the best for the site and those who visit
 9 it. If, once this debate has concluded, BTP retains
 10 primacy, then it must do so with a clear memorandum of
 11 understanding between the two forces and, should BTP's
 12 primacy continue, GMP will offer the services of its
 13 CTSA to work together with the BTP CTSA within the terms
 14 which must be set out in the memorandum, which will make
 15 clear which CTSA has primacy.
 16 This is not a struggle for power or dominance
 17 between two organisations. However this is ultimately
 18 resolved, the two organisations will work together
 19 collaboratively, but, and this is the important part,
 20 within the clear terms of a written understanding, and
 21 that should be the case for the arena as it should also
 22 be for every other site which fits into this same BTP
 23 and local force category.
 24 Second, for any audit to be worthwhile, it has to be
 25 detailed. An audit of the arena would only have been of

1 use if it had found the CCTV blind spot and the
 2 confusion regarding the scope of pre-egress checks.
 3 That is not the work of a moment. Indeed, it has taken
 4 this public inquiry to unearth those problems.
 5 Third, on Monday, Mr Weatherby raised some important
 6 questions at pages 79 to 81 of the transcript
 7 {Day55/79:1} and out of respect to him and those he
 8 represents, I will do my best to respond to them. This
 9 is part of what he said:
 10 "GMP should be clear in recognising that not only
 11 should the CTSA have made clear that the service was
 12 purely advisory, but he should have made clear that SMG,
 13 and ShowSec too, should have had dedicated CT
 14 expertise."
 15 And later he added:
 16 "Will GMP accept that their expert CTSA should have
 17 been proactive in saying to operators they needed
 18 dedicated expert advice and management because the
 19 challenges were manifestly beyond the service they were
 20 able and resourced to provide?"
 21 To the first part, it was clear to SMG that the
 22 service was purely advisory. Miriam Stone accepted
 23 that. To the second part, as reference has already been
 24 made, it was not part of NaCTSO guidance that such
 25 advice should be considered, let alone given, and we do

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1 not say that in any desire to be defensive or protective
 2 of Mr Upham; that is the evidence.
 3 But putting the merits of the evidence to one side
 4 for the moment, GMP does believe that there is value in
 5 a memorandum of understanding between the CTSA and the
 6 site that would resolve once and for all one of the
 7 disputes which has arisen here. GMP also believes that
 8 NaCTSO should consider making it part of the system that
 9 CTSA should contemplate whether certain major and
 10 complex sites should seek either external advice or the
 11 appointment of an internal expert and, if so, to make
 12 that recommendation to the site. We believe that the
 13 evidence has demonstrated that such a change to the
 14 system may be of benefit to the site itself and those
 15 who pay to attend it. We would support such a change.
 16 In what is a relatively unusual relationship between
 17 CTSA and site, there should be as much clarity as
 18 possible. Furthermore, a national body such as CTPHQ
 19 does not need the support of a local force, but for the
 20 avoidance of doubt GMP supports the observations in
 21 CTPHQ's written submissions concerning the introduction
 22 of a Protect duty. The fact that taking appropriate
 23 protective security measures is optional for the owners
 24 and operators of crowded places does not provide
 25 sufficient protection for the public.

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1 In conclusion, sir, this: a person unaware of this
 2 attack and this inquiry, who happened to stumble across
 3 certain parts of these proceedings on YouTube, might
 4 have gained the impression that in 2017 we were
 5 ill-prepared to meet a terrorist attack. That would not
 6 be right. Much had been done and was being done to
 7 deter hostile acts. There had been considerable efforts
 8 from both public and commercial organisations to prepare
 9 and protect.
 10 More could have been done, and that will always be
 11 the case, but that does not mean that nothing was done
 12 or that that which was done was wholly inadequate. In
 13 the multiple forensic confrontations of a public
 14 inquiry, it can be too easy to forget that the
 15 responsibility for this appalling attack lies with two
 16 irrational and wicked minds, who thought that their
 17 perverse ideology could justify the slaughter of adults
 18 and children.
 19 It is also too easy to forget that all of us here,
 20 notwithstanding our differences, want the same outcome:
 21 improved preparedness, deterrents and detection in the
 22 future.
 23 Those, sir, are our submissions.
 24 SIR JOHN SAUNDERS: Mr Horwell, I'm very grateful. I just
 25 wonder whether you can help me on one matter. The issue

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1 of primacy of, in particular, policing events which take
 2 place at the arena, it is possible that matters raised
 3 in chapter 10 will have an influence on that. Could you
 4 remind me: has any agreement been reached as to primacy
 5 in dealing with an emergency at the arena?
 6 MR HORWELL: Sir, not to my knowledge. I cannot believe
 7 there would be circumstances in which, if there were to
 8 be a major incident at the arena, that GMP would not
 9 take primacy of that for obvious reasons, but there has
 10 been, to my knowledge, no discussion or agreement to
 11 that effect. But that is plainly what happened on the
 12 night of this attack and, in my view, is likely to
 13 happen again.
 14 SIR JOHN SAUNDERS: Right. We will obviously be hearing
 15 more about that in chapter 10. All it means is that any
 16 recommendations I made about primacy, it might not be
 17 possible to do that simply on the matters in chapter 7,
 18 it might have to wait. In the meantime, of course I'm
 19 perfectly prepared to make recommendations if required,
 20 but the reality is that the police forces in general and
 21 policing in general are probably in a better position to
 22 make those objective decisions than I am with the
 23 cumulative knowledge that they do have and therefore
 24 I would urge them to carry on with their discussions to
 25 try and reach some sort of agreement if at all possible

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1 and not simply await my recommendation.
 2 MR HORWELL: Those words, sir, will be very helpful in
 3 driving forward the discussions and hopefully
 4 a conclusion between the two organisations, so thank you
 5 for that.
 6 SIR JOHN SAUNDERS: Thank you, Mr Horwell.
 7 Mr Greaney.
 8 MR GREANEY: Sir, just before we turn to Mr Laidlaw, you are
 9 quite right that the issue of primacy is something that
 10 we will be considering in further and considerable
 11 detail in chapter 10. In particular we will be hearing
 12 from Deputy Chief Constable Pilling of Greater
 13 Manchester Police who was one of those involved in the
 14 correspondence that we've looked at and we'll hear again
 15 from Assistant Chief Constable O'Callaghan of British
 16 Transport Police, and the policing experts, of course,
 17 will help us to draw the strands together in relation to
 18 that and other issues.
 19 Having made those remarks, we'll next invite
 20 Mr Laidlaw to make his submissions on behalf of ShowSec,
 21 and could we ask him, please, to identify a time round
 22 about 11.30 that is convenient to him for a break,
 23 please.
 24 MR LAIDLAW: Yes, of course.
 25 Can I check, sir, that you can hear and see me?

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1 SIR JOHN SAUNDERS: I can hear and see you and I'm grateful
 2 for your speaking note as well, which I have up in front
 3 of me.
 4 Submissions by MR LAIDLAW
 5 MR LAIDLAW: Thank you very much.
 6 The nature and the scale of the atrocity that took
 7 place on 22 May, the loss of so many lives and the
 8 grievous and permanent damage done to the lives of many,
 9 many others, along with the task that the Home Secretary
 10 has set for you, sir, requires, as ShowSec understands,
 11 that the company's policies, procedures and its approach
 12 to the management of the crowd attending the concert and
 13 others should be very carefully examined, the purpose of
 14 that examination plainly being to see whether it, the
 15 company, could have done more to prevent or mitigate
 16 what happened and to ensure that lessons are learned for
 17 the future. Where criticism is merited in those parts
 18 of your first report may make for uncomfortable reading
 19 for the company, but ShowSec, as its behaviour
 20 throughout this inquisitorial process has already
 21 demonstrated, is determined to react in a positive way.
 22 Neither the company nor its workforce will forget
 23 that Abedi's attack resulted in the murder of
 24 22 innocent people and it is they, but also the broader
 25 public the families wish to see protected in the future,

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1 who lie at the centre of the inquiry.
 2 Just a few words or observations by way of
 3 introduction before I come to the substance of our
 4 submissions as well as dealing with a number of the
 5 points more recently made, primarily by the families.
 6 There are seven in all in this introductory chapter and
 7 perhaps I could start at your paragraph 4, please, which
 8 is the approach of the company to these proceedings.
 9 In our written closing submission, we have laid
 10 emphasis upon the conspicuous candour and openness with
 11 which ShowSec and its directors have acted in this
 12 inquiry. That, of course, was both their moral and
 13 their legal obligation under the statute, which has
 14 given life to inquiries of this sort, but that honesty
 15 and decency goes further than that. And contrary to the
 16 submissions of some of those who act for the families,
 17 it is the clearest of indications that they did care
 18 about safety at the arena and that the company was not
 19 cutting corners at the expense of security or anything
 20 like that.
 21 What do I mean by behaviour indicative of candour
 22 and openness? Well, throughout these proceedings and
 23 beforehand, material potentially damaging of the good
 24 reputation ShowSec enjoys was promptly disclosed and
 25 failings and shortcomings were frankly acknowledged.

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1 Where reflection revealed shortcomings, as will
 2 inevitably be the case for every state and corporate
 3 entity involved in this inquiry, ShowSec has been
 4 prepared to acknowledge those failings and to address
 5 them. The significant changes and the improvements
 6 brought forward since the attack, as set out by
 7 Mr Harding in his witness statements and you have the
 8 references to them, should serve to remind us all, as we
 9 promised at the outset of these proceedings, that
 10 ShowSec would and has reacted in a positive and not an
 11 entirely defensive way to the terrible events of
 12 May 2017.
 13 Second, fairness. Along with this inquiry's
 14 obligation to provide the families with the thorough and
 15 fearless investigation they call for, ShowSec is also,
 16 as we know you will readily accept, entitled to
 17 fairness. In light of the withering criticisms made of
 18 the stance taken by the company we represent, let me set
 19 out what I mean.
 20 Fairness requiring, we submit, not simply that
 21 ShowSec's policies, procedures and actions be considered
 22 and judged in a way which is balanced, but crucially in
 23 a manner which is also reflective of and proportionate
 24 to the role it played in the public areas of the
 25 City Room, the extent to which the company had CT

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1 responsibilities and the position that it occupied
 2 in the hierarchy of security providers.
 3 Fairness also requires that when criticism is made
 4 or points are taken against ShowSec, those criticisms or
 5 points should be examined for a solid factual basis.
 6 There are some striking examples of criticism of ShowSec
 7 and its witnesses where regrettably that is not the
 8 case. These are particularly to be found in the
 9 submissions of Mr Atkinson and Mr Cooper, to which
 10 I will come.
 11 These amount to points which are bad, which lack any
 12 sort of evidential basis, and which should not have been
 13 made. No doubt, I hope, having reflected upon the
 14 submissions to come, those points and certainly the most
 15 egregious of the personal attacks launched upon
 16 Mr Harding's integrity by Mr Atkinson in particular will
 17 be withdrawn.
 18 Fairness also requires that we are not simply
 19 required, as appears to be the position taken by both
 20 Mr Weatherby and Mr Cooper, to accept the opinion of
 21 the experts where they appear to lack the appropriate
 22 expertise or are making points which require examination
 23 and testing. That is what the process of calling
 24 evidence and affording the opportunity to challenge
 25 provides and it is the testing, although whether it has

1 all been helpful is for you to determine, it is the
 2 testing which allows you, sir, to make informed
 3 decisions and recommendations.
 4 In this context Mr Weatherby on Monday, and
 5 I provided the reference to the transcript, said, and
 6 I quote:
 7 "[He could] not recall objection having been taken
 8 to the appointment of the experts."
 9 That is not in fact correct, although I am not
 10 suggesting that this would necessarily have come to
 11 Mr Weatherby's attention. Concern was expressed by
 12 those representing the company in its correspondence
 13 with ILT.
 14 (3), the hierarchy. As for the hierarchy of those
 15 with responsibility for the safety of the public
 16 attending the arena and the importance of placing
 17 ShowSec's obligation within these, there are
 18 Mr Weatherby's submissions on the issue of whether the
 19 Government has discharged its Article 2 obligation.
 20 We will not seek to add to his points but we would
 21 suggest he is plainly right that the correct and logical
 22 approach for the inquiry to take is first to analyse the
 23 responsibilities of the state and its agencies and how
 24 they discharge those responsibilities before turning to
 25 those of the corporate CPs at work in those areas.

1 We make this submission because there can be no
 2 doubt the primacy for securing the safety of the public
 3 in the City Room lay with the state and with the police.
 4 As it was put by the policing experts in their final
 5 report, and I quote:
 6 "We have latterly been advised that there may be
 7 an issue in relation to whether or not the City Rooms
 8 fell under the operation and control of those managing
 9 and providing security for the arena itself and may be
 10 a matter for the inquiry to consider. That does not
 11 alter the situation from a policing perspective as the
 12 City Rooms were demonstrably a public place at the time
 13 of the attack. The primary access to the City Rooms is
 14 via a high-level walkway between the City Rooms and the
 15 public area of Victoria Station. The walkway was also
 16 an area open to public access."
 17 Whether it was appropriate for BTP to have primacy
 18 for the policing of the arena did not feature as
 19 an issue which was the subject of evidence within
 20 chapter 7, although it is plainly of considerable
 21 importance and we will come on to set out the opinion of
 22 the policing experts in due course.
 23 However, when considering the security arrangements
 24 on 22 May 2017, the inquiry will no doubt have to
 25 consider which force it was that was best placed to

1 secure the safety of the public in that area and what,
 2 if any, was the impact of responsibility being placed
 3 upon a relatively small national force that did not
 4 specialise in the policing of mass public entertainment
 5 and in 2017 had no meaningful counter-terrorism
 6 experience or capacity.
 7 Regardless of the shortcomings of the operator of
 8 the venue and its provider of crowd management services,
 9 our submission is that the inquiry is bound as a matter
 10 of both law and logic to look as its starting point
 11 at the performance of the police, whether or not the
 12 policing function should have been discharged by BTP or
 13 GMP, and the extent to which, if at all, the state
 14 through the police had turned its mind to the risks of
 15 a terrorist attack in the City Room and the mitigation
 16 of that risk, along with the question whether it gave
 17 effective direction to ShowSec on event days, who were
 18 at work managing the crowds in that area.
 19 There can be no doubt, as we imagine you will find,
 20 what was plainly required was the coordination of ideas
 21 and resources of both the state and private businesses,
 22 which echoes a submission that Mr Horwell has just made.
 23 That was plainly not achieved just by the CTSA PSIA
 24 system, but it could have been achieved by a far more
 25 rigorous focus on security issues by police, the local

1 authority, the emergency services, along with private
 2 businesses at multi-agency meetings and at ground level
 3 by greater coordination and information sharing between
 4 the police, SMG and ShowSec.
 5 ShowSec's role and its responsibility in terms of
 6 the security of the crowd entering and leaving the venue
 7 was not simply subordinate to that of the state and its
 8 agency, but also to SMG. It's not a matter of passing
 9 the buck or of ignoring its responsibility, that is
 10 a fact and that again is the legal position.
 11 The situation which confronted ShowSec had important
 12 consequences. In particular and by way of example, as
 13 against the arrangements in place in May 2017 it was
 14 certainly not possible for ShowSec staff to have
 15 prevented an individual intent on carrying out a suicide
 16 attack from entering that part of the Victoria Station
 17 complex where Abedi detonated his device.
 18 Contemporaneous standards. One further observation
 19 about approach and it is, we suggest, another feature of
 20 the striving for fairness in the approach to be adopted,
 21 which, as we know, you will be anxious to achieve for
 22 all, and it's this: if ShowSec is found wanting in any
 23 respect then it is submitted, as was made clear during
 24 the cross-examination of Dr BaMaung and Colonel Latham,
 25 that the inquiry should also consider whether the

1 company fell short of recognised standards or whether in
 2 fact there were at the relevant time clear and readily
 3 accessible standards against which to judge and measure
 4 its performance.
 5 That becomes more important when regard is had to
 6 the scathing tone of the criticisms made by Mr Cooper at
 7 paragraph 3.1 of his document, where he asserts that
 8 those failings were failings, and I quote "as judged by
 9 the standards of 2017". Neither are we alone in making
 10 this submission because you will have noted and heard
 11 Mr O'Connor yesterday that SMG is encouraging the
 12 inquiry to take a similar approach. ShowSec's position,
 13 for the reasons set out in the written closing and to
 14 which we will turn, is that careful scrutiny of the
 15 available evidence shows by way of example that at the
 16 time of this attack there was a general lack of clarity
 17 as to how to compile a risk assessment that dealt with
 18 risks of terrorism and that much of the available
 19 information was in fact difficult to access.
 20 Further, despite the security experts referring to
 21 the availability of the external advice, they were
 22 unable when pressed to identify where in 2017 that might
 23 be found. They also conceded that there were no
 24 standards in relation to counter-terrorism training
 25 at the time. Nor apparently can either Dr BaMaung or

1 Colonel Latham assist as to ShowSec's standing amongst
 2 its competitors.
 3 I promise ShowSec understands the point you made
 4 about the standard of training, but the company
 5 maintains that this can only be done fairly by giving
 6 some consideration as to whether there existed any
 7 contemporary standards that it failed to meet and
 8 that is all the more important in light of the position
 9 that Mr Cooper has taken.
 10 If there is to be criticism, then the appropriate
 11 way to present that failing, if of course it be
 12 appropriate, will be making it clear, as Mr O'Connor has
 13 submitted, that the failing has not been identified by
 14 reference to any standard contemporary to those in place
 15 in 2017 but as a forward-looking recommendation.
 16 (5), the limitations of expert evidence and
 17 hindsight. ShowSec, as you know, has been critical of
 18 the approach of the security experts in a number of
 19 respects and expresses a concern whether they have truly
 20 understood their duties both to the inquiry and to the
 21 CPs. It could not sensibly be said that Colonel Latham
 22 and Dr BaMaung do not have considerable expertise in
 23 security matters, but neither had any expertise in crowd
 24 management and both accepted, as I've said, that they
 25 had not considered ShowSec's performance by the context

1 of prevailing industry standards.
 2 Further, Colonel Latham appeared to regard his own
 3 regime at the O2 as the gold standard from which other
 4 policies and procedures could be judged. Not only was
 5 he plainly wrong as to that, but his stance in that
 6 regard is an indication that he had failed to understand
 7 the role of the expert in proceedings of this sort.
 8 Furthermore, and despite their protestations to the
 9 contrary, there are examples, in particular in relation
 10 to hostile reconnaissance, as we've set out, of the
 11 experts applying a considerable measure of impermissible
 12 hindsight to their analysis and conclusions.
 13 As to hindsight, ShowSec accepts that the inquiry is
 14 entitled to look to the situation that prevailed in 2017
 15 from the perspective of 2021 and that that necessarily
 16 involves an element of hindsight. That, however, is
 17 very different from criticising those in 2017, who did
 18 not and perhaps could not have appreciated then what has
 19 become or seems obvious now. And you made that point
 20 in the passage which we have set out below.
 21 So ShowSec endorses the approach that you have set
 22 out with the caveat that it should extend to events not
 23 just on the night of 22 May but also to the period
 24 leading up to it.
 25 (6), the approach to fact-finding. The company, in

1 common with SMG, does not take issue with the general
 2 approach to fact-finding as advanced by Mr Atkinson at
 3 paragraphs 5 to 19 of his written submissions or to the
 4 families' invitation that you should take a flexible
 5 approach to the issue, the starting point being the
 6 civil standard of proof. We have one reservation and
 7 I hope this is not contentious, it's this: the more
 8 serious the allegation being made, the more cogent the
 9 evidence needed to prove it.

10 When serious allegations such as misleading the
 11 inquiry or profit before safety are raised, then there
 12 is the requirement for cogent evidence before the
 13 allegation could be said to have been proved on the
 14 balance of probabilities. We have given you reference
 15 to a speech with which you'll be well familiar.

16 (7), ShowSec's position. In striking contrast to
 17 the allegations of ducking responsibility that litter
 18 the submissions of the families, ShowSec has accepted,
 19 and it accepted this at the outset of this hearing, that
 20 there are areas in which it has fallen short, namely in
 21 respect of its risk assessment and of bag-checking
 22 procedures. However, our submission is that neither of
 23 these flawed processes caused or contributed to either
 24 the bombing or the extent of the casualties. Neither,
 25 we suggest, were they reflective of a relaxed or

1 complacent approach to security generally.

2 The company, as you know, also finds itself
 3 criticised for making these causation-type points even
 4 though your own legal team explicitly called for
 5 submissions on this very issue.

6 Our position is that the evidence has established
 7 that ShowSec provided a well-trained and experienced
 8 workforce to SMG on 22 May 2017. It was in fact a far
 9 more experienced workforce than its contractual
 10 obligations required or for which it was being paid. We
 11 submit that its training was not simply appropriate, it
 12 was thorough and consistent with the nature of the
 13 services it provided.

14 Although Mohammed Agha may not have completed his
 15 training with the diligence ShowSec was entitled to
 16 expect, that training did not stop with the induction
 17 CT module. The training was further supplemented and
 18 enhanced by briefings and experienced supervisors. The
 19 core message delivered via the training and briefings
 20 was the need for vigilance and prompt upward reporting,
 21 which, as Dr BaMaung and Colonel Latham accepted, and
 22 I provided the references to you, the company had
 23 achieved. In this respect, ShowSec's message to its
 24 staff was completely aligned with the national guidance.

25 In pointing out that its staff, including Mr Agha

1 and Kyle Lawler, were trained to know what to do when
 2 confronted by a suspicious individual, ShowSec is not
 3 seeking to shift blame or to scapegoat. Why Mr Agha and
 4 Mr Lawler did not act in accordance with their training
 5 must be for you and you will note that the company did
 6 not seek to examine either young man, to whom it
 7 continues to offer its support. ShowSec's point is
 8 different. It is that if there were failures on the
 9 part of those two, then these cannot be attributed to
 10 a lack of appropriate training.

11 Finally, and whether or not there were failures on
 12 the part of ShowSec or members of its staff or indeed
 13 SMG and/or BTP, the fact remains, as you were to
 14 acknowledge in your opening words at the beginning of
 15 this hearing, that Salman Abedi was plainly determined
 16 and entirely committed to killing himself and as many
 17 others as he could. Whilst his unchallenged presence
 18 at the mezzanine level raises important questions that
 19 you will address in due course, there can be little
 20 doubt that even had he been spoken to by a member of
 21 ShowSec staff or a police officer before egress, he
 22 would still have detonated his bomb.

23 I set out for you, sir, as you can see in the
 24 speaking note the structure to the submissions which are
 25 to come, along with the cross-references. Can I pick it

1 up, please, from paragraph 26 for you. This is
 2 chapter 1, ShowSec's role at the Manchester Arena, its
 3 place in the hierarchy and the question whether that
 4 involved the provision of specialist CT services and the
 5 assertion of profit before safety.

6 I begin with the role at the arena. I return to
 7 a submission I made by way of introduction. In order to
 8 determine whether any inadequacies in the security
 9 arrangements constituted a failure by the company we
 10 represent, we argue, as I've said, that it is necessary
 11 first to establish and delineate the nature of ShowSec's
 12 role and responsibility and the place that a crowd
 13 management company occupied within the hierarchy of
 14 those bearing responsibility for the safety of those
 15 attending events.

16 There's a danger of being rather deflected from this
 17 task, which we can illustrate, with reference to the
 18 written policies and procedures of the company we
 19 represent. These written documents have been the
 20 subject of the most searching of examinations during the
 21 course of the chapter 7 evidence. But that exercise,
 22 I hasten to add an entirely understandable exercise,
 23 should not obscure by way of example the lack of any
 24 significant or contemporary documented policies and
 25 procedures produced for the arena by BTP.

1 You'll remember that they had no written risk
 2 assessment, there were no written briefings and the
 3 like , and as a result it may have seemed to some that
 4 SMG and ShowSec bore exclusive responsibility for the
 5 safety of those in the City Room. Perhaps more to the
 6 point, some of the closing submissions, both in writing
 7 and those made during the course of the last 2 days,
 8 have somewhat lost sight of what it was reasonable or
 9 practicable for a crowd management company to achieve
 10 within this hierarchy.

11 As I have said, primacy for combating the risk of
 12 a terrorist attack lies with the state and it is
 13 exercised through its security and police services .
 14 It is these organisations that have access to expertise,
 15 information and resources far in excess of those
 16 available to a crowd management and event security
 17 company. The role of the police in overseeing the
 18 security arrangements at the arena, whether that which
 19 was actually performed by BTP or that which ought to
 20 have been performed by GMP with their greater CT
 21 experience and resources, and who there are strong
 22 grounds for arguing should have taken responsibility for
 23 this major venue, have again, as I have submitted,
 24 barely been touched upon in chapter 7.

25 Dr BaMaung and Colonel Latham in expressing their

1 views have almost entirely ignored the part the public
 2 might have expected the police to play, both before and
 3 during events such as the Ariana Grande concert and the
 4 role of the security services has yet to be explored.

5 There were just passing references to BTP's part in
 6 policing the arena in the first iterations of their
 7 report. This topic then occupied just 15 pages out of
 8 500—plus in the final version, and much of that was an
 9 attempt at an analysis of which officers had actually
 10 been available for duty on 22 May and which was, in that
 11 respect, inaccurate.

12 But the evidence has shown, and BTP have frankly
 13 conceded this, significant failures in the manner in
 14 which BTP delivered its CT function. Instead the focus,
 15 at least thus far in the inquiry, for securing the
 16 safety of the crowd attending events on the arena has
 17 fallen, so it might appear, almost exclusively upon SMG
 18 and ShowSec, although, as Mr Weatherby has correctly
 19 pointed out, that is primarily a policing function to
 20 maintain security and to keep the public safe, as he
 21 put, and I quote "particularly at times of high crowd
 22 density".

23 In due course the inquiry will have to consider
 24 whether both the public and indeed these two companies
 25 were and are entitled to expect rather more in terms of

1 ownership from the state's agencies in respect of the
 2 responsibility for the safety of those attending events
 3 and those employed by SMG and ShowSec in the areas
 4 surrounding a venue such as the arena.

5 Can I turn then to the legal position and the
 6 opinion of the policing experts. The duties of the
 7 police include the protection of the public and the
 8 prevention of crime. That is not contentious, but if
 9 authority is needed for the proposition then we have
 10 provided it. The City Room, as is clearly established,
 11 was a public area, accessible to a huge number and
 12 variety of people. Those attending the arena, those
 13 escorting or accompanying attendees to and from it,
 14 those travelling to and from the railway station or the
 15 car park, those using the area as a shortcut or part of
 16 their journey to and from work, those attending the
 17 go-kart circuit and those working at the sites within
 18 the complex, such as JD Williams.

19 In May 2017, and for many years before, although
 20 this appears to have been almost entirely ignored in the
 21 submissions of Monday, it is beyond doubt that ShowSec's
 22 staff had no right to prevent anyone from entering the
 23 City Room or to search anyone who was not intending to
 24 enter the arena. If a person attending the event
 25 refused to be searched, the only sanction available to

1 ShowSec staff was to refuse that individual entry.

2 Now that there is an extended perimeter, the manner
 3 in which ShowSec discharges its responsibilities has
 4 changed because its staff can now search people prior to
 5 entering the City Room and to refuse entry to anyone not
 6 attending an event. However, in 2017, the
 7 responsibility for security in the City Room, and we'll
 8 come to an attempt to define the limits upon that
 9 obligation, was discharged by its training of its staff
 10 to remain alert and vigilant and having effective
 11 reporting systems and evacuation procedures.

12 In stark contrast to the limits upon ShowSec's
 13 ability to secure safety, the police, whether it be an
 14 event day or a dark day, always retained responsibility
 15 for the safety of the public in the entire complex.
 16 They did have the ability to intervene founded on
 17 well-established legal principles.

18 The arena, as I've said, sat in an area to which
 19 at the time the public had unrestricted access, whether
 20 they were attending the arena or not. They could not be
 21 protected by ShowSec, they were entitled to be protected
 22 by the police. And it is inaccurate as a matter of law
 23 to assert, as GMP do in their closing submission, and
 24 I quote:

25 "Either SMG or ShowSec or a combination of both was

1 responsible for the provision of CT mitigation and
 2 security [and then these words] in the areas outside of
 3 the arena during an event.”
 4 If by making that assertion GMP is contending that
 5 the police bore no responsibility at all , the areas
 6 outside the arena are plainly within the jurisdiction of
 7 the police when dealing with counter—terrorism.
 8 As I have said, Dr BaMaung and Colonel Latham have
 9 not provided any views that they may have on the next
 10 important issue, which is which force should have
 11 primacy, although it is a matter that Mr Weatherby has
 12 touched upon at paragraph 40 of his written submissions.
 13 His view, as is ours, reflects the position taken by the
 14 policing experts in their final report. Let me set that
 15 out so those listening can understand the point,
 16 conscious of course that this is evidence to come.
 17 This is what they have said:
 18 “We are not persuaded that the routine provision of
 19 policing at the arena by BTP is the best way in which
 20 the safety of users of the arena may be assured. BTP
 21 are experts in the policing of the high—risk railway
 22 network, which contains complex hazards and
 23 restrictions .”
 24 BTP are not experts, as far as we know, in the
 25 policing of places of mass public entertainment. For

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1 BTP to have primacy in such places simply on the basis
 2 of commercial ownership by Network Rail appears to be
 3 counter—intuitive.
 4 Next they say:
 5 “The arena is described as one of the busiest venues
 6 in the world and the largest indoor arena in Europe.
 7 This means that policing one of the busiest venues in
 8 the world is not the responsibility of one of the
 9 largest police forces in England, which surrounds the
 10 arena, GMP, instead it is policed by a transport police
 11 force that is spread thinly and is commanded from
 12 Birmingham and London.”
 13 And they repeat the point about BTP’s
 14 specialisation :
 15 “This may appear to be a semantic difference [the
 16 policing experts continue]. However, consider the
 17 reality of the situation on the ground. Any BTP officer
 18 deployed to Victoria Station and the arena are not
 19 routinely connected to GMP, they are not deployed or
 20 briefed by GMP. Generally speaking, BTP will have
 21 little knowledge of events in the centre of Manchester
 22 and conversely, GMP will have little knowledge of events
 23 taking place in Victoria Station or the arena.”
 24 They continue:
 25 “One effect of the application of primacy on the

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1 night of the arena concert was that the BTP officers on
 2 duty for the concert operated as an isolated island
 3 unconnected to GMP and the policing of
 4 Greater Manchester. The BTP focus appeared to us to be
 5 exclusively inward rather than recognising that the
 6 arena was part of a much wider policing and social
 7 environment. We do not believe that BTP officers on
 8 duty on 22 May had been in touch with the surrounding
 9 GMP division to exchange information, explore emerging
 10 risks or to coordinate policing action to protect the
 11 14,000 audience, comprising many children and young
 12 people, attending the arena concert, many of whom may
 13 have been considered vulnerable leaving a concert late
 14 at night. We have seen no evidence of any prepared
 15 BTP/GMP policing operation for that night. Equally,
 16 we have seen no specific operation order which addresses
 17 the BTP operation of the arena on 22 May 2017 or for any
 18 other arena event. The deployment of largely parallel
 19 police agencies between whom there was minimal contact
 20 and an absence of joint planning likely increased the
 21 risk to users of the arena.”
 22 And then this:
 23 “It is our view in light of the events at the arena
 24 that it cannot continue to be appropriate for
 25 a specialist railway transport police force to have

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1 primacy over a majority public entertainment venue. The
 2 Manchester Arena could be more effectively policed and
 3 public safety enhanced by GMP so the planning,
 4 preparation and response are exerted through a single
 5 police agency employing cohesive and comprehensive
 6 integrated emergency management.”
 7 Again, setting out these views, and I absolutely
 8 accept that this is evidence to come, is not an example
 9 of ShowSec seeking to distract or deflect
 10 responsibility . The fact remains that primary
 11 responsibility for the safety of the public in the
 12 City Rooms rested with the state through its police
 13 services .
 14 The point is this , that if it is the view that in
 15 due course you were to reach the view that the policing
 16 of the arena was not in the hands of the most
 17 appropriate police service then it obviously reflects
 18 first an important missed opportunity properly to
 19 analyse, plan for and mitigate the risks of terrorism .
 20 Secondly, as far as ShowSec are concerned, it provides
 21 the important context to its position and its asserted
 22 failings and shortcomings, and that is particularly so
 23 when the company and its staff find themselves being
 24 criticised by GMP, the Home Office force who the
 25 policing experts view as far better placed to take up

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1 the policing responsibility .
 2 And again you may think that Mr Weatherby at his
 3 paragraph 42 has captured the point neatly. He put, and
 4 I quote:
 5 "The failure of liaison between the GMP and BTP was
 6 a missed opportunity to achieve more coherent and
 7 effective CT planning across the arena and
 8 Victoria Station complex."
 9 The question also has impact on your consideration
 10 of the value of some of the points made on behalf of the
 11 families , and perhaps I can take the point Mr Cooper
 12 makes at paragraph 3.4 of his written submissions.
 13 There he submits that:
 14 "There was a failure to adequately plan or review
 15 the security provision in light of the changing
 16 methodology of terrorist attacks", meaning PBIEDs.
 17 In respect of that sort of a point, is it
 18 unreasonable for counsel representing a private company
 19 in 2017 at an arena with the complexity and challenges
 20 that Manchester presented to pose the question: isn't
 21 that the role of the state through the police who could
 22 be expected to bring their expertise to it so as to
 23 ensure that the crowd management company doing what was
 24 expected of it ?
 25 And again, you may think that Mr Weatherby has the

1 point at his paragraph 16. There he wrote:
 2 "Individual failings by SMG, ShowSec managers with
 3 respect to risk assessment, security layering ,
 4 monitoring and patrolling system and supervision would
 5 have been addressed by competent and adequately
 6 resourced CT expertise. Likewise, proper systems,
 7 audited in operation would have reduced the room for
 8 individual failings by stewards such as Mr Agha,
 9 Mr Lawler, or a lack of coordination by BTP."
 10 The inquiry will have to await the evidence of the
 11 policing experts, but would they have expected GMP, in
 12 seeking to assess the risk to eventgoers at the arena,
 13 to have reviewed ShowSec's methods of operating at that
 14 venue? And if GMP had done that, would the experts have
 15 expected GMP to have picked up the failings, or at least
 16 some of them, in the operation that Mr Horwell now
 17 points to at paragraph 4 of his written closing?
 18 Next in the hierarchy of responsibility to SMG. It
 19 was and is SMG, as occupier and operator of the arena,
 20 who had responsibility for security in the City Room.
 21 In terms of its relationship with ShowSec, as is
 22 accepted, it was SMG who occupied the dominant position
 23 in that contractual relationship , contracting as they
 24 did services from ShowSec. It was by way of
 25 illustration SMG who determined how many staff ShowSec

1 were to provide for any event. It was SMG who had the
 2 relationship with GMP's CTAs and BTP, and it was SMG
 3 who were invited to the various events and training ,
 4 such as the Sherman exercise provided by GMP.
 5 It follows that any assessment of ShowSec's
 6 contractual duties must start with its stewarding
 7 services agreement with SMG, which set out and defined
 8 the limits of its contractual obligations along with
 9 an analysis of what it was the company was obliged to do
 10 pursuant to any statutory or common law duties.
 11 As set out in the agreement, and we dealt with this
 12 in the opening note, ShowSec was contracted to provide
 13 crowd management and event security services. CT was
 14 not a specified service in the schedule to the
 15 agreement, although as part of its wide-ranging duties,
 16 and as the company plainly recognised, in providing
 17 stewarding and event services ShowSec was required to
 18 identify the threats to attendees at the arena
 19 associated with terrorism, plan to mitigate those risks ,
 20 and then to implement that plan.
 21 Over and above its contractual duties, ShowSec
 22 of course shared both with SMG and the police statutory
 23 duties to its staff and certain members of the public
 24 under sections 2 and 3 of the Health and Safety at Work
 25 Act 1974, that ShowSec owed a duty under section 3 to

1 members of the public queueing to enter the arena,
 2 inside the arena and leaving the arena appears clear .
 3 However, the extent to which that duty extends to
 4 preventing an act of terrorism rather than dealing with
 5 or seeking to mitigate the consequences of such an
 6 attack is less easy to define, nor is it by any means
 7 clear that it was ShowSec who owed any protection-type
 8 duty to members of the public who were not attending an
 9 event, whether they were in the City Room to meet those
 10 who had attended an event or whether they were passing
 11 through.
 12 In contrast, you'll have noted that Mr Cooper seeks
 13 to argue that sections 2 and 3 applied to members of the
 14 public at large and in parallel he suggests they owed
 15 duties at common law. At 2.3 of his document he says
 16 this:
 17 "There can be no dispute that both SMG and ShowSec
 18 owed duties to protect both concert attendees and
 19 members of the public in the City Room from, amongst
 20 other risks of harm, the threat from terrorism."
 21 As I have said, it is accepted that ShowSec owed
 22 a duty pursuant to section 3 to those who were attending
 23 the arena. However, the statutory duty, as you will
 24 know, and as a matter of statutory interpretation ,
 25 arises from the conduct of its undertaking. So the

1 first question must be: what was the nature of ShowSec's
 2 undertaking? Further, the scope of any duty is far from
 3 clear. Did it encompass a duty to prevent a terrorist
 4 attack or to take all reasonably practicable steps to
 5 avoid the consequences of a terrorist attack? Are those
 6 duties in fact two ways of saying the same thing?
 7 Whatever the nature of the duty, did it extend to those
 8 attending the event, those waiting for attendees and/or
 9 the public at large?

10 As you'll well know, sir, the criminal law does not
 11 generally impose a duty on any individual to prevent
 12 crime, and when it does, it does so in clear terms.
 13 Section 7 of the Bribery Act and those sections of POCA
 14 are examples which we have cited.

15 Further it is not accepted that ShowSec owed
 16 a common law duty of care to anyone to prevent
 17 a terrorist attack. Again, although it is no part of
 18 the inquiry's function to determine liability, the
 19 inquiry will understand that the general principle
 20 is that a person is under no duty to take care to
 21 prevent harm occurring to another through a source of
 22 danger not created by that person unless that individual
 23 has either assumed responsibility to protect the other
 24 from danger, the person has a special level of control
 25 over the danger, or that person's status creates an

1 obligation to protect. Again, we've cited authority
 2 there for you.
 3 Neither does the reference to ShowSec's opening
 4 statement, to be found in footnote 109 of Mr Cooper's
 5 submissions, in which he says there is no dispute that
 6 ShowSec owed duties to members of the public in the
 7 City Room from the threat of terrorism, neither does
 8 that accurately set out what was said there. One needs
 9 to read from our document, the entirety of
 10 paragraphs 1.8 to 1.13 to see the full context to the
 11 point.

12 Next, within this chapter, ShowSec's role -- sorry,
 13 I can see Mr Greaney come on to the screen.

14 SIR JOHN SAUNDERS: I was just going to say. Would it be
 15 convenient for you to have a break now, is that all
 16 right?

17 MR LAIDLAW: Of course, absolutely, I should have realised
 18 the time.

19 SIR JOHN SAUNDERS: Not at all. We'll rise for 15 minutes.

20 If I haven't managed to completely finish my cup of
 21 coffee, I hope you won't find it disrespectful if
 22 I drink it during your submissions. I meant to say that
 23 to Mr Cooper yesterday. We'll adjourn for 15 minutes.
 24 Let's say 11.50.

25 (11.33 am)

1 (A short break)

2 (11.50 am)

3 SIR JOHN SAUNDERS: Mr Laidlaw, just before we start again,
 4 can I mention one thing. You mentioned the statement by
 5 Lord Nicholls about the burden of proof and the balance
 6 of probabilities, the more serious allegation requiring
 7 more cogent evidence. My recollection, which may be
 8 inaccurate, is that the Supreme Court may have revisited
 9 that topic in the meantime. If I discover that's
 10 correct, I will make sure you get to know and if it
 11 requires any further submissions -- it's not the most
 12 central part of your submissions, I understand -- we'll
 13 give you the opportunity to respond if we do find that
 14 it has been revisited. But as I say, I may be entirely
 15 incorrect about that.

16 MR LAIDLAW: I don't think you are incorrect. It is
 17 a topic, isn't it, which has exercised, in the civil
 18 context, the minds of the Supreme Court on a number of
 19 occasions? We'll also look and, if we find anything,
 20 send it through to you.

21 Sir, I'm at your paragraph 55. For those who are
 22 looking at the written submissions, ShowSec's written
 23 submissions, it's 28.

24 Against those observations I made before we broke
 25 about ShowSec's position within the hierarchy, as I have

1 described it, the submissions as to the legal duties
 2 which were placed or were not placed on ShowSec,
 3 what was it that could reasonably have been expected of
 4 the company by way of the part that it undoubtedly had
 5 in helping to secure the safety of those attending the
 6 events at the arena?

7 At paragraph 28 of the written, but 55 of the note
 8 you are presently looking at, I have set out what we
 9 said at paragraphs 17 to 19 of the oral opening
 10 submissions, which I won't read out in its entirety.
 11 But we made the submission, which we maintain, that the
 12 limits of that which could reasonably be expected of
 13 ShowSec staff were really summed up by two words:
 14 vigilance in terms of its management of the crowd, both
 15 in terms of hostile reconnaissance and suspicious
 16 behaviour of the sort which might present risk to
 17 concertgoers, and then, if there were concerns of that
 18 sort, that those would be escalated promptly.

19 So we would ask you, please, when you have resolved
 20 the various issues which come before it to turn your
 21 mind as to whether you think that is a submission which
 22 can survive the examination which we have been
 23 undertaking.

24 The issue, of course, is whether ShowSec, as has
 25 been maintained by SMG, held itself out as providing

1 specialist counter—terrorism advice. This gave rise to
 2 one of the few disputes between SMG and ShowSec. There
 3 has been something of a retreat by SMG, but despite the
 4 evidence of Dr BaMaung and Colonel Latham it is not
 5 a point, as is clear both from Mr O'Connor's written and
 6 oral submissions, that SMG are prepared entirely to
 7 abandon.

8 I accept of course it is no part of your job leading
 9 a public inquiry, with all that you have to contend
 10 with, to settle disputes between the CPs, but it is
 11 a question which is not without significance. Our
 12 position, as we set out at your paragraph 57, is this:
 13 that the written and oral evidence of Mark Harding,
 14 Mark Logan, the statement of Simon Battersby, who
 15 delivered with Mr Logan the NAA/EAA event in April 2016,
 16 and who also undertook the stewarding audit, along with
 17 the lack of any relevant contractual term, the fact that
 18 any training that ShowSec provided was based on publicly
 19 available material and the fact that after the bombing,
 20 SMG sought specialist advice from Guidepost — all those
 21 factors go to demonstrate that ShowSec was not, as we
 22 submitted, offering, purporting to offer or providing
 23 specialist CT services.

24 Further, Dr BaMaung in agreeing that there were
 25 other companies employing ex—service personnel that did

1 provide such specialist services and which in more years
 2 had become prevalent said this:

3 "I don't believe it's [that's reference to ShowSec]
 4 a company that markets itself as having significant CT
 5 expertise at all."

6 And we submit that the views expressed by
 7 Miriam Stone and James Allen as to ShowSec's purported
 8 expertise and the extent to which they relied upon it
 9 were not reasonably held and we would invite you, sir,
 10 to reject them.

11 There is a crossover between the concepts of crowd
 12 management security and counter—terrorism, but those
 13 concepts are still distinct. Crowd management, as the
 14 name suggests, deals with the management of groups of
 15 people into, within and from an event. Event security
 16 is concerned with preventing either people or items from
 17 entering a venue, and other SIA—licensable activities
 18 such as controlling access to back of house and stage
 19 areas, and CT is a highly specialised area traditionally
 20 falling within the remit of the police and the security
 21 services. That distinction was accepted with some
 22 qualification by Dr BaMaung.

23 More generally, when dealing with security providers
 24 at the O2 and in response to a direct question from you
 25 as to whether crowd management companies were security

1 specialists in a CT specialised way, Colonel Latham
 2 expressed the view they were, and I quote:

3 "Crowd safety people first and I felt that I was,
 4 without being disrespectful to them, teaching them
 5 terrorism."

6 Whether or not the inquiry accepts the totality of
 7 his evidence, and there is good reason why in part it
 8 should not, this passage, we say, gives a true
 9 reflection of the capabilities and experience of a crowd
 10 management and event security company in its place
 11 in the industry in 2017 in relation to CT.

12 I turn next, please, to the question whether in
 13 performing its role, did ShowSec put profit before
 14 safety? The point has already been made: every business
 15 will seek to maximise revenue and minimise cost. This
 16 is far removed from putting profit before safety, which
 17 in this case would involve a decision not to perform
 18 a particular task or to implement a particular policy on
 19 the grounds of cost in the knowledge that, by doing so,
 20 safety was being compromised.

21 Contrary to the assertions made by some CPs, ShowSec
 22 is not in the scheme of things a large company, nor does
 23 it generate profits at anything other than acceptable
 24 levels. On a proper analysis of the evidence it was
 25 plainly not in ShowSec's economic interest to agree with

1 SMG to supply too few staff generally or fewer
 2 SIA—licensed staff than were required effectively to
 3 perform ShowSec's obligations. SMG paid ShowSec per
 4 member of staff supplied and at a higher rate for
 5 SIA—licensed staff. It inevitably follows the more
 6 staff, the more qualified staff employed by SMG, the
 7 greater the profit for ShowSec.

8 As to numbers, as I've said, those were imposed on
 9 ShowSec by SMG.

10 Putting to one side the cold economic arguments the
 11 inquiry has also had the benefit of seeing the evidence
 12 of the directors, Mr Harding, Mr Logan, the regional
 13 manager Tom Bailey, and the head of security on the
 14 night, Tom Rigby. We would submit for your
 15 consideration that ShowSec is plainly a well—established
 16 company run by experienced, thoughtful and highly
 17 motivated individuals. Nothing in their evidence or the
 18 manner in which they gave their evidence even begins to
 19 justify an allegation of putting people at risk for the
 20 sake of profit.

21 Despite that clearly being the position and for
 22 reasons which appear unclear, Mr Atkinson has chosen to
 23 impugn the integrity of Mr Harding. At paragraph 39 of
 24 his written closing — and I am afraid he repeated this
 25 on Monday — he said:

1 "Regrettably it appears that Mr Harding attempted to
 2 mislead the inquiry through his assertion that it would
 3 be to ShowSec's commercial advantage for SMG to order
 4 more SIA staff in that they were more lucrative.
 5 ShowSec's 2017 accounts, which were signed by him,
 6 identified that the largest risk facing ShowSec was the
 7 potential impact of the shortage of SIA workers and that
 8 too few licence-holders could mean that ShowSec could
 9 maintain fewer contracts. The more likely explanation
 10 is that ShowSec knowingly and deliberately used
 11 unlicensed staff to conduct licensable activity for
 12 commercial gain."

13 What is really regrettable is that Mr Atkinson chose
 14 to make this serious allegation on the basis of
 15 a partial reading of the document upon which it relies.
 16 And to compound that error of judgement and the
 17 unfairness of the assertion, Mr Atkinson did not give
 18 Mr Harding any opportunity to deal with the point.

19 Turning then to the statement accompanying the 2017
 20 accounts, the entirety of what Mr Harding said, having
 21 identified that recruitment and retention of staff was
 22 one of the principal risks facing ShowSec, along with
 23 operational risk, competition and regulation and
 24 legislative impact was as follows, and I draw from the
 25 words in the accounts which were as follows:

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1 "Of these, the largest risk facing ShowSec is the
 2 potential impact of the shortage of SIA workers in the
 3 UK. ShowSec is working to help develop possible
 4 solutions to this problem in the interests of itself,
 5 the SIA and the Government. A reduction in the supply
 6 of licence-holders could lead to a significant increase
 7 in wages and a more measured approach by ShowSec
 8 regrading which contracts it can maintain, especially at
 9 times of peak demand."

10 The 2017 accounts then reveal how ShowSec chose to
 11 deal with the problem of the lack of SIA-qualified staff
 12 and the answer was, as it says, it trained them at its
 13 own expense.

14 After a further reference to the key risk of the
 15 potential shortage of SIA workers in the UK, the
 16 document at page 5 states:

17 "ShowSec is providing SIA training to increasing
 18 numbers of its own workers."

19 The document shows that in 2017, which was the first
 20 year ShowSec was able to provide its own SIA training,
 21 it trained 216 of its staff. At page 6 of the document,
 22 under the heading "Future developments", it reads and
 23 I quote:

24 "During 2018 ShowSec aims to continue upskilling its
 25 workforce through SIA training to address this

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1 significant issue of the potential shortage of SIA
 2 workers."

3 Mr Atkinson has also chosen to refer to later sets
 4 of accounts, his footnote 64, that are not in evidence
 5 in order to bolster the point. In fact, as will be
 6 apparent to anyone reading that document, these show
 7 that in 2018 it trained a further 259 members of its
 8 personnel and in 2019 a further 301. Thus, from
 9 a casual workforce of approximately 4,000, by the end of
 10 2019, ShowSec had provided SIA training to 776, a figure
 11 which does not include those who'd already been SIA
 12 trained by other providers. That is not the action or
 13 the response of a penny-pinching organisation. ShowSec
 14 had identified the problem prior to 2017 and gained
 15 authorisation to provide SIA training by 2017 and had
 16 continued to do so.

17 Those were serious allegations and again, as
 18 a matter of fairness, they should be roundly and
 19 explicitly rejected.

20 Further, Mr Atkinson's attack upon Mr Harding
 21 ignored the evidence of Mr Logan given in response to
 22 Mr Atkinson's own questions. We have provided the
 23 reference to the transcript on Day 39.

24 Having agreed it was better for ShowSec for more SIA
 25 staff to be employed within the limit of the numbers of

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1 SIA staff available, Mr Logan did not agree with the
 2 suggestion that the possible limit to the number of
 3 available SIA staff was always a factor, and we have set
 4 out his evidence on that issue where in terms he said
 5 and I quote from within paragraph 68:

6 "We in Manchester had a staffing pool of 744 staff
 7 of which 400 stewards and the remaining 344 were SIA,
 8 plus supervisors, plus management."

9 The question which was asked was this:

10 "So does it follow from that that whatever other
 11 explanation, there was for non-SIA staff at the arena
 12 doing SIA jobs, it wasn't because there was a shortage
 13 of SIA staff available?"

14 And Mr Logan's answer was:

15 "That's correct."

16 Mr Cooper on this issue of penny-pinching has
 17 claimed that the only reason for Agha's position at the
 18 grey doors was revenue protection.

19 In support of that contention he refers to
 20 a footnote in Miriam Stone's evidence from Day 30.
 21 However, the transcript, when read in full, as we have
 22 set out, reveals that Miriam Stone said precisely the
 23 opposite. Again, it was another allegation of revenue
 24 protection, penny-pinching, profit before safety,
 25 however one describes it, made without any evidential

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1 foundation and in fact against evidence which was
 2 precisely to the contrary.
 3 Finally, Mr Atkinson sought to argue that the
 4 evidence demonstrates that staffing cuts were made. The
 5 evidence demonstrates nothing of the sort. The
 6 documents cited by him are evidence of a discussion that
 7 was taking place between SMG and ShowSec as a result of
 8 the increase in the minimum wage. It is clear from
 9 those documents that reductions in personnel did not
 10 take place, although there were redeployments and
 11 efficiencies. Again, it is regrettable that Mr Atkinson
 12 asserts that a document states something that it does
 13 not. He wrote:
 14 "Mr Harding was asked directly, 'Were you aware of
 15 SMG at least investigating a reduction in staffing
 16 levels?', to which he replied no. That was untrue, he
 17 co-wrote the email with Sharkey, Setting a 4% target in
 18 reduction."
 19 In fact, the document he cites states this:
 20 "The starting point of this journey will be to
 21 consider how we deploy stewards and SIA personnel with
 22 a view in the short-term to reduce our hours by 4%, ie
 23 4 hours in a 100."
 24 It is abundantly clear that staffing levels were not
 25 to be cut but the way in which personnel were deployed

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1 was to be reviewed and the email continues:
 2 "The idea would be to take each role and timeline it
 3 across the evening to see where later starts and earlier
 4 finishes would be possible."
 5 And this was part of the process that led to the
 6 stewarding audit carried out by Mr Battersby. There are
 7 a number of recommendations for the more efficient
 8 deployment of staff at pages 4, 6 7 and 8 of that
 9 document, but there is no recommendation for personnel
 10 numbers to be cut.
 11 In short, ShowSec rejects any suggestion that it
 12 deliberately or otherwise compromised safety in the
 13 pursuit of profit. It is very easy to do damage, as has
 14 been done, by the use of the headline-grabbing language
 15 "Profit before safety" and the like, which we've heard
 16 again over the course of the last couple of days. What
 17 will not or may not be reported is the analysis in
 18 response, which shows that there is no basis for such
 19 allegations.
 20 I turn then to chapter 2, the adequacy of the risk
 21 assessment, the best way in which to assess risk, and
 22 the difficulties in this regard confronting a company in
 23 ShowSec's position in 2017.
 24 Whilst it was for SMG to assess the risk to those
 25 attending at the venue, in its opening statement and in

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1 its schedule of responses to the criticisms of the
 2 experts, ShowSec accepted in terms the inadequacy of its
 3 Manchester Arena risk assessment, {INQ001477/1}.
 4 Without in any sense seeking to detract from this
 5 concession, we suggest that the inquiry should be
 6 prepared to acknowledge the following. First, that
 7 there was little or no guidance available to a company
 8 in ShowSec's position as to how to compile a CT risk
 9 assessment. The author of the risk assessment,
 10 Mr Rigby, gave evidence that he had completed an IOSH
 11 course on the assessment of risk from a health and
 12 safety perspective, but this course did not include any
 13 CT element.
 14 (2), the information that was available to the
 15 industry was to be found in a variety of locations, not
 16 all of which were immediately obvious or accessible.
 17 (3), even now there is confusion as to the best way
 18 to construct a risk assessment and the issues to this
 19 day that remain unidentified or unresolved include
 20 whether the risk of a terrorist attack should fall to be
 21 addressed as part of a health and safety risk assessment
 22 or as a wholly distinct issue, to what extent if at all
 23 the threat level should feed into the assessment of
 24 risk, and how likelihood should be calculated if it is
 25 to be calculated at all.

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1 Can I turn to those three submissions and to us
 2 seeking to make them good. First, we have suggested
 3 there was little or no guidance available to a company
 4 in ShowSec's position as to how to compile a CT risk
 5 assessment and the point, I think, can be made shortly.
 6 None of the documents, whether from NaCTSO, CPNI or any
 7 other source that have been scrutinised in chapter 7
 8 have identified whether and to what extent the same risk
 9 assessment can or should encompass both
 10 terrorist-related and non-terrorist-related risks.
 11 Next, we've submitted that the information which was
 12 available to the industry was to be found in a variety
 13 of locations, not all of which were immediately obvious
 14 or accessible, and we have submitted that in 2017, on
 15 an analysis, there was no clear publicly available
 16 guidance as to how to construct a risk assessment that
 17 focused on terrorism.
 18 The Green and the Purple Guides refer to the
 19 guidance offered by NaCTSO and CPNI. None of the NaCTSO
 20 guidance documents provided that information, instead
 21 they refer to the CPNI document "Protecting Against
 22 Terrorism". This in itself is an example of the
 23 difficulties facing a company in ShowSec's position in
 24 2017 and it is something of a pattern.
 25 One document refers the reader to another, which, as

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1 can be seen, may itself refer the reader elsewhere. The
 2 CPNI document "Protecting Against Terrorism" poses the
 3 question in short: how likely is it that the business or
 4 its staff could be a direct target of a premeditated
 5 attack? To which the answer in a vast majority of cases
 6 is going to be, as you have said on more than one
 7 occasion, not very likely at all. And it later states:

8 "The risk assessment process involves making logical
 9 assumptions about the likelihood of a threat and its
 10 potential impact should current security measures fail
 11 to protect it."

12 Which is of course a reflection of the traditional
 13 health and safety approach.

14 The risks identified in this document range from
 15 a bomb in or near the main entrance, a suspect package
 16 received through the post, an employee using access to
 17 sell confidential information, the introduction of an IT
 18 virus, to petty theft. However, there is nothing about
 19 the six most common forms of attack, such as VBIED,
 20 MBIED and MTFA and so on. And the identification of
 21 impact includes not only injuries and fatalities but
 22 financial loss, impacts on productivity, reputation and
 23 client confidence.

24 The document purports to signpost further guidance
 25 on conducting risk assessments. Therefore to find the

1 information the starting point was a NaCTSO guidance
 2 document that then directs the reader to a CPNI document
 3 which in turn leads on to other CPNI documents. Those
 4 documents are in fact of limited relevance given that
 5 one is risk assessment for personal security, or
 6 personnel security, which focuses on the risks posed by
 7 employees and the second, operational requirements,
 8 contains a further reference to yet another CPNI
 9 document entitled "Principles of Risk Assessment", which
 10 itself requires a log-on and password to access and is
 11 therefore not publicly accessible.

12 As you will recall, Dr BaMaung and Colonel Latham
 13 referred extensively to PAS127, the "Checkpoint Security
 14 Screening of People and Their Belongings" guide, both
 15 in the context of risk assessments and search regimes.
 16 There is no doubt that this is an important document
 17 and, further, that neither SMG or ShowSec were aware of
 18 it notwithstanding the fact that it dates from 2014.
 19 Certainly there is no evidence of CTSA Ken Upham drawing
 20 SMG's attention to PAS127.

21 In terms of its content, it provides useful guidance
 22 on checkpoints and searches, but it also deals with how
 23 risk is to be assessed. DAC D'Orsi, as she was, gave
 24 evidence as to NaCTSO's aim to have all relevant
 25 information on a single IT platform, which ShowSec fully

1 supports.

2 PAS127 was not on either the NaCTSO or the CPNI
 3 websites and even its title does not necessarily suggest
 4 that it is CT specific it's an example of a document
 5 that would only be found if the searcher knew where to
 6 look but not otherwise.

7 In fact, PAS127 is not produced by NaCTSO or CPNI
 8 but by BSI, the British Standards Institution, which is
 9 not a body that is primarily focused on CT, and there
 10 are over 50,000 standards books and related publications
 11 in the BSI shop. Browsing by subject there's nothing
 12 specific to CT, although there are general categories of
 13 risk, security and health and assessment.

14 At the bottom of the first column at page 7 of
 15 PAS127, there is yet another example of being sent to
 16 the website of a different organisation, in this case
 17 the Institute of Risk Management where in order to
 18 access any publication one needs to be a member of the
 19 institute.

20 The third point we made, as you recall, is that even
 21 today confusion remains as to the best way to conduct
 22 a risk assessment. As to the assessment of risk,
 23 traditionally it's assessed by giving both likelihood
 24 and impact numerical values which are then multiplied.
 25 The Purple Guide refers to risk as the product of

1 probability and impact, in other words a mathematical
 2 calculation. In discussion during the evidence called
 3 in chapter 7, you, sir, have pointed out the inadequacy
 4 of this method when assessing the risk of terrorism
 5 because the likelihood of a terrorist attack occurring
 6 in any given location may be minimal, but should it take
 7 place, the impact may be enormous.

8 Colonel Latham's evidence, you may think on this
 9 point, was inconsistent. At times he spoke of material
 10 risk, which did not focus on the likelihood of an event
 11 occurring, and on a model of threat vulnerability
 12 impact. However, his initial answer to one of your
 13 enquiries referred to a mathematical computation of
 14 likelihood, and he said:

15 "Sir, one of the things I would expect to be
 16 considered would be likelihood and any risk assessment
 17 mechanisms look at likelihood and come up with
 18 a mathematical computation as to whether something was
 19 judged to be impossible, unlikely, highly, highly
 20 likely, or something similar on a sliding scale. Many
 21 risk assessments would make that sort of assessment."

22 Even PAS127 refers to the likelihood of a risk
 23 eventuating. It is suggested that organisations should
 24 pose the following question: how likely is this
 25 organisation operating at locations A, B and C to be

1 vulnerable to an attack or incident utilising threat
 2 items X, Y and Z and what would be the impact of
 3 a successful attack? This may not be a helpful way of
 4 looking at risk and you indicated that what might be an
 5 approach to be preferred was to consider material risk .
 6 In other parts of the document the question is posed
 7 somewhat differently:
 8 "Consider the likelihood of a successful attack and
 9 the likelihood of a successful attack should be
 10 considered from different threat scenarios explicitly
 11 taking into account existing security measures."
 12 The point which you will readily see -- if this
 13 document is to be helpful it should be clear and
 14 unambiguous. There is nothing in it that clearly and
 15 unambiguously states that the risks of terrorism should
 16 be assessed differently from other risks or sets out how
 17 likelihood should be measured.
 18 Colonel Latham was also to say that the risk
 19 assessment should be compiled by somebody with, and
 20 I quote:
 21 "The necessary knowledge and experience to conduct
 22 robust risk assessment and who can defend those risk
 23 assessments and, if that isn't the case, then the
 24 organisation should seek expert advice or should seek
 25 appropriate training to put them in a position where

1 they conduct an effective and robust risk assessment ".
 2 There are a number of difficulties with that view.
 3 It is not clear whether terrorism can or should fit
 4 within a standard risk assessment. No one has provided
 5 an example of a suitable risk assessment. There is no
 6 evidence of any available training on the topic of risk
 7 assessments in 2017, or where such training or advice
 8 would be found.
 9 So I turn then to ShowSec's position in respect of
 10 risk assessments by way of summary. It is accepted as
 11 a general statement of principle that a risk assessment
 12 cannot be a static document, it must be flexible enough
 13 to deal with new threats and/or changed circumstances.
 14 In practice, however, the threat level in 2017 had
 15 not changed since August 2014 and nor had the identified
 16 terrorist methodologies. ShowSec's response to the
 17 Bataclan and to the Stade de France attacks involved
 18 immediately contacting senior management to ensure they
 19 reviewed policies and procedures with their clients and
 20 updated its staff via a mailshot in which they were
 21 reminded of:
 22 "The importance of being vigilant at all times and
 23 making sure you listen to instructions given out in
 24 briefings is heightened in such circumstances. Please
 25 remember that the CT module on our e-learning platform

1 is always open if you wish to refresh the key points in
 2 it."
 3 Mr Atkinson has asserted that the evidence disclosed
 4 by ShowSec reveals that only 5.28% of the recipients
 5 clicked the link contained in this mailshot. In fact,
 6 as is obvious from the face of the document from which
 7 he drew that figure, the 5.28% refers to those who
 8 clicked on the link in the first 24 hours. Further,
 9 this figure does not include those who accessed material
 10 through ShowSec's e-learning portal.
 11 No evidence has been adduced to show where a company
 12 in ShowSec's position could have gone in 2017 in order
 13 to obtain the necessary expertise to construct a risk
 14 assessment that focused on the risk of terrorism or as
 15 to whether such expertise was even readily available
 16 in that year.
 17 You'll remember the evidence provided right towards
 18 the end of chapter 7 by the present chair of the UK
 19 Crowd Management Association. He said at paragraph 33
 20 of his statement:
 21 "Today there are a number of companies that offer
 22 specialist CT advice, but they are rare and were even
 23 more unusual in 2017."
 24 The information available referred, sometimes in the
 25 same document, the likelihood both in terms of the

1 likelihood of an attack occurring and the likelihood of
 2 a successful attack given current security measures. In
 3 short, as we have submitted, the available guidance
 4 lacked both clarity and consistency. And again, it was
 5 Mr Weatherby, who you may think neatly summarised the
 6 position at paragraph 13 in his team's document, where
 7 he wrote:
 8 "However helpful, the publicly available NaCTSO and
 9 CTSA service was inadequate for the challenges provided
 10 by the arena."
 11 Notwithstanding the criticisms advanced by some of
 12 the families' counsel on Monday that ShowSec had not
 13 sought specialist advice since the bombing, Mr Harding
 14 has actually set out very clearly the steps that ShowSec
 15 have taken.
 16 Can I set those out at this point. In terms of
 17 training, ShowSec has secured places for its senior
 18 management on a CT risk management course at the
 19 University of Cumbria and has commissioned further CT
 20 risk management courses for its area managers and
 21 operational executives. These courses are all delivered
 22 by Storm 4 Events Limited, a company consisting of
 23 former CT SECOs. Storm has also undertaken a review of
 24 ShowSec's CT risk assessment process and further
 25 enhancements to the risk assessment process are set out

1 in Mark Harding's statement.
 2 We have submitted that the flaws in the risk
 3 assessment were not causative and neither should the
 4 risk assessment be looked at in isolation .
 5 Consideration, we know, will be given by you to the
 6 other documentation, such as the CT awareness document
 7 produced in response to the attacks in France, which
 8 Tom Rigby said were intended to, and I quote, "dovetail
 9 into the other risk assessment". And in particular, the
 10 training and briefings given to the staff along with the
 11 evidence of the security experts, as set out in the
 12 final report, that staff had been appropriately trained
 13 to identify and report suspicious activity .
 14 Finally, there is no evidence that ShowSec's risk
 15 assessment influenced SMG's choice of either control
 16 measures or staffing numbers. Indeed, as we know, these
 17 were not shared between the two companies and, as
 18 Mr Atkinson has said, responsibility lay with SMG.
 19 I come then to chapter 3, the searching of those
 20 attending events at the arena. ShowSec has accepted
 21 that bag checks at ingress, a licensable activity , were
 22 being carried out by non-SIA-licensed staff. Whether
 23 there were insufficient SIA-licensed staff to carry out
 24 this activity will be for SMG to address.
 25 Mr Atkinson in his oral submissions gave the

1 impression that this was a concession only recently
 2 made. He used the phrase "it is now accepted". That is
 3 simply wrong. It was accepted publicly at the outset of
 4 these hearings and it was the company itself which
 5 produced the correspondence to show how its error had
 6 come about.
 7 It is, however, clear, notwithstanding the shortfall
 8 in terms of ShowSec's approach in this regard, that that
 9 failing was not causative of the attack. Abedi made no
 10 attempt to enter the arena at ingress or at all , and
 11 during his reconnaissance he had been present at ingress
 12 on 18 May, and he of course would not have appreciated
 13 the difference between licensable and non-licensable
 14 activity . It may be argued that he plainly had been
 15 deterred after his hostile reconnaissance on that date
 16 from attempting entry.
 17 Just other points emerging, please, from this issue .
 18 At paragraph 1.29 of his closing submission, Mr Cooper
 19 wrote this:
 20 "The principal purpose of the check was to determine
 21 whether the individual possessed food or drink that had
 22 not been purchased at the venue. It should be
 23 emphasised that the issue relating to bag searches is
 24 very relevant to the approach and attitude of
 25 SMG/ShowSec to their security responsibilities."

1 ShowSec does not accept that the evidence
 2 in relation to the search procedures is somehow
 3 indicative of a lax attitude to safety . This is also to
 4 ignore the clear evidence of Mr Middleton. He said on
 5 Day 19:
 6 "Not only revenue protection, it was also a safety
 7 aspect. Have they got a big glass bottle in the bag
 8 that could cause damage? Yes, it was to identify food
 9 and beverage but not purely as revenue, more a safety
 10 measure."
 11 And he repeated much the same point in a further
 12 exchange later that day.
 13 Nor was it an inflexible policy. Mr Middleton also
 14 gave evidence that staff would not confiscate drinks
 15 from small children and they would also allow the
 16 elderly to decant water from water bottles into a safer
 17 container.
 18 Chapter 4, the patrolling or searching of the
 19 mezzanine floor and the nature and adequacy of the
 20 pre-egress checks. ShowSec does not accept, as you
 21 understand, sir, that at any stage it had agreed to
 22 provide or had been instructed to provide the patrols
 23 that SMG Europe had contracted to provide pursuant to
 24 the FM agreement. Neither the contract nor the evidence
 25 could possibly justify such a conclusion.

1 In his written submissions at paragraph 1.19, and he
 2 repeated this point late on Monday afternoon, Mr Cooper
 3 said this:
 4 "SMG were contractually required to undertake
 5 regular foot patrols of the arena complex on a 24-hour
 6 basis."
 7 And then this:
 8 "And ShowSec, as SMG's agent, had also been
 9 signatories to the agreement establishing that
 10 obligation."
 11 The footnote, footnote 22, that purports to evidence
 12 this proposition refers to {INQ001420/1}, which is one
 13 of four versions of the FM agreement, all of the same
 14 date, disclosed to the inquiry. They're each the same.
 15 It is that version which Mr Cooper argues has made
 16 ShowSec a signatory to the FM agreement and an agent.
 17 Mr O'Connor made the point late yesterday morning
 18 that what Mr Cooper appears to have done, because this
 19 was not a matter ever explored with Mr Harding, was to
 20 seize upon a single one of what are in fact four
 21 versions of the same document, and he has focused on the
 22 version which, as Mr O'Connor explained, was mistakenly
 23 disclosed by SMG with the back-end of the stewarding
 24 service agreement to it. That second document does,
 25 of course, as we all know, have Mr Harding's signature

1 upon it.
 2 In fact, had Mr Cooper or his team looked at any of
 3 the other three versions of that same FM agreement,
 4 including the one reissued by SMG to correct the error,
 5 Mr Cooper would have seen ShowSec was not a party or
 6 a signatory to the FM agreement. Indeed, nowhere in the
 7 evidence has it ever been suggested that ShowSec had
 8 been a party to that agreement, which was of course
 9 between the two SMG entities.

10 Within this speaking note at paragraphs 110 to 113
 11 we have provided the references to each of the four
 12 versions of the same documents, along with the analysis,
 13 so all will be able to see the mistake Mr Cooper has
 14 said.

15 I will travel on, if I may, in your document,
 16 please, to paragraph 114, please, next.

17 We will deal with the question of Deister patrols
 18 separately, but in terms of ShowSec’s contractual
 19 obligation, it is clear beyond any doubt that it had not
 20 contracted to undertake SMG’s obligations under the FM
 21 agreement on either event or non-event days.

22 That is not, I’m afraid, an end to the errors which
 23 emerge from Mr Cooper’s document on the responsibility
 24 for patrols. Because at his paragraph 1.21, he stated:
 25 "SMG executives have stated that it was their

1 expectation that ShowSec would discharge responsibility
 2 for Deister patrols on their behalf during the hours of
 3 an arena event."

4 It is inaccurate to say that SMG executives expected
 5 ShowSec to perform Deister patrols. The only person who
 6 did so was the witness Mr Cowley, whose evidence on this
 7 topic was met with evident scepticism by both ILT and
 8 yourself. And from the transcript of the evidence on
 9 Day 26, we have set out the exchanges, both between you
 10 and your team with Mr Cowley on that issue to make good
 11 that point. And when others have seen the speaking note
 12 later today, they will be able to check that again
 13 Mr Cooper was in error.

14 There’s another serious inaccuracy at paragraph 1.24
 15 of Mr Cooper’s submissions, a point repeated forcefully
 16 to you in his oral submissions on Monday afternoon. He
 17 said this:

18 "It was of note to the families, both that Mr Beak’s
 19 view of his pre-egress and mezzanine responsibilities
 20 seemed to be in accordance with the working practices of
 21 other long-standing and senior colleagues although [and
 22 these are the important words] in seemingly flat
 23 contradiction with documentation setting out the scope
 24 of CT mitigations ShowSec had agreed to provide at the
 25 arena."

1 A more careful analysis and reading of the document
 2 shows that to be another bad point. In fact, the
 3 passage quoted at footnote 40, {INQ012031/7}, which
 4 comes from ShowSec’s CT awareness document for the
 5 Manchester Arena does not contradict Mr Beak. Again,
 6 for your purposes, and so of course others can check,
 7 we have set out in the speaking note those four
 8 paragraphs, which I will not take time to read. Instead
 9 I will go on to paragraph 119 to make the point.

10 It is clear that the first three paragraphs from the
 11 CT document cited by Mr Cooper, read as a whole, refer
 12 to ShowSec staff patrolling inside the arena, and
 13 that is confirmed by the terms of the fourth paragraph,
 14 which reads as follows:

15 "Access Control teams positioned on each door can
 16 also be deployed outside the immediate vicinity of the
 17 venue to investigate areas on the approach to the
 18 venue."

19 And the final six words plainly do not include the
 20 mezzanine, which is not an approach to the arena.

21 Having taken a little time to correct the errors and
 22 the inaccuracies to be found in Mr Cooper’s document, in
 23 respect of patrols can we address, albeit briefly, what
 24 we accept to be a more important issue, namely the
 25 extent to which ShowSec staff checked the mezzanine

1 level pre-egress.

2 The evidence reveals a clear difference between the
 3 two companies as to the extent of ShowSec’s
 4 responsibility for checking the mezzanine level
 5 pre-egress. ShowSec staff correctly did not regard the
 6 mezzanine as an egress route because it affords no means
 7 of exit from the City Room at that level.

8 Whatever assumptions SMG had made, there is no
 9 evidence in fact other than the pre-egress sheet itself
 10 that SMG ever directed ShowSec to patrol the mezzanine,
 11 no SMG witness spoke of giving that as an instruction.
 12 Further, Colonel Latham was of the opinion that SMG had
 13 a responsibility to ensure that the work they expected
 14 to be done was in fact being carried out and, in answer
 15 to a question from you, sir, said that he would not have
 16 expected SMG to be ignorant of the fact that for
 17 a considerable period of time ShowSec staff were simply
 18 checking from the bottom of the stairs.

19 There was, we would suggest, plainly a breakdown in
 20 communication between the two companies, but it is
 21 grossly to exaggerate and to distort, as Mr Cooper has
 22 said, that this issue was, and I quote:

23 "... symptomatic of a relationship between SMG and
 24 ShowSec which was more dysfunctional than either are
 25 prepared to acknowledge."

1 Such an assertion, we suggest, again cuts right
 2 across the evidence, which during the hearing was not
 3 the subject of challenge. Whatever the criticisms to be
 4 made of either SMG or ShowSec, it is clear that the two
 5 companies sought to and did work closely together and
 6 they were plainly working hard to deliver a common
 7 objective that eventgoers should both enjoy themselves
 8 and be safe when they were attending events at the
 9 arena.

10 In terms of a causative failing, even if ShowSec
 11 staff had understood that SMG required the mezzanine
 12 floor to be inspected pre-egress, the visit to that
 13 level would not have taken place until at some point
 14 between 10 and 10.15, by that time of course Abedi was
 15 in place and the numbers waiting to collect concertgoers
 16 had already grown. The terrible reality is, you may
 17 feel, even if confronted by ShowSec staff, Abedi would
 18 still have detonated the device and the loss of life
 19 would certainly or very likely have followed.

20 Chapter 5 is training, the training of ShowSec
 21 staff, how the training model compares both with 2017
 22 and contemporary standards, and then briefings and the
 23 experience.

24 Training. The company's position in respect to
 25 training can be made shortly. ShowSec does not accept

1 that its training, developed through Derby University,
 2 was inadequate when considered in the round and
 3 certainly not by 2017 standards.

4 During the course of chapter 7 the company adduced
 5 evidence, unchallenged evidence, as to the significant
 6 time and money that ShowSec had invested in training.
 7 From the witness box, Mr Harding, an individual of
 8 considerable experience in this field, said he was not
 9 aware of any other company in the industry that offers
 10 and can provide the level of training that ShowSec does
 11 or commits the same level of resources to that training.

12 The training records for the full-time staff at work
 13 on 22 May demonstrate the depth of training achieved by
 14 such permanent members as Perry, Bailey and Rigby.
 15 In addition to the compulsory modules it can be seen
 16 that they undertook courses in drug awareness, enhanced
 17 searching, working in the football industry, business
 18 conduct and ethics, IOSH management safety, traffic
 19 management, data governance and privacy training. This
 20 is true of more of its casual staff as well.

21 Mr Middleton had completed courses such as
 22 understanding disability and discrimination, working in
 23 the backstage area of an event, working in a festival
 24 environment, drug awareness, and enhanced searching.
 25 And even Mr Lawler had completed courses on working in

1 front of stage pit barriers, working in an incident
 2 response team and traffic management.

3 What did arise during the course of the chapter 7
 4 evidence, but it arose as a result of the disclosure the
 5 company made, was the issue whether ShowSec had the
 6 capacity to monitor whether staff seeking work with the
 7 company had completed appropriately the compulsory
 8 training it required of applicants.

9 Before Mr Agha's evidence, Mr Harding had not
 10 understood that its university—provided software package
 11 had that capability. It was in order to check Mr Agha's
 12 evidence that he'd not spent the time he ought to have
 13 done on the CT module that Mr Harding sought help from
 14 the service provider as to whether it was possible by
 15 interrogating the system to say how much time an
 16 individual had spent completing the various relevant
 17 modules.

18 Mr Agha's ability to defeat ShowSec's clear efforts
 19 to ensure its workforce were properly trained, if
 20 that is what the records show, was then rather seized
 21 upon by a number of the parties to the inquiry and
 22 indeed the experts. Mr Cooper, at his paragraph 1.49,
 23 asserted it must have been obvious that there was a risk
 24 that young, minimum-wage employees asked to undertake
 25 substantial training may take shortcuts.

1 It was not so obvious. Until Mr Harding's work,
 2 that point had not occurred to either Dr BaMaung or
 3 Colonel Latham, and it does not figure in any version of
 4 their reports. Neither was it an issue that had struck
 5 any CP. And there was plainly, we would suggest, an
 6 element of opportunism displayed by some involved in
 7 this inquiry.

8 Two points fall to be made. First, the evidence
 9 shows the need for caution in interpreting the data,
 10 which has had to be recreated to show what may have been
 11 available at any given point in time and reveals only
 12 the time spent on the last occasion a staff member
 13 accessed the material, and it was for those reasons that
 14 Mr de la Poer, when discussing the issue with
 15 Mr Harding, urged caution.

16 Secondly, sir, you will remember the difficulty that
 17 Colonel Latham experienced in answering the question how
 18 it was he assured himself that his staff, whether
 19 subcontracted or sub-subcontracted staff, at the O2 were
 20 sufficiently trained. And in short, he relied on the
 21 contractors and his monitoring of their performance to
 22 ensure that the workforce had been appropriately
 23 trained.

24 In reality, even leaders in this area of the
 25 training of its workforce, as ShowSec plainly are, had

1 not in 2017, in common with Colonel Latham, recognised
2 that it might be possible to monitor compliance with
3 online training expectation.

4 As for training delivered by way of online courses,
5 there can in truth and in reality be no sensible
6 criticism made of ShowSec given that is how training
7 across the whole host of disciplines is taught. Indeed,
8 I would venture to suggest it is mainly by online
9 courses that training anywhere is now taught, certainly
10 in the early stages. In particular, the present
11 ACT Awareness course, which has replaced Griffin, is
12 only available online.

13 Mr Harding, during the course of his evidence, has
14 also set out the compelling reasons, which include the
15 geographical spread of ShowSec's work, its part-time and
16 seasonal nature and the like, why it is not open to
17 ShowSec to offer extensive classroom training to those
18 applying for stewarding positions.

19 The criticism that potential recruits were not paid
20 for their training was also seized upon. That was
21 unfair and unjustified. It ought to have been tempered
22 by an acknowledgement for the reasons explained by
23 Mr Harding that it's reflective of the practice across
24 the industry, as Colonel Latham accepted.

25 In terms of refresher training, ShowSec encouraged

1 its staff to visit its e-learning platform, again for
2 the reasons Mr Harding has set out: the casual,
3 part-time and widely spread nature of the workforce.
4 It is simply not practicable to make classroom-based
5 refresher training mandatory.

6 Counter-terrorism is also but one of a number of
7 topics when regard is had to the sheer variety of events
8 at which this company provides CM services that could be
9 the focus of refresher training along with topics such
10 as ingress and egress, fire safety or emerging risks,
11 topics every bit as important to the safety and
12 management of large crowds at a venue such as the arena.

13 ShowSec's solution and their way of addressing that
14 issue involved inviting staff to visit the online
15 platform, to read updates by way of carrying out
16 thorough and detailed briefings at every event, a topic
17 to which we will come.

18 In order to meet what we argue to be the misplaced
19 criticism of the security experts to be found in the
20 various iterations of their reports that ShowSec fell
21 short in the standards of training it offered to its
22 workforce, the inquiry will recall that Mr Harding has
23 set out at some length how the CT element of the
24 training provided by ShowSec in 2017 compared with the
25 SIA door supervision training provided by Highfield, the

1 NVQ that is taken by those who wish to work as stewards
2 at sports grounds, and the current ACT programme.

3 The detailed analysis of both the training and the
4 guidance that was and is available to companies such as
5 ShowSec is to be found at appendix B of our closing
6 submissions, paragraphs 114 to 147, and I will not
7 obviously take time to repeat the entirety of that
8 exercise now.

9 Instead, and confident that you, sir, will either
10 have completed your ACT training and you will remember
11 it, or you will remind yourself of it before the first
12 report is issued, what might be a more profitable
13 exercise on this issue will be to compare the ACT
14 content along with that which NaCTSO had made publicly
15 available at the time of the attack against that which
16 ShowSec was offering its staff by way of a CT induction
17 module back in 2017.

18 I say that because nobody has sought to criticise
19 the quality of the ACT course, the production of which
20 has been universally praised by Dr BaMaung and
21 Colonel Latham, and which has been held up as something
22 of a template for what might have been made available.

23 We remind ourselves, of course, that the glossy ACT
24 presentation, which was produced some years later and
25 after the attack, benefits from the resources of the

1 Home Office and is a course which all of us are to
2 undertake.

3 Mr Atkinson, at page 46 of his written submissions,
4 paragraph 109, had this to say about the ACT training:

5 "The evidence also demonstrated that ACT training is
6 widely considered to be the best CT training available.
7 It is in-person, interactive and the understanding of
8 the attendees can be tested."

9 Two pieces of NaCTSO training have featured heavily
10 in the evidence. The guide for bars, pubs and
11 nightclubs and the guide for arenas and stadia. The
12 arena guidance contains the following:

13 "It is accepted there is no concept of absolute
14 safety or absolute security in combating the threat of
15 terrorism. It is possible through the use of the
16 guidance to reduce the risk to as low as reasonably
17 possible."

18 A little later:

19 "Hillsborough taught us a critical lesson: safety
20 must always have priority over security. Remember
21 terrorism is a crime. Many of the security precautions
22 typically used to deter criminals are also effective
23 against terrorists."

24 Both documents stress the importance of vigilance
25 and reporting. They say in terms:

1 "The vigilance of your staff is essential to your
 2 protective measures. Staff must have confidence to
 3 report suspicions, knowing that reports, even false
 4 reports, are taken seriously."
 5 Training is stated to be particularly important.
 6 In the bars and clubs guidance, the role of door
 7 supervisors, which in the context of the arena staff
 8 means SIA—licensed staff, is set out. Again the
 9 touchstone is vigilance and upward reporting.
 10 Both the bar and clubs and the arena and stadia
 11 guidance contain more written material on the issue of
 12 hostile reconnaissance than appears in ShowSec's CT
 13 module. However, ShowSec's module covered all the same
 14 material by embedding links to both Operation Fairway
 15 and Eyes Wide Open.
 16 In light of the criticisms voiced by Dr BaMaung and
 17 Colonel Latham about the amount of space given to CBR
 18 attacks in ShowSec's training, it is worth considering
 19 the emphasis given to those various different methods of
 20 attack in the NaCTSO guidance because PBIED or suicide
 21 attacks are given just a single page in each document.
 22 By way of contrast, CBR takes up three or four pages
 23 in the guidance. Similarly, information security also
 24 takes up four times as much space as PBIEDs. It is
 25 notable that in dealing with that form of attack, the

1 first three bullet points deal with vehicles and
 2 preventing vehicle access.
 3 The page which was transposed into ShowSec's CT
 4 module concludes with the words:
 5 "There is no definitive physical profile for
 6 a suicide bomber so remain vigilant and report anyone
 7 suspicious of the police."
 8 It is interesting to note the observations of
 9 Mr Weatherby at paragraph 13 in his team's written
 10 documents. After making the point that SMG and ShowSec
 11 did not have dedicated CT expertise in—house, he says
 12 in the next sentence:
 13 "However helpful, the publicly available NaCTSO
 14 material and CTSA service was substantially inadequate
 15 for the challenges presented by the arena, which posed
 16 an attractive and vulnerable target for extremists such
 17 as IS."
 18 As for the NaCTSO training provided by way of
 19 Griffin and Argus, ShowSec's more senior staff on the
 20 ground with supervisory roles did attend for Griffin, in
 21 some cases on more than one occasion. Casual staff did
 22 not attend for Griffin training. The level of detail
 23 in that presentation was a good deal more than that
 24 required for somebody performing a steward function.
 25 Contrary to the point made by Mr Atkinson at

1 paragraph 56 of his written submissions that only 13 of
 2 its staff at work at the arena were Griffin trained,
 3 that, as I've said, was deemed more appropriate only for
 4 its senior staff.
 5 In any event, Mr Harding has said that in
 6 December 2016, when the ability to do so was made
 7 available to the company, ShowSec has begun delivering
 8 that training shortly before the attack. Although Argus
 9 training dealt with issues such as hostile
 10 reconnaissance, the main focus of that training was what
 11 to do in the event of an attack taking place.
 12 At paragraph 7 of his written closing submissions
 13 Mr Weatherby was critical of ShowSec's failure to learn
 14 the lessons of Operation Sherman. He has presumably
 15 mistakenly overlooked the fact that the police, on this
 16 occasion in the shape of GMP, failed to invite ShowSec
 17 personnel to that exercise, and again the focus of that
 18 presentation was how to respond to an attack that
 19 already had occurred.
 20 Next to the ACT Awareness course which, as I have
 21 said, post—dates the attack at the arena. There are
 22 currently two types of ACT training: one to be taken by
 23 the individual on their own and another to be taken
 24 through an organisation or a company. At the conclusion
 25 of the course, the participant can download

1 a certificate to prove they have completed it.
 2 In general terms, we submit there is little
 3 difference between ShowSec's CT e—module and the ACT
 4 course, although, as I accept, the ACT production is
 5 more professional in terms of its presentation.
 6 And then in the next few paragraphs, if you just
 7 would be good enough to glance through them, we look at
 8 the various modules in ACT, making the point that it's
 9 a pretty straightforward presentation with quite simple
 10 questions being asked, which then permit the participant
 11 to move to the next stage.
 12 Can I take you to paragraph 151, please, because
 13 there is this point to be made. At the time of the
 14 bombing in Manchester, both the NaCTSO guidance on pubs
 15 and clubs and on arenas and stadia were out of date,
 16 referring as they did to "See, tell and act". In
 17 contrast, in fact, ShowSec's CT module dealt with "Run,
 18 hide and tell". And it was not until after the attack
 19 that NaCTSO's crowded places guidance, which came in in
 20 June 2017, referred also to the up—to—date guidance of
 21 RHT.
 22 It is also notable, and we make the point at 153,
 23 in the version of the ACT course that the individual
 24 takes, there is no mention of PBIED attacks. This is
 25 not a criticism, I hasten to add, we launch against

1 NaCTSO. It simply demonstrates there may be more than
 2 one way of presenting and explaining important
 3 information to a general audience. But it also
 4 illustrates in the event of some future attack it'll be
 5 possible to unpick the ACT Awareness training for flaws
 6 and for missing material, as Dr BaMaung and
 7 Colonel Latham have sought to do in preparation of their
 8 work on behalf of the inquiry. Whether that would be or
 9 is fair and balanced is another matter.

10 The submission that ShowSec makes when regard is had
 11 to the entirety of the analysis which appears at the
 12 second of our appendices in our written document,
 13 paragraphs 114 to 147, is that its training was at least
 14 equivalent to the nationally available guidance and
 15 material and in some respects it was superior to it.
 16 The limited references to CT in the Green and
 17 Purple Guides, the NVQ qualification, the SIA training,
 18 reflect the fact that CT is but part of what the target
 19 audience of these courses needed to know. CT, by
 20 contrast, formed a significant portion of ShowSec's
 21 mandatory training.

22 We recognise, of course, that any training can be
 23 improved and we have sought to do so, for example, by
 24 providing more written information in relation to
 25 hostile reconnaissance. That is not to say that the

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1 training was inadequate in 2017 and there is certainly
 2 no evidence it fell below contemporary standards.

3 In short, we argue that its CT module extracted
 4 pertinent material from the publicly available guidance
 5 and made it accessible and relevant to its staff.

6 Some of the criticisms, for example with regards to
 7 layout, are little more than nitpicking or criticism for
 8 criticism's sake; others are inconsistent. ShowSec is
 9 criticised on the one hand for providing too much, but
 10 then, on the other, for not including text on the topic
 11 of hostile reconnaissance in addition to the Fairway and
 12 Eyes Wide Open videos. More importantly, Dr BaMaung was
 13 unable to identify where ShowSec could have gone in 2017
 14 to obtain the necessary expertise.

15 Can I just complete this chapter and then I'll pause
 16 if I may for lunch?

17 Further, the fact that staff were expected to
 18 complete training unpaid, another point seized upon,
 19 before their first shift was not out of kilter with
 20 industry practice. Although Colonel Latham made
 21 suggestions as to how the quality of training could be
 22 assured, it was clear from his answers later that whilst
 23 he trusted his contractor to provide appropriately
 24 trained staff, he was in no position to check himself
 25 the extent to which the subcontracted staff or indeed

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1 the sub-subcontracted staff had been trained and nor did
 2 that workforce necessarily complete any venue-specific
 3 training before their first shift.

4 Dr BaMaung agreed that the two things he would hope
 5 a workforce such as ShowSec's had been taught were
 6 vigilance and reporting. He agreed it would be unfair
 7 to judge ShowSec without reference to contemporary
 8 standards, although he had no evidence as to what those
 9 standards might have been. And you'll recall that
 10 he was taken to the module, ShowSec's CT module, during
 11 his cross-examination.

12 Colonel Latham also accepted that ShowSec required
 13 SIA licence-holders who wished to work for them both to
 14 undergo the CT module and venue familiarisation. We
 15 submit neither should ShowSec's CT training be seen in
 16 isolation: the requirement to be vigilant and to report
 17 upward was stressed throughout its training.

18 Mr Harding has identified a number of areas where
 19 ShowSec staff were encouraged to be vigilant and to
 20 report upwards in the non-terrorist context, which
 21 included reporting accidents, issues at ingress or
 22 crowd-related issues generally, gas leaks and the like.
 23 In short, as we submit, vigilance and reporting were
 24 part of ShowSec's culture.

25 Shall I stop there, sir?

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1 SIR JOHN SAUNDERS: Yes.

2 MR LAIDLAW: Mr Greaney, do I have about half an hour or
 3 35 minutes left?

4 MR GREANEY: That's my calculation as well, about
 5 35 minutes.

6 MR LAIDLAW: Thank you.

7 SIR JOHN SAUNDERS: Before we break, can I just raise two
 8 points with you? The first is simply a question of
 9 fact, which I am doing this from memory so I may well
 10 have got it wrong, so please forgive me if I have. You
 11 said that the Griffin training was designed for more
 12 senior staff. I actually thought the evidence was that
 13 it was designed for all staff and it was the Argus
 14 training that was for senior staff. Perhaps you could
 15 check that.

16 MR LAIDLAW: Certainly.

17 SIR JOHN SAUNDERS: Thank you. The second matter is
 18 something on which I would invite you to make
 19 submissions if you wish. This is not said in any sense
 20 to make life difficult and it may be you're coming to it
 21 later and I haven't noted it, but it is said to give you
 22 the opportunity to deal with it.

23 It's in relation to the SIA training of the people
 24 doing the bag checks. I understand perfectly the point
 25 you're making about Mr Atkinson's points. I also

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1 completely take on board your submissions and arguments
 2 that it was not causative of anything which happened.
 3 But we did hear evidence, and again this is from memory,
 4 so if I've got this inaccurate in any way you'll forgive
 5 me, that as from 2013 ShowSec knew, because they had
 6 been told by the SIA, that bag checks should be done by
 7 SIA staff. There was also evidence from Miriam Stone
 8 that she made an enquiry of ShowSec as to whether there
 9 should have been SIA staff and got no response. It
 10 follows that from 2013 to 2017, ShowSec continued to
 11 employ people on bag checks who they should have known
 12 at that stage shouldn't have been doing it, so there
 13 were a number of people involved in that conversation
 14 who knew that.

15 An inference that could be drawn is that they knew
 16 perfectly well what they should be doing and they simply
 17 carried on regardless. I give you the opportunity of
 18 dealing with that if you wish to but it is entirely up
 19 to you.

20 MR LAIDLAW: Of course. My team will check, of course. My
 21 sense is that, as always, your recollection is sound.
 22 That is a perfectly fair --

23 SIR JOHN SAUNDERS: I won't remark on that!

24 MR LAIDLAW: Well, you have almost without exception had an
 25 extremely good memory about the evidence. I also think

1 you're right about the evidence, so it's a problem which
 2 had persisted from 2013 to 2017. As far as the
 3 inference, which is plainly for you to consider, I would
 4 caution you against that in this sense, not that it's an
 5 excuse, but that recognition existed at a senior level
 6 and I think the explanation, which was either given or
 7 was attempted to be given, was: what ShowSec had failed
 8 to do, and they had plainly failed to do this, was to
 9 make sure that people knew how that issue had been
 10 resolved on the ground at Manchester.

11 SIR JOHN SAUNDERS: Right. Okay.

12 MR LAIDLAW: Sir, I think you're right, but my team will
 13 obviously check and I will tell you if we are wrong in
 14 our recollection but my sense is that you are right.

15 We'll check about the Griffin training, whether
 16 I got it the wrong way round.

17 SIR JOHN SAUNDERS: Right. And follow up in writing if it's
 18 more convenient, whichever way you wish. It's simply to
 19 give you the opportunity.

20 MR LAIDLAW: We'll try and give you an answer so there's an
 21 end to countless further submissions. Thank you.

22 SIR JOHN SAUNDERS: Mr Greaney?

23 MR GREANEY: Just before we rise, if that's the right way of
 24 putting it, and as a matter of courtesy to other counsel
 25 who are waiting to make their submissions, can we

1 indicate that if Mr Laidlaw is not much longer than his
 2 35 minutes, we do think there will be sufficient time
 3 for you to hear the submissions of each of the four
 4 remaining core participants this afternoon.

5 SIR JOHN SAUNDERS: Okay. Thank you very much. We'll have
 6 an hour's break, so 2.05.
 7 (1.06 pm)

8 (The lunch adjournment)

9 (2.05 pm)

10 SIR JOHN SAUNDERS: Mr Laidlaw.

11 MR LAIDLAW: Can I just deal with those three points, just
 12 before we broke. The case in the Supreme Court is
 13 Maughan [2020], 3 Weekly Law Reports, 1298. That
 14 involved the Supreme Court following Lord Nicholls in H,
 15 in other words saying that the civil standard of proof
 16 did not involve a sliding scale but for serious
 17 allegations cogent evidence was required. Sir, I think
 18 that was the case you had in mind.

19 SIR JOHN SAUNDERS: Yes, probably, thank you.

20 MR LAIDLAW: As far as the position about checking or
 21 searching of bags, these are the 2013 emails produced by
 22 Mr Harding, the reference is {INQ035987/45-49}. If
 23 I just deal very briefly with the chronology, there was
 24 one thing that both you and I overlooked. Miriam Stone
 25 had made the enquiry on 15 July 2013. There were some

1 (inaudible: distorted) backwards and forwards internally
 2 at ShowSec, then on 26 July ShowSec were told by the SIA
 3 that it was a licensable activity in an email which was
 4 copied to Mr Harding and Mr Logan.

5 Malcolm Wise from ShowSec said he would get the SIA
 6 legal team to write a letter, presumably consistent with
 7 the advice that he had received, and that they would
 8 pass it on to the client, SMG, so there was plainly an
 9 intention that ShowSec would tell SMG. That was chased
 10 by Mr Harding in October of 2013, and there it appears
 11 to have laid, no doubt overlooked, at a management level
 12 with all the other things that the management team would
 13 have been concerned with.

14 I ought just to say this, that the disclosure of
 15 2013 material by Mr Harding would, I think, on any view,
 16 in proportionate terms, fall outside that which would
 17 normally be searched for or looked at, and his bringing
 18 that forward, as he did in his witness statement, in our
 19 submission is further testament to the openness that
 20 ShowSec have demonstrated to your inquiry and more
 21 particularly to Mr Harding's integrity and to his
 22 honesty.

23 As far as Griffin is concerned, you are right,
 24 I need to retreat and to identify an error I have made.
 25 Lucy D'Orsi's statement -- and the reference is

1 {INQ025466/20}, paragraph 74 — states that Griffin is
 2 both for supervisors and front line staff, so your
 3 recollection was sound.
 4 Mr Bailey, you may remember, had said that it was
 5 elements of Griffin which had informed the CT awareness
 6 document that he produced, so I'm in error, I need to
 7 apologise and I need to modify the submission that
 8 I have made to you.
 9 SIR JOHN SAUNDERS: There is no apology necessary. I'm
 10 grateful for you and your team doing the work you have
 11 obviously done over lunchtime. Thank you for that.
 12 MR LAIDLAW: Sir, in your document and the document which we
 13 made available to everybody else a little bit later,
 14 we're at paragraph 160, so it's back to training and,
 15 in that context, briefings and the experience of ShowSec
 16 staff.
 17 At paragraph 1.28 of his submission, Mr Cooper
 18 turned to stewards, and within that quote that we have
 19 set out in your document he said this:
 20 "The stewards' role was to meet and greet customers,
 21 scan tickets and direct customers to their seats. They
 22 were not expected nor trained to profile the crowd nor
 23 to seek to identify suspicious behaviour."
 24 Two points fall to be made. First, we provided
 25 a detailed analysis of what stewards were expected to do

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1 in our written submissions — that's paragraphs 59 to
 2 69, 71, 74 to 79 — namely to look out for suspicious
 3 behaviour and to report it. So there's a clear body of
 4 evidence which is undermining of the point Mr Cooper was
 5 seeking to make.
 6 Secondly — and you made this point, sir, on
 7 a number of occasions — stewards, by law, are
 8 prohibited from profiling because that's a designated
 9 activity and therefore licensable conduct under the 2001
 10 Act.
 11 So when Mr Cooper says, as he did at paragraph 1.33,
 12 that:
 13 "Mr Atkinson understood his role as being focused on
 14 customer service."
 15 That is in fact an accurate reflection of what the
 16 role was. And whilst there may be an issue as to how
 17 effective or workable the licensing or licensable system
 18 is, those are not issues for ShowSec to answer.
 19 Turning then to training. As well as online
 20 training and that on the ground, ShowSec received
 21 briefings at every event they attended. The head of
 22 security, as you remember, briefed the supervisor who
 23 then themselves went on to brief the staff. Mr Lavery,
 24 a former policeman of 30 years' experience, who has not
 25 worked for ShowSec for several years now and was not, as

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1 you recall, reticent in expressing views about
 2 the shortcomings of the industry generally, described
 3 the briefings given by Tom Rigby, who was head of
 4 security on the night, as:
 5 "Always thorough, always in depth, knew the subject
 6 matter back to front. There wasn't really anything he
 7 didn't cover."
 8 And he agreed that Tom Rigby always dealt with CT
 9 and did so appropriately and well. The keystone was
 10 vigilance and then witnessing the supervisors briefing
 11 this to the staff.
 12 As far as Mr Rigby is concerned, he had worked, as
 13 you recall, for ShowSec since 2007. He had been head of
 14 security since 2015. He had held an SIA door
 15 supervisor's licence for about 10 years or so. And in
 16 fact, he also held an SIA public space surveillance
 17 licence. He seems to have completed the course before
 18 the attack, but not received confirmation until after
 19 it. He too had completed, obviously, ShowSec's
 20 CT e-module, he had attended the management development
 21 programme and Griffin and Argus training along with
 22 tabletop exercises and he always gave CT briefings to
 23 his supervisors whether it was the topic of the day or
 24 not, which included looking out for suspicious
 25 characters, reporting mechanisms, "Run, hide and tell"

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1 and the HOT procedure, which was intended to be
 2 disseminated by the supervisors to the staff. He also
 3 gave evidence of the briefing room and counter-terrorism
 4 literature on the walls.
 5 As for the experience of ShowSec staff, on
 6 22 May 2017, ShowSec provided SMG with an extremely
 7 experienced bank of its own staff who had collectively
 8 received over 18,000 briefings at the arena alone. That
 9 stands in contrast to the position at the O2, as I have
 10 described. As against the 17 supervisors and managerial
 11 staff SMG had ordered and paid for, ShowSec provided
 12 a workforce that was significantly overqualified, namely
 13 33 supervisors and managerial level staff who had an
 14 average age of 37 and an average service of 7 years.
 15 And the overall ratio of supervisors to staff was just
 16 under 1 to 5. Given this degree of experience, the fact
 17 there may not have been a specific CT briefing on the
 18 night may, as a point of significance, fall away.
 19 The evidence, we suggest, demonstrates that this
 20 training and the experience of this workforce was
 21 regularly put into practice as the security experts
 22 concluded in their finalised report where they wrote:
 23 "Security staff in and around the City Room were
 24 sufficiently trained for them to know that they should
 25 report suspicious activity and to know how to do so."

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1 Subsequently, Dr BaMaung and Colonel Latham have
2 sought to resile somewhat from that conclusion on the
3 basis they had been persuaded to change position by the
4 evidence of Mr Agha, and I'll come to that in the
5 following chapter.

6 The company submits through me that the evidence
7 given by the ShowSec witnesses, which in large part
8 appears to have been ignored by the family groups in
9 their written submissions, and which is set out for you
10 below at your paragraphs 167 to 172, clearly demonstrate
11 that its staff at ground level were appropriately
12 trained to recognise and to react to hostile
13 reconnaissance. As I said, I have set out, or we have
14 set out, in the note that you have that material.
15 I will not read it out again. It's also to be found at
16 paragraphs 64 to 69 of our written submissions.

17 The evidence has not been the subject of challenge
18 and we would submit respectfully that you can safely
19 conclude that the staff on duty at the arena on the
20 night of Abedi's attack had been well trained and they
21 knew perfectly well what to look for and what they
22 should do if such behaviour was noted.

23 Can I take you on then, please, passing over that
24 summary, to 173 and the beginning of chapter 6.
25 Chapter 6 is the evidence of Mohammed Agha and

1 Kyle Lawler and the evidence of Colonel Latham in
2 respect of, as he described it, inadequate supervision.

3 The evidence of both young men obviously presents
4 you, sir, running this inquiry, with difficult problems,
5 perhaps for different reasons. Either Mr Agha
6 deliberately spent as little time as possible on his
7 training for ShowSec, which he accepted included being
8 shown materials that were capable of informing him about
9 the terrorist threat, or he's not telling the truth
10 about this and, in doing so, he is misguidedly trying to
11 minimise his responsibility.

12 He certainly did not inform ShowSec of the
13 deficiencies in his SIA training such as they may have
14 been. Whichever version is true, his own evidence
15 demonstrates that he knew that his role involved looking
16 out for suspicious people who he would identify by their
17 demeanour or if they were doing anything out of the
18 ordinary. That is what he said. If he became aware of
19 anything suspicious he knew he was to escalate the
20 matter to a radio holder or a supervisor. That state of
21 knowledge may not be surprising given his experience.
22 He'd worked 69 shifts previously of which over 30 were
23 at the arena, and he accepted that he was a highly
24 experienced steward.

25 Contrary to the oral evidence Colonel Latham gave,

1 it was only Mr Agha who said that he'd had to ask
2 a colleague what he was supposed to do having been
3 assigned to guard the grey doors. Whether he is
4 truthful about that is of course for you.

5 In fact, that colleague has made no mention of such
6 a conversation in the witness statement he has provided
7 to the inquiry. In the passage I've passed through,
8 there is reference to Mr Middleton's practice at the end
9 of his briefings of asking those in charge if there was
10 anything they did not understand to speak to him. That,
11 Mr Lawler, confirmed happened on 22 May.

12 This passage of Colonel Latham's evidence in which
13 he purports to come to a factual finding, based on
14 a misstatement of the evidence, is but an example that
15 underlines, we submit, the care that needs to be taken
16 before accepting the evidence of an expert who appears
17 not to have a full and proper understanding of his role.

18 As far as supervision and contact with other members
19 of staff is concerned, Mr Agha was relieved by
20 Jordan Beak at 19.31. He spoke to Mr Lawler at 19.44
21 and 20.38, and he left his post to speak to a ShowSec
22 supervisor, Donald Barrett, at 20.30.

23 He was approached by and spoke to an unknown member
24 of ShowSec staff at 21.11, who appears to have relieved
25 him, to allow him to go for a toilet break.

1 In the hour before detonation, there was a radio
2 holder in the City Room for all but 2 minutes of that
3 period and it follows that Colonel Latham's comments
4 about a lack of supervision cannot really withstand an
5 accurate summary of the evidence.

6 Colonel Latham went on to say that in hindsight it
7 might have been better for Mr Agha to have a radio,
8 though in fairness to the colonel he also said that
9 there were good reasons why he did not, making the point
10 that the supply of radios is limited and there's a need
11 to avoid chatter on the airways.

12 As for Kyle Lawler, he started work for ShowSec when
13 he was 16; he was 18 by the time of the attack. He
14 accepted frankly, you may think, that the trauma of the
15 incident had had a significant effect on him and his
16 ability to recall precisely what happened. He gave,
17 however, a clear and plainly accurate account of the
18 training he had received.

19 Early on in his ShowSec career he had gained an
20 understanding of the sorts of behaviour that would raise
21 suspicions, namely avoiding eye contact, fidgeting,
22 sweating, taking in the CCTV cameras, asking staff
23 random questions, not fitting the demographic of the
24 event, being inappropriately dressed for the season or
25 weather, carrying a large bag. He certainly knew what

1 to look out for.

2 In summary he would look to see whether a particular
3 person was consistent with what should be happening
4 in the particular environment. During the induction
5 visit to the arena on 6 May, Tom Rigby had said that if
6 staff saw someone suspicious the protocol was to inform
7 control either directly if they had a radio or
8 indirectly through a radio holder. Mr Lawler would make
9 his observations, get the detail through to control so
10 they could find him on the CCTV and then give him
11 advice.

12 As a result of his training, he understood the HOT
13 procedure in respect of suspicious items. Mr Lawler's
14 SIA training, consistent with the evidence I summarised
15 before we broke, was delivered by ShowSec in a classroom
16 in January 2017. He recalled that the counter-terrorism
17 part was a long, detailed interactive session lasting
18 a minimum of a couple of hours. It covered past
19 terrorist attacks, looking at what might be considered
20 suspicious and what to do in the event of finding
21 someone or something suspicious. Eyes Wide Open was
22 shown.

23 During the supervisor briefings, Mr Lawler said CT
24 was always mentioned or touched upon. Sometimes it was
25 generic and gone over and it went over, for example, the

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1 HOT procedure, but on other occasions it was more
2 detailed. The threat level was covered in briefing.

3 He considered that the training he received from
4 ShowSec was adequate to deal with the situation where
5 a suspicious person had been drawn to his attention.

6 On 22 May 2017, Mr Middleton had not briefed the
7 threat level but did go through the HOT procedure. It
8 was the first time Mr Lawler had worked on the bridge,
9 so after Mr Middleton asked if everyone knew what they
10 were doing, Mr Lawler took time to approach Mr Middleton
11 to ask about his role, which Mr Middleton then
12 explained. We would suggest for your consideration,
13 sir, that against this body of evidence there can be no
14 dispute that both Mr Agha and Mr Lawler were
15 appropriately trained and both knew precisely what they
16 should do if confronted by an individual whose behaviour
17 had given rise to suspicion.

18 Each had undertaken SIA training in 2017.
19 Counter-terrorism had been a specific briefing topic on
20 3 to 6 May and on 8 May, so Mr Agha had received that
21 briefing on the 3rd and Mr Lawler had received it on the
22 3rd, 4th and 8th.

23 We would argue that you should reject both Mr Agha's
24 evidence that he had not understood what his role on the
25 grey doors was and Colonel Latham's evidence that he was

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1 inadequately supervised.

2 Chapter 7, missed opportunities both in the days
3 before the attack and on 22 May 2017. ShowSec accepts
4 that there was a missed opportunity when Mr Agha failed
5 to follow his training and briefings and to escalate as
6 a matter of urgency the concerns of a member of the
7 public to the event control room.

8 Further, if his statements are accurate, it appears
9 Mr Lawler also missed another opportunity at
10 approximately 22.23 when Mr Agha directed his attention
11 to the bomber. The evidence has shown that this was not
12 the result of inadequate training in either case.

13 Looking then at the hostile reconnaissance prior to
14 the attack, we suggest that the evidence of the security
15 experts in relation to the chances of Abedi being
16 identified as he conducted hostile reconnaissance
17 between 18 and 21 May is unrealistic and tainted with
18 hindsight. By way of example, Abedi walked past
19 Mr Lavery, a former police officer with 30 years
20 experience, on 18 May and stood near him while he
21 watched the queue for no more than 40 seconds. That was
22 the same day that Mr Lavery followed and reported a male
23 he believed was involved in hostile reconnaissance,
24 obviously a different young man.

25 On 22 May, Abedi can be seen to go briefly to the

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1 mezzanine. The fact that he was a young man wearing
2 a hat cannot possibly make him suspicious, nor is there
3 any reason to regard him as being any more suspicious
4 than the man who was standing at the foot of the
5 JD Williams stairs for the entire period that Abedi was
6 in the City Room on that occasion.

7 The argument set out in Mr Atkinson's submissions at
8 paragraph 31 that had stills been taken of the man who
9 it is accepted was not Abedi on the 21st and had those
10 stills then been shown to ShowSec staff it would have
11 been more likely that Abedi would have been identified
12 as suspicious on the 22nd does not really stand up to
13 any sort of scrutiny.

14 Is it seriously to be suggested that ShowSec staff
15 should have been particularly on the alert for young
16 Asian or Arabic looking males who were wearing casual
17 clothes and carrying a bag? That would seem to fly in
18 the face of the official advice, which was not to
19 profile people by reason of appearance or ethnicity.

20 Turning then to missed opportunities on the night,
21 including the use of CCTV. The experts note that Abedi
22 had started to enter the City Room at 18.34, but had
23 then turned, possibly so it was suggested, as a result
24 of seeing BTP officers. We would suggest it is wholly
25 unrealistic to expect either a CCTV operator or indeed

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1 a member of ShowSec staff at ingress to notice Abedi as
 2 he approached the doors, notice that within a matter of
 3 seconds he appears to have changed his mind, to notice
 4 the presence of BTP officers and then to link the two.
 5 Mr O'Connor's cross-examination of Colonel Latham on
 6 whether it could reasonably be said that Salman Abedi
 7 should have stood out as suspicious as he walked towards
 8 the City Room demonstrates, we would suggest, the
 9 dangers of hindsight.

10 At the highest it might be said that if someone
 11 monitoring the CCTV had noticed Abedi on one of his
 12 visits to the City Room when he was wearing his rucksack
 13 they might have been suspicious and called for further
 14 investigation. However, the inquiry has heard just how
 15 many CCTV screens there were and certainly, so far as
 16 the event control room was concerned, the focus was on
 17 the movement of the crowd.

18 The distinction that Colonel Latham sought to draw
 19 between the position of BTP officers at 20.48 and
 20 ShowSec staff at 20.51 is another example of the
 21 unreality of his evidence and of an opinion which verges
 22 on the unfair. Nothing had changed in those 3 minutes.
 23 The railway station as a transport hub is just as much
 24 a target for a PBIED attack as was the arena. Nobody
 25 could have sensibly suggested that the BTP officer

1 should have found Abedi suspicious when he walked past
 2 them and Colonel Latham should not have expressed any
 3 other view about the ShowSec staff who he passed just
 4 3 minutes later.

5 It'll be for you to make factual findings, sir, as
 6 to whether Mr Agha was or was not trying to contact
 7 Mr Middleton after his conversation with Mr Wild, but on
 8 the assumption that he was then the issue becomes one of
 9 how hard he tried rather than whether or not he knew
 10 what to do.

11 You'll recall what he said. He said:
 12 "I was just thinking, like, what's he up to, what
 13 does he have in his bag. My first concern was just
 14 getting it reported because I'm not aware of what the
 15 situation is. There's nothing clear in my head what it
 16 can be so I need to get it reported."

17 Mr Middleton accepted that he had told Mr Agha
 18 he was not to leave the doors unless they were covered
 19 by another member of staff but Mr Agha would be expected
 20 to contact a radio holder even if that meant shouting.
 21 This is in fact advice consistent with the guidance to
 22 be found in the Purple Guide, which states under
 23 the heading "Conduct of stewards":

24 "Ensure that stewards understand that they should
 25 not leave their place without permission."

1 Earlier in the evening, as I have said, Mr Agha had
 2 in fact left his position in order to speak to
 3 Mr Barrett. He accepted that he could leave his
 4 position in the event of an emergency, although after
 5 he'd spoken to Mr Wild he did not regard the situation
 6 as falling within that category.

7 After failing to attract Mr Middleton's attention,
 8 he did attract the attention of a radio holder in the
 9 form of Mr Lawler by shouting his name, waving him over
 10 and leaving his position.

11 In fairness to Mr Agha, it is difficult now to get
 12 a sense of the degree of urgency with which Mr Wild had
 13 approached him. According to Mr Agha, Mr Wild, and
 14 I pick from his evidence:

15 "... wasn't panicked or anything like that, he just
 16 said it in like an ordinary way."

17 Mr Agha accepted he had not directed Mr Wild to
 18 Mr Middleton, who was standing a relatively short
 19 distance away.

20 Much, as you'll recall, has been made of the
 21 disquiet felt by members of the public when they saw
 22 Abedi, but again in fairness to both Mr Agha and
 23 Mr Lawler, it is important not to lose sight of the fact
 24 that the only person to have actually expressed any
 25 concern to a member of staff was Mr Wild. And as

1 you will see, we have set out the evidence of the other
 2 members of the public for you between 191 and 196 of
 3 this note and that's 88 to 92 of the written document.
 4 So I will pass through those, if I may, just to make
 5 sure that I finish within my time slot.

6 Can I take you, please, to paragraph 196 now. What
 7 is of note, again when one ensures that one is looking
 8 at Agha's evidence with fairness and with a degree of
 9 sympathy to the position he found himself in, is that
 10 after Mr Wild had expressed his concern to Mr Agha, he
 11 then left the City Room for a period of 6 minutes,
 12 leaving his partner behind. If that was an indication
 13 of the level of concern that he had expressed then that
 14 might explain Mr Agha's desultory effort to attract the
 15 attention of others and the manner in which he in turn
 16 communicated any disquiet to Mr Lawler.

17 Certainly Mr Lawler's action, as seen to the CCTV
 18 footage when leaving the City Room, are not those of
 19 someone who believed that something so terrible was
 20 about to occur.

21 Mr Middleton was shown the CCTV footage of Mr Agha
 22 apparently trying to contact him. He said Mr Agha could
 23 either have walked over or shouted to him. Sir, you've
 24 been to the arena now on at least two occasions and you
 25 can judge for yourself the practicalities of that for

1 yourself.
 2 Had he been informed of Abedi's presence and the
 3 concerns from the public, Mr Middleton said he'd have
 4 radioed control. Neither had Mr Perry seen Mr Agha
 5 trying to attract their attention and he would have
 6 expected him to have come over. Mr Beak was unaware of
 7 Mr Agha's efforts to make contact and he too would have
 8 expected him to raise a voice.

9 Mr Lawler was the only witness to suggest there was
 10 any problem with radios. However, his evidence is that
 11 after he left the City Room he cannot recall trying to
 12 use the radio. At egress there would be a call over the
 13 radio to maintain radio silence unless it was urgent.
 14 Neither Mr Perry nor Mr Beak had ever experienced such
 15 an issue.

16 According to Mr Atkinson, Mr Lawler made no mention
 17 of any conversation with Mr Agha when he rejoined him
 18 and neither did he seem anxious. He was not trying to
 19 make calls on his radio, although he may have been
 20 fiddling with the press-to-talk button.

21 The fact that after speaking to Mr Agha and
 22 returning to his position on the bridge, Mr Lawler sent
 23 three people back into the City Room at 22.29 is
 24 a further indication that he was not overly concerned
 25 about what he'd been told or had seen. As he put it:

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1 "It suggests I wasn't concerned about what I'd
 2 witnessed."

3 There is, as I have said, also his body language as
 4 can be seen on the CCTV footage.

5 In summary, the evidence demonstrates that ShowSec
 6 staff, including Mr Agha and Mr Lawler, were properly
 7 trained and knew what to do. Both had recently
 8 completed or should have completed SIA training, and as
 9 you have already pointed out, and Colonel Latham
 10 appeared to accept this, the fact that an opportunity
 11 was missed cannot of itself lead to a conclusion that
 12 the person who missed it lacked training.

13 So just in the last 2 or 3 minutes to our final
 14 submissions, drawing the threads as it were together.

15 First, we submit it would be to fall into error to
 16 cast judgment on ShowSec and its areas of responsibility
 17 without explicit reference to its part in the hierarchy
 18 of those charged with securing the safety of the public
 19 in the City Room. When those representing the families
 20 talk of ShowSec's systemic failings, they too have
 21 overlooked this. Thus far, insufficient attention has
 22 been paid to the part that the victims of this terrible
 23 attack were entitled to expect the state, through the
 24 police, to play, be that BTP or, as would have been far
 25 more appropriate, GMP, because in truth it was GMP, with

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1 their experience in CT, who should have taken charge of
 2 safety at the arena.

3 A proper risk assessment by the police may well have
 4 identified the inevitable cracks in a system or in any
 5 system prepared by two private companies without having
 6 the benefit of their expertise or the expertise of the
 7 police and access to the relevant material. As it was,
 8 ShowSec was left to do its best without the support both
 9 they and the public were entitled to.

10 Secondly, what we suggest is absolutely clear and
 11 now firmly established by the evidence is that the
 12 arrangements in place in May 2017, in terms of public
 13 access to the City Room, were not in any sense ShowSec's
 14 responsibility. On 22 May its staff had no lawful means
 15 of preventing the bomber entering that area or making
 16 his way up to the mezzanine level. This is not
 17 a question of the company we represent sheltering behind
 18 excuses. It is no more or less than a recognition of
 19 the challenges the City Room presented and what was
 20 permissible and lawful for ShowSec staff to achieve.

21 The sad fact is that the public's unrestricted
 22 access to the City Room provided an opportunity which
 23 was ruthlessly exploited by a terrorist who was
 24 perpetrating an appalling criminal act. If the bomber
 25 had been confronted by a visit from ShowSec staff to the

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1 mezzanine level as part of the pre-egress checks, or
 2 indeed any police officer who ought to have been on
 3 duty, we can have no real idea of what he the bomber
 4 might have done. Would he have set the device off
 5 immediately or might he have pushed himself into
 6 a similar position as that he was able to take up at
 7 22.31?

8 Thirdly, much of the criticism made of ShowSec by
 9 a number of the advocates representing the families and
 10 aspects of the language used to frame the extent of
 11 those criticisms has been and is inappropriate,
 12 unjustified and unhelpful. Those epithets are easy to
 13 employ but the substance to much of it has been found on
 14 proper examination to be wanting.

15 There were failings and failings which the company
 16 has accepted: the risk assessment was found wanting and
 17 the bag checking was a licensable activity. I have made
 18 the point, as for the checking of bags, it's tolerably
 19 clear that in his hostile reconnaissance Abedi had in
 20 fact seen ShowSec staff at work and had been deterred
 21 from any thought he might have had for mounting his
 22 attack at the beginning of the event. The admitted
 23 failings were not, and plainly not, causative.

24 Fourth and elsewhere, as we sincerely hope the
 25 company will have demonstrated from the calibre and the

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1 integrity of its senior management team, ShowSec was
 2 plainly determined to do its best. The training it
 3 offered was comprehensive, detailed and market leading.
 4 Each member of its staff was taught, and more
 5 importantly understood, that vigilance was required of
 6 them to promptly bring to the attention of the event
 7 control room anything of concern. It was also both an
 8 experienced but a committed workforce that ShowSec had
 9 provided to SMG on the night of this attack.

10 Fifth and finally, there are the very substantial
 11 efforts to make improvements as are set out in the
 12 changes made statements which make good ShowSec's
 13 promise to learn lessons and to improve on its
 14 performance.

15 Those, sir, are our submissions.

16 SIR JOHN SAUNDERS: Thank you very much, Mr Laidlaw, I'm
 17 grateful.

18 Mr Greaney.

19 MR GREANEY: We will next hear from Ms McGahey on behalf of
 20 the Secretary of State for the Home Department.

21 SIR JOHN SAUNDERS: Thank you.

22 Ms McGahey.

23 Submissions by MS MCGAHEY

24 MS MCGAHEY: Sir, the inquiry and the core participants have
 25 the written submissions made on behalf of the Home

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1 Secretary and her supplementary submissions on the issue
 2 of Article 2 of the European Court Convention on Human
 3 Rights, and I don't propose to repeat what was said in
 4 them now.

5 But I would like to use this time to address two key
 6 issues that were raised by the families in their oral
 7 submissions and the first is the progress being made by
 8 the Government in respect of the proposed Protect duty.

9 It is absolutely obvious that the delay in launching
 10 the Protect duty consultation is causing great
 11 frustration among the families and I can say that that
 12 frustration is shared by all who have been involved in
 13 developing it and in the process. But getting things
 14 right is crucial and the Government has been very
 15 concerned that many businesses, especially smaller ones,
 16 would really struggle during this pandemic to
 17 participate in a consultation exercise.

18 If the voices of those who would have to implement
 19 the duty are not heard and plans are made without their
 20 input, then there's a real risk of the Government
 21 pressing ahead and promoting obligations that would just
 22 not be workable in practice.

23 However, I can now say that the Government is
 24 committed to launching the consultation by the end of
 25 next month, so that's by the end of February. The plan

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1 is for the consultation period to last for 18 weeks
 2 instead of the usual 12. That will take the
 3 consultation period into the summer. It is hoped very
 4 much that businesses will be operating more normally by
 5 then and they should therefore be in a position to
 6 engage meaningfully with the consultation.

7 The consultation will ask for responses on questions
 8 relating to four key issues. Firstly, who would the
 9 Protect duty apply to? Secondly, what would a proposed
 10 duty require stakeholders to do? Thirdly, how should
 11 compliance work? And fourthly, how would Government
 12 support those affected by a Protect duty?

13 The Government will take consultation responses into
 14 account as well as any recommendations made in your
 15 chapter 7 report, sir, as the Government develops both
 16 the draft legislation and the subsequent guidance
 17 that is to go with it.

18 The basic intention behind the proposed Protect duty
 19 is that owners and operators of publicly accessible
 20 locations will be required to consider and take forward
 21 appropriate and proportionate protective security
 22 measures and I know, sir, that the question of what
 23 would be proportionate is one that you have already
 24 raised.

25 What is proportionate is likely to vary according to

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1 the size and nature of the organisation and, of course,
 2 also the activities that that organisation undertakes
 3 and there will be detailed guidance to help those who
 4 have to implement the Protect duty.

5 The second major issue that I would like to address
 6 is a legal one concerning the relevance of the state's
 7 duties under Article 2 of the European Convention on
 8 Human Rights to the inquiry's work.

9 I should emphasise that this issue concerns only the
 10 language used by you, sir, to record any findings. The
 11 Home Secretary wants to make clear that she does not
 12 seek in any way to restrict your right to make findings
 13 of fact, however critical they may be of anyone at all,
 14 or to make any recommendations that you choose to make.
 15 The Home Secretary had previously understood that some
 16 of the families were inviting you to record a finding
 17 that there was no Article 2 compliant legal or
 18 procedural framework in place on 22 May of 2017, and in
 19 response to that understanding, last week we filed brief
 20 overview submissions on the question of whether an
 21 inquiry report can make findings about the state's
 22 discharge of its Article 2 duties.

23 Our proposition then was that any determination as
 24 to whether the legal framework governing protective
 25 security in crowded places breached Article 2 would

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1 amount to an infringement of the statutory prohibition
 2 on the determination of civil liability which is
 3 contained in section 2.1 of the Inquiries Act.
 4 But following the submissions of Mr Weatherby
 5 Queen’s Counsel on Monday, we now understand that that
 6 proposition is not controversial. However, Mr Weatherby
 7 clarified that the families he represents are inviting
 8 you to find that the current framework of laws does not
 9 comply with Article 2. He has made clear that the
 10 reasons the families seek this finding is to ensure that
 11 the Government acts with greater urgency to take
 12 whatever steps are necessary to remedy any deficit.
 13 At the outset I should make clear that the Home
 14 Secretary absolutely understands the families’ concerns
 15 that underpin this request. But for the impact of the
 16 pandemic, the Protect duty consultation would probably
 17 have been launched almost a year ago and the changes
 18 that the families and Ms Murray, in particular, have
 19 been so instrumental in promoting would have been much,
 20 much closer to completion.
 21 But the Home Secretary would like to offer the
 22 families her reassurance on this point. She remains
 23 wholly committed to the mandatory Protect duty. There
 24 is now a firm timetable for the consultation and a huge
 25 amount of work has been done behind the scenes. The

1 process for introducing the legislation is now well
 2 underway and, sir, I can say without intending any
 3 disrespect at all to you or to the inquiry, the Home
 4 Secretary’s commitment will continue regardless of the
 5 way in which you choose to express your findings of the
 6 adequacy of the legal framework.
 7 May I turn now to the question whether you should
 8 make the finding that the families seek. The Home
 9 Secretary’s respectful response is that no such finding
 10 should be made. It is for the courts in civil or public
 11 law proceedings and not for statutory inquiries to make
 12 findings on the state’s discharge of its Article 2
 13 obligations. That is for good reason. In civil
 14 proceedings the arguments are well-defined at the outset
 15 of the proceedings and evidence is called to address
 16 those specific issues.
 17 It’s the Home Secretary’s respectful submission that
 18 your task, sir, in this inquiry is to consider the
 19 matters set out in the terms of reference. Where you
 20 find there to be inadequacies, those inadequacies should
 21 be identified in the report and reflected in the
 22 recommendations you make, using whatever language you
 23 consider to be appropriate. But the wording of any
 24 report is subject always to the statutory prohibition in
 25 section 2 of the Inquiries Act, so this inquiry should

1 not make any determination of criminal or civil
 2 liability, and our submission is that any finding as to
 3 whether the current legal framework governing protective
 4 security in crowded places is in breach of Article 2
 5 would amount to an infringement of that statutory
 6 prohibition on the determination of civil liability.
 7 There is a distinction between factual findings as
 8 to the adequacy or otherwise of the systems and policies
 9 and framework governing security in crowded places and
 10 a finding as to whether any inadequacies amounted or
 11 whether they currently amount to a breach of the state’s
 12 Article 2 general duty.
 13 Whether there is or whether there was a breach,
 14 firstly, requires the scope of the general duty to be
 15 defined, and in my submission that’s a really complex
 16 issue, both in law and evidentially. To take one
 17 example, any attempt to isolate protective security
 18 fails to take account of the national framework of laws,
 19 precautions, procedures and means of enforcement which
 20 the state operates as a whole to protect the lives of
 21 citizens.
 22 To put it another way, when viewed in isolation,
 23 a single piece of the jigsaw may very well appear to be
 24 inadequate, but any apparent inadequacy may be negated
 25 entirely when that single piece of the jigsaw is placed

1 within the larger picture of the much wider national
 2 framework, and in my respectful submission it’s the
 3 framework as a whole that has to be considered when the
 4 state’s compliance with its Article 2 general duty is
 5 assessed.
 6 If that is right, any consideration of a breach of
 7 Article 2 would then require a detailed analysis of the
 8 factual situation, whether in 2017 or today, against the
 9 totality of the state system. You asked Mr Weatherby
 10 Queen’s Counsel, sir, earlier this week whether any
 11 other Council of Europe jurisdiction has something
 12 similar to the Protect duty, and in my submission that
 13 question in itself provides another illustration of the
 14 sort of issues that might be raised, the sort of
 15 evidence that might be raised, and the level of detail
 16 that would be needed in order to address questions of
 17 Article 2 compliance.
 18 It is our respectful submission that embarking on
 19 such a task is not within the scope of this inquiry, and
 20 in any event, just in practical terms, it’s absolutely
 21 definitely not something that could be achieved to
 22 enable you to write a report that could be published in
 23 May of this year.
 24 On the question of what happens in other countries
 25 we are currently taking instructions, but officials to

1 whom we have been able to speak so far are not aware of
2 any mandatory protective security duty of the general
3 sort that the current UK Government is proposing. Where
4 there is legislation elsewhere, it tends to protect
5 specific aspects of country's infrastructure such as its
6 transport network.

7 During the Protect duty consultation period the
8 Government will, through its embassies, be asking other
9 countries for their experiences and learning from them,
10 but at the moment we do not have, I'm afraid, the
11 detailed information that we would need to give you
12 a completely accurate answer to your question.

13 In summary, the Home Secretary's submission is that
14 you should not consider in the chapter 7 report whether
15 Article 2 was breached on 22 May 2017 or indeed whether
16 the current system breaches Article 2. If, sir, you are
17 still minded to address Article 2 issues in the report
18 then the Home Secretary does respectfully request that
19 you should first require further detailed legal
20 submissions, both from core participants and counsel to
21 the inquiry, addressing, first of all, the law on the
22 Article 2 general duty and, secondly, the question of
23 evidential sufficiency. We would then ask that you
24 determine both the scope of the general duty and the
25 need for further evidence with a view to making a ruling

1 on those issues before deciding whether to consider any
2 question of breach in your chapter 7 report.

3 I should make clear that the Home Secretary, for the
4 reasons I have just set out, does not advocate further
5 consideration of the Article 2 issue, but I should
6 emphasise again that a decision not to make a finding on
7 Article 2 compliance absolutely does not prevent you
8 from making the types of findings on the facts that
9 Mr Weatherby Queen's Counsel and the other core
10 participants seek if those findings are supported by the
11 evidence. It is absolutely open to you to find that
12 something was inadequate because it didn't achieve its
13 intended purpose or because the defined purpose was too
14 limited to address the problem that needed to be solved.
15 That difference is one of language, it is not one of
16 substance at all, and we submit not one that should
17 affect in any way findings that you choose to make.

18 Sir, as I said at the outset, you already have our
19 written submissions in more detail on other issues, so
20 unless I can assist you further, those are the
21 submissions on behalf of the Secretary of State.

22 SIR JOHN SAUNDERS: You can, Ms McGahey, on a number of
23 things. I just want to clarify a few things that I have
24 said and why I've said them.

25 First of all, this is not directed to you but it's

1 directed to Mr Weatherby. Perhaps he would like to
2 either send me a document or tell me that he agrees with
3 your analysis of what he's actually asking me to do.
4 That's first.

5 The second thing is that my reason for asking about
6 any other country's Protect duty and if they have them
7 was not designed to be an Article 2 question at all, it was
8 designed that if I am going to be making recommendations
9 in relation to the Protect duty, it would actually be
10 nice to know if anyone else had gone down this line
11 because it is always quite a good idea not to reinvent
12 the wheel if someone has invented it first. That was
13 the reason for that.

14 In relation also to the Protect duty, you will
15 appreciate that as the evidence in chapter 7 has gone
16 along, I have been giving that obviously thought and
17 it is not entirely -- when making a compulsory duty,
18 such as is suggested for a Protect duty, actually the
19 mechanics of it and the different stages which have to
20 be gone through, it's not actually entirely
21 straightforward. So you may or may not be able to
22 answer this question, but will the consultation document
23 set out a detailed proposal for how the Government
24 proposes to make the Protect duty work and to be
25 compulsory and the factors it would take into account to

1 assess proportionality or is it really going to be
2 a series of questions from which the legislation will
3 then go on from that basis?

4 MS MCGAHEY: Sir, I can't answer your question with
5 certainty, I'm afraid. But my understanding is that
6 it's the latter, that it is a series of open-ended
7 questions. I can take instructions.

8 SIR JOHN SAUNDERS: That's helpful to know. Because some
9 analysis, it seemed to me, of what will be required and
10 what factors need to be taken into account may be of
11 some assistance if I'm making recommendations.

12 At the risk of being considered to have an obsession
13 which licensing law, which I do not have, can I just
14 raise a couple of issues relating to your response in
15 your written document in relation to licensing and what
16 the Home Secretary at the moment intends to do.

17 So paraphrasing, it is said that licensing
18 committees will be able to take into account questions
19 of terrorist attacks and the risk of them in deciding
20 whether to grant licences. Indeed, it's accepted in
21 your document that that comes within the terms of the
22 Licensing Act. But the Government says, never mind
23 that, never mind the fact you haven't been doing it so
24 far, we're not going to give you any guidance in the
25 licensing guidance. I just wonder whether someone might

1 like to reconsider that, as it sounds not entirely
 2 logical to me.
 3 MS MCGAHEY: Sir, I can certainly take further instructions.
 4 As we set out in the document, the underlying reason for
 5 that stance is that work is being done on the Protect
 6 duty and the guidance to go with it, and the Home
 7 Secretary's intention would then be to revisit the
 8 Licensing Act guidance if necessary, once that work had
 9 been done, because there's likely to be a very
 10 significant overlap.
 11 SIR JOHN SAUNDERS: Okay. That's absolutely fine as long as
 12 they do have it in mind to do, because I'm sure
 13 licensing committees, particularly if they haven't at
 14 the moment considered it, if they now feel that perhaps
 15 having seen the evidence of this inquiry and what has
 16 been said that they do need to, they might like a bit of
 17 help with it. Anyway, that is one point.
 18 The second point is this, and I'm afraid this is the
 19 sort of misunderstanding which — maybe it's my fault
 20 for the way I expressed it, clearly because a lot of
 21 people appear to have this misunderstanding. I am not
 22 suggesting, and I do not suggest, that the Licensing Act
 23 would cover what is required by a Protect duty.
 24 It would clearly not, because it doesn't cover, apart
 25 from anything else, all the other premises that you wish

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1 to cover.
 2 But if there is a Protect duty, the way it is
 3 presently phrased, it would come into force after
 4 licensed premises — this is what I'm considering —
 5 have already been built. So if you had licensed
 6 premises like the arena being built coming out on to
 7 a grey area, people might have concerns about that and
 8 it might be impossible to deal with any proper Protect
 9 duty which is imposed.
 10 Licensing committees, on the other hand, decide in
 11 advance of building whether or not they would grant
 12 a licence, so that would allow the Protect duty to be
 13 considered at a stage before the building takes place
 14 and the developer spends all the money on it. That
 15 could easily be achieved by at the same time and in the
 16 same legislation as introduced the Protect duty, add
 17 compulsory licensing conditions to licensing licences.
 18 Certainly you could make it for ones in the future.
 19 Because your document, with respect, I don't think
 20 expressed what I was thinking about.
 21 It just seems practical and pragmatic, but obviously
 22 if someone could just have a look at that again rather
 23 than take some idea that I'm trying to replace the
 24 Protect duty by the Licensing Act, which I am not in any
 25 way.

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1 If you take that away as well, I'd be grateful.
 2 MS MCGAHEY: Of course, sir.
 3 SIR JOHN SAUNDERS: The third thing is, as you know, I've
 4 had helpful documentation and recommendations from
 5 Jeremy Phillips Queen's Counsel and from the
 6 Licensing Institute. Would you object to me referring
 7 your document, your written document, to them for any
 8 further comment from them? Of course it would be
 9 provided to you afterwards.
 10 MS MCGAHEY: No, sir, not at all. Our submissions are
 11 public documents.
 12 SIR JOHN SAUNDERS: I understand that, but I would be asking
 13 for someone else's comment on it rather than my own.
 14 Thank you very much for that.
 15 Mr Weatherby, you look like you're ready to say
 16 something.
 17 MR WEATHERBY: You asked me a question so I thought I'd...
 18 I'll happily put in a further short document reiterating
 19 what we've done in writing and orally so far.
 20 In respect to whether the analysis that has been put
 21 today, we have repeatedly said we're not asking you to
 22 determine liability. We want a finding that the system
 23 in place was not compliant with Article 2, and there's
 24 a distinction which we set out yesterday. We'll happily
 25 put in a further document trying to make it more clear.

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1 SIR JOHN SAUNDERS: Okay. I'm not sure that's quite what
 2 Ms McGahey was saying in submissions just now, but if
 3 we can at least understand where we are in that, that
 4 would be a great help. Thank you very much,
 5 Mr Weatherby.
 6 Mr Greaney.
 7 MR GREANEY: Sir, thank you, we're going to hear from
 8 Mr Butt on behalf of Counter-terrorism Policing
 9 Headquarters, and you should in the last 15 minutes or
 10 so have received Mr Butt's speaking note.
 11 SIR JOHN SAUNDERS: I will find that, so just give me
 12 a moment, please.
 13 (Pause)
 14 Submissions by MR BUTT
 15 MR BUTT: Sir, in an inquiry into the terrible murder of
 16 22 innocent people, it is inevitable that the focus will
 17 be upon what went wrong. In doing so, it is important
 18 that we don't lose sight of the good work that is done
 19 by Counter-terrorism Policing at a national and local
 20 level across the four strands of CONTEST. It is no
 21 comfort to those who lost loved ones to be told that the
 22 UK authorities are highly effective at preventing
 23 terrorist attack, but that is the case. We stop
 24 terrorists in the vast majority of cases. As DAC D'Orsi
 25 said at paragraph 6 of her first witness statement, in

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1 2017 alone 13 attack plots were foiled .
 2 The evidence about national training and guidance
 3 has also been reassuring. Overwhelmingly, where the
 4 guidance and training provided by NaCTSO has been
 5 examined, it has been described positively by those
 6 representing the families and other core participants
 7 and by the inquiry security experts. The evidence has
 8 shown that this guidance and training is both
 9 comprehensive and of real benefit in countering the
 10 terrorism threat.
 11 Examples of this include NaCTSO products such as
 12 Griffin and Argus, training videos such as Eyes Wide
 13 Open, and the various advisory messages and guidance
 14 issued to both the CTSA Network and the wider industry.
 15 Where concern has been expressed about NaCTSO
 16 guidance and training, this in the main part has been to
 17 express concern that engagement with the process and
 18 implementation of CTSA recommendations is voluntary,
 19 hence the universal support in this inquiry for the
 20 introduction of a Protect duty, which NaCTSO supports as
 21 set out at paragraphs 4 and 5 of our written
 22 submissions, and as explained by DAC D’Orsi in evidence.
 23 There has been no serious attempt by anyone in this
 24 inquiry to criticise the training of CTSA’s and nobody
 25 has disputed the evidence of DAC D’Orsi, endorsed by the

1 inquiry experts, that CTSA’s are amongst the most highly
 2 skilled CT advisers in the country.
 3 The evidence about Ken Upham and all of those who
 4 work so hard in the public interest to keep us safe has
 5 also been mainly positive. NaCTSO repeats that Mr Upham
 6 is obviously a hard-working and dedicated police
 7 professional and my client thanks him and all of the
 8 CTSA’s who work hard to keep us all safe.
 9 When searching for what improvements can be made, as
 10 you must in this inquiry, sir, it is important not to
 11 lose sight of the fact that the UK has such a highly
 12 skilled resource available free of charge to qualifying
 13 businesses and not-for-profit organisations across the
 14 country. You have full written submissions on behalf of
 15 CTPHQ, which have an important but discrete role in
 16 chapter 7, and I certainly will not read out those
 17 submissions.
 18 But by reference to them, I wish to address six
 19 topics raised by other CP’s and the inquiry experts. The
 20 first relates to external areas in the context of
 21 protective security improvement activity, PSIA.
 22 Obviously, a good deal of PSIA will focus upon ways
 23 to protect those within a site. This is unsurprising
 24 because an attack within a crowded place would normally
 25 cause the greatest number of casualties. That is why

1 crowded places are targeted by terrorists in the first
 2 place and that is why crowded places are afforded
 3 a special status and provided special protection by the
 4 state.
 5 It is because of the work that has been done to stop
 6 an attack where the impact would be highest that target
 7 hardening occurs and terrorists have to pick targets
 8 which are less attractive to them by reference to
 9 impact, but more vulnerable to attack.
 10 That crowds within places such as the arena are well
 11 protected shows that the Protect strand of CONTEST is
 12 working. It is a sign of the effectiveness of CT
 13 measures, including detecting hostile reconnaissance,
 14 reporting suspicious activity and search and screening
 15 at this and other venues that terrorists look to less
 16 attractive targets.
 17 But as I stated in opening, that does not mean that
 18 areas outside a site are ignored either within the PSIA
 19 process or otherwise. There is no express or implied
 20 limitation to be found in the PSIA tool or guidance that
 21 restricts CTSA advice to internal areas. The phrase
 22 "protecting a crowd within a site" does not appear
 23 anywhere in the PSIA tool or guidance, all of which
 24 reference protecting people at a site or at a crowded
 25 place, and Ms Forster very fairly accepted she could

1 find no example of this phrase being used. There are no
 2 such documents.
 3 All core participants now agree that PSIA is and was
 4 in 2017 not solely concerned with activity within
 5 a site’s demise. GMP accept at paragraph 94.1 of their
 6 closing submission that some aspects of PSIA relate to
 7 external areas. Work external to a site, of course, is
 8 undertaken at the very beginning of the process, with
 9 the site survey using the onion layer approach, looking
 10 at the site from outside in, from the environment to the
 11 external areas, the shell and then the interior itself.
 12 This is basic CTSA training and something all CTSA’s will
 13 be familiar with. That included Dr BaMaung from his own
 14 CTSA experience and Liz Forster from hers, as they both
 15 confirmed in evidence.
 16 The arena survey conducted by Mr Archibald
 17 considered the City Room and was available to Mr Upham,
 18 who decided to use this rather than conducting a new
 19 survey, which was, on the evidence, a reasonable
 20 decision. Of course, some attack methodologies will by
 21 definition require advice about PSIA outside the demise
 22 of a site. Obvious examples are non-penetrative and
 23 penetrative vehicle attacks and placed IEDs.
 24 At paragraph 26 of the CTPHQ submission, I have
 25 provided references to the tool and to the PSIA guidance

1 which set out examples of external PSIA, including
 2 traffic exclusion zones, physical stand-off, hostile
 3 vehicle mitigation and searching bins and foliage and
 4 external areas. The suggestion that PSIA only relates
 5 to protecting a crowd within a site is unsustainable.
 6 Neither can it seriously be suggested that when
 7 considering person-borne improvised explosive devices,
 8 PBIEDs, and their methodology, advice is either
 9 explicitly or implicitly restricted to activity within
 10 a site.
 11 Suggested activity for PBIED methodology, which the
 12 tool invites CTSA to consider, includes invacuation and
 13 evacuation, which we'll look at very clearly in the
 14 context of egress, and a capability to increase security
 15 at times of increased threat.
 16 In relation to that third example, Dr BaMaung agreed
 17 that an obvious consideration for PBIED under this
 18 heading would be pushing back the perimeter, as
 19 suggested in both the 2015 NaCTSO guidance note number 2
 20 of 2015 and the NaCTSO guidance in force at the time of
 21 the attack, and specifically there in the section
 22 relating to suicide attack, namely PBIED, and all of
 23 references to that NaCTSO guidance are at paragraph 27
 24 of my written submission.
 25 We provide at paragraph 28 an example of this

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1 working in practice, where just such a recommendation
 2 was included within the British Transport Police
 3 Victoria Station action plan, as agreed at the time of
 4 the attack. And indeed, of course it was Liz Forster's
 5 evidence that she would have expected Mr Upham to have
 6 advised SMG about extending the perimeter or possibly
 7 closing the City Room because she believed that he had
 8 done so, and whatever factual finding the inquiry comes
 9 to in this regard, such a recommendation was included
 10 for consideration in the NaCTSO guidance issued to CTSA
 11 and sites at the time of the attack.
 12 For their part, SMG accept that they considered
 13 pushing back the perimeter, but decided this was not
 14 possible due to the extent of their demise. This is
 15 precisely the sort of problem that can be solved by
 16 working in partnership with neighbours and by engagement
 17 with local authorities under that broad heading of
 18 partnership, which brings me to my second topic.
 19 It has been suggested that partnership working is
 20 confined to, for example, intelligence sharing with
 21 neighbours, and as a result is perhaps of limited
 22 practical effect. It has been suggested that hard-edged
 23 solutions cannot be achieved under the partnership
 24 examples provided in the tool and the guidance.
 25 On behalf of NaCTSO, that is not something we can

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1 accept. It understates the importance of a critical
 2 area of CT protective security. It is correct that
 3 Dr BaMaung was asked questions about partnership by
 4 Mr Horwell on behalf of GMP, but he was only asked about
 5 a single example of this in the tool, namely
 6 communication-sharing protocols. This does not mean
 7 that partnership is only about information sharing and
 8 could not therefore include steps to assist in extending
 9 perimeters into areas of shared ownership. That is not
 10 the evidence.
 11 What Mr Horwell asked Dr BaMaung about -- and this
 12 is at Day 42, page 236, line 12 {Day42/236:12} --
 13 related only to communication-sharing protocols.
 14 Dr BaMaung said he would take the content of what has
 15 been called the drop-down menu, the text embedded in the
 16 spreadsheet, from GMP's counsel; of course, it was put
 17 correctly to him. But communication-sharing protocols
 18 is only one of the five examples of suggested activity
 19 under the broad heading of partnership provided in the
 20 tool and all five of them are set out at paragraph 30 of
 21 my written submission.
 22 These five examples are but examples. Dr BaMaung in
 23 fact agreed, returning to the question of extending
 24 a perimeter into areas of shared ownership, that this
 25 was precisely what partnership working in PSIA can

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1 resolve and, more generally, the experts were of the
 2 view that partnership is a means by which CTSA can
 3 advise as to protective security beyond the perimeter of
 4 a site.
 5 Partnership has always been one of the key messages
 6 that NaCTSO has sought to convey as to how businesses
 7 can keep us and their staff safe. It's a theme that
 8 runs through the PSIA tool from its launch and all of
 9 the guidance. Vital CT work is done by partnership
 10 between businesses, local authorities, the police and
 11 NaCTSO every day, and my client is anxious that nothing
 12 is said in this inquiry to undermine the importance of
 13 this.
 14 The third topic is egress. Whilst egress is not
 15 specifically mentioned as a location or timing of an
 16 attack in the PSIA tool, that is not necessarily
 17 a weakness. Egress is not an attack methodology. Any
 18 of the six methodologies, with the possible exclusion of
 19 a postal IED, could be deployed at an egress point or
 20 during egress. I know, sir, that you will be careful
 21 not to allow a disproportionate focus to be placed on
 22 egress because that was when and where this terrible
 23 attack occurred. That could have serious unintended
 24 consequences.
 25 Whilst the tool and guidance do not focus

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1 specifically on egress as a risk area, it was a matter
 2 that CTSA as an industry would have been aware of from
 3 the guidance relating to PBIED methodology. I gave one
 4 example earlier of evacuation and invacuation plans
 5 being a specific activity the tool would score sites for
 6 in relation to PBIED, and Dr BaMaung agreed that these
 7 would involve consideration of egress and ingress, and
 8 it is not hard to see why, as it involves taking a crowd
 9 out of a site to keep them safe or bringing them inside
 10 if an attack happens in an external area and this can be
 11 safely done.

12 There is also reference to, for example, the
 13 importance of and vulnerability of exits in the
 14 guidance, the need to monitor security and CCTV focused
 15 upon exits and how hostile individuals or potentially
 16 hostile individuals paying attention to exits is likely
 17 to be suspicious of itself .

18 Security advice, though, is not confined to the
 19 examples in the PSIA tool or guidance. Your experts
 20 agreed that the scheme was designed to be flexible and
 21 the examples in the tool were not exhaustive, nor should
 22 they be seen as being proscriptive . All relevant
 23 witnesses, including Ms Forster, agreed with this, and
 24 Dr BaMaung said that the guidance encouraged a creative
 25 approach and that CTSA's were encouraged not to be bound

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1 within the box of PSIA. They were encouraged to use
 2 their extensive training to conduct their own research
 3 and to be flexible and creative in how they provided
 4 PSIA advice to a site.

5 You can see from the references in our submission at
 6 paragraph 23 that this was a consistent message NaCTSO
 7 conveyed to all CTSA's. Dr BaMaung also agreed that
 8 NaCTSO events such as Argus and Griffin were conduits to
 9 share an understanding of what the terrorist threat may
 10 be.

11 I have in this regard taken witnesses from GMP and
 12 SMG to the Argus stadia facilitator notes, which would
 13 have been used not just at the launch of that event in
 14 May 2015 but at each and every session when the event
 15 was cascaded consistently nationally, including in the
 16 north-west, including at the Manchester Arena. It is
 17 an important document given some of the evidence and
 18 questioning in this inquiry.

19 It has been suggested, including by ShowSec at
 20 paragraph 137 and earlier this afternoon, that as the
 21 focus of Argus was apparently what to do in the event of
 22 an attack taking place, it is somehow not relevant to
 23 preventing an attack. That is not something NaCTSO can
 24 agree with. The purpose of Argus events generally and
 25 this course in particular is described at various points

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1 in the evidence. Argus focuses upon how to prepare for
 2 a terrorist attack, to identify measures to help an
 3 organisation prevent, manage and recover from
 4 a terrorist incident. This language is used in every
 5 document.

6 For example, GMP produced Business Sentinel
 7 newsletters at {INQ034437/180} in which, in a GMP CTSA
 8 comment, Argus events are described as being events
 9 which explore how to prevent, handle and recover from
 10 a terrorist attack. That is exactly how the invites to
 11 the Argus stadia launch described the event: how to
 12 prevent, handle and recover from a terrorist attack.
 13 The speaker notes introduced the event in the same terms
 14 and deal with prevention throughout, most notably at
 15 pages 14 to 16 and 28 to 32.

16 This Argus event and all Argus events had exhaustive
 17 input upon prevention. It is wrong to suggest that
 18 Argus could somehow be ignored in relation to
 19 prevention. To do so is to misunderstand training that
 20 ShowSec claim in their PowerPoint presentation their
 21 staff were familiar with.

22 Whilst not as strikingly similar as the Argus
 23 scenario, the October 2016 Griffin training also
 24 includes an input on a 2015 terrorist attack outside
 25 a venue in Bavaria, which was delivered by way of PBIED

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1 at the end of the event and during egress.

2 Can I briefly address you, sir, on the question of
 3 "something is better than nothing". At paragraph 46 of
 4 the Slater & Gordon submission it is said, and this is
 5 in the context of relevance to a different point being
 6 made about voluntary engagement with PSIA:

7 "At the national level the NaCTSO approach of
 8 'something is better than nothing' led to a degrading of
 9 standards."

10 Can I immediately accept that Mr Cooper and his team
 11 have very fairly balanced that sentence elsewhere in
 12 their document. And as I say, that sentence needs to be
 13 read in the context it was entirely properly put in.

14 I would just respectfully remind you, sir, that
 15 there is no evidence to support a degrading of standards
 16 under this slogan. The evidence was this was
 17 a well-intentioned initiative that aimed to ensure that
 18 opportunities to save lives by introducing
 19 cost-effective measures were not ignored. So-called
 20 gold-standard recommendations were still made and if
 21 sites would not agree to these then they would be
 22 recorded as not agreed on the action plan, leaving
 23 a clear audit trail .

24 Dr BaMaung agreed that this in fact led to an
 25 increase in affordable, achievable protective security,

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1 and that to his knowledge there was no basis to say that
2 it led to penny-pinching or a degrading of standards.

3 Can I be very clear, though: the point made by the
4 families about the language is well made, it is
5 accepted, and it is not a phrase that is used any more
6 by NaCTSO.

7 Sir, my final observation relates to a proposed
8 recommendation made by Mr Weatherby on behalf of his
9 clients and supported to an extent by GMP. It is the
10 suggestion that certain crowded places should or must
11 engage private sector CT expertise and this should be
12 something CTAs advise upon.

13 NaCTSO can see force in the argument that an
14 organisation such as SMG would benefit from CT advice
15 at the arena above and beyond that which was provided by
16 a CTSA. We find it somewhat surprising that such an
17 organisation would need to be told this by the police
18 and that it would not be something that they would
19 realise via their own risk assessment and governance
20 procedures.

21 If it were to be recommended that all or many tier 1
22 and tier 2 sites would be in effect mandated to bring in
23 private sector advice then there could be unintended
24 consequences, certainly if this were to the exclusion of
25 CTSA input. There are excellent private sector

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1 companies out there, but that excellence is not
2 universal. There would be concerns about quality
3 assurance and consistency of delivery.

4 It was and is always open to CTAs to advise that
5 sites obtain private security assistance, whether that
6 be by SIA staff, specialist SIA-accredited advice or
7 more sophisticated advice such as external consultants,
8 and no change in approach is required to allow that to
9 happen in the future.

10 Care must of course be taken, though, with this for
11 the reasons explained by DAC D'Orsi. CTAs are not
12 experts on strategic governance of the business
13 operating the site. A CTSA will advise on the level of
14 threat, vulnerabilities from the six attack
15 methodologies and potential mitigation. This advice
16 should recognise the particular operating cycle of the
17 site and its physical layout. But whether the
18 complexity of a site requires further private security
19 advice is something the site will always be far better
20 able to understand than a CTSA.

21 We will, sir, of course constructively engage with
22 any recommendation made and we look forward to doing so.
23 As I say, we can see the force in the argument that the
24 arena would have and now does benefit from private CT
25 advice.

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1 Sir, can I, for the last time in chapter 7, express
2 on behalf of my clients our sincere condolences to those
3 who have lost their lives in this terrible attack. Some
4 of those who work within CTPHQ have had the privilege of
5 meeting the bereaved families, or some of them, and have
6 asked me to pass their gratitude for the generosity and
7 patience the family members have shown in these
8 meetings. Ultimately we all want the same thing in this
9 inquiry and, sir, we hope to continue to work with you
10 towards that goal.

11 Those are my submissions.

12 SIR JOHN SAUNDERS: Thank you very much, Mr Butt, I'm
13 grateful.

14 Mr Greaney.

15 MR GREANEY: Sir, the next two submissions, which are the
16 final two submissions, are submissions that in our
17 judgement you should hear together, so that's to say
18 they ought not to be separated overnight. We need to
19 have a break at this stage come what may.

20 We know in the case of Kyle Lawler, his counsel,
21 Ms Naqshbandi, intends to be around 15 or 20 minutes.
22 I'm not certain at the moment how long Mr Williams on
23 behalf of Mohammed Agha intends to be. If he is online,
24 it might be helpful to hear from him what his time
25 estimate is so that you, bearing in mind that we

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1 recognise that it's not easy to listen to these
2 submissions one after another, can decide whether to
3 hear the final two submissions this afternoon or first
4 thing tomorrow morning. I can see Mr Williams is now
5 on.

6 MR WILLIAMS: I hope to be about 15 or 20 minutes. I have
7 sent a short note through to you and I hope you have
8 received that.

9 SIR JOHN SAUNDERS: I have. Mr Williams, are you happy to
10 carry on then? We'll have a break now, but are you
11 happy to complete tonight?

12 MR WILLIAMS: Yes, I think that would assist everybody
13 in the inquiry. Hopefully it will assist you.

14 SIR JOHN SAUNDERS: Thank you.

15 Mr Greaney, unless there are any other
16 representations anyone wants to make, we will finish the
17 hearings this afternoon. Would 10 minutes be long
18 enough?

19 MR GREANEY: Ten minutes will be long enough, I'm certain.

20 SIR JOHN SAUNDERS: So we will start again at 3.40.

21 Thank you.

22 (3.30 pm)

(A short break)

24 (3.40 pm)

25 SIR JOHN SAUNDERS: Ms Naqshbandi, it is now your turn. Can

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1 I just say before you start, because you are the last
 2 one to start after a break: there may be many
 3 disadvantages in remote hearings, but it's very much
 4 easier to start on time when you just have to press
 5 a button, so thank you very much.
 6 Submissions by MS NAQSHBANDI
 7 MS NAQSHBANDI: Thank you, sir.
 8 By the time Kyle Lawler was told of
 9 Christopher Wild's concerns, Salman Abedi was already
 10 in the City Room, counting down the final minutes before
 11 detonating his bomb:
 12 "Once in the City Room [Colonel Latham concluded in
 13 answer to you about the chances of something happening]
 14 it's very unlikely that having done all that
 15 preparation, got to his attack position and then been
 16 rumbled, it is unlikely that he is going to stand up and
 17 successfully walk home with his IED."
 18 This was a man who had been spoken to by two members
 19 of the public, probed by one as to what he was doing,
 20 yet continued undeterred in his plan.
 21 That is part of the context within which we invite
 22 you to view Kyle Lawler's actions that night. Had he
 23 made the report to control, a supervisor would have been
 24 sent to speak to Salman Abedi and it is likely that he
 25 would have carried out his plan sooner than he did. It

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1 was highly unlikely that no one would have been
 2 murdered. Whatever Kyle Lawler did, the appalling
 3 reality is that people were going to die.
 4 He has accepted that he gave untruthful accounts
 5 after the attack and he has tried to explain why in
 6 evidence to you. You will recollect that he said this:
 7 "I was very emotionally confused. I would say
 8 distraught. I think at the time I was trying to protect
 9 myself because I was blaming myself for the tragedy. It
 10 was a way for me to tell myself that it was not my
 11 fault. I could not face the criticism that may have
 12 flowed from my actions. I was not strong enough or
 13 mature enough to deal with the situation. I felt
 14 terrible guilt for what had happened. I was almost
 15 crippled by it. I was in a terrible place and I remain
 16 so."
 17 It may not be a completely satisfactory explanation
 18 in what was a shocking situation to have found himself
 19 in, learning as he did that the man he saw had detonated
 20 a bomb. However, the criticisms that are made of his
 21 various accounts come without any contextual
 22 understanding of his situation, of the impact of that
 23 night in the days and months that followed.
 24 Giving evidence in this inquiry, publicly
 25 live-streamed as it was, in view of those who lost loved

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1 ones, under the watchful eye of the media, probed by
 2 highly experienced barristers, in the witness box for
 3 a long time, for a young person such as Kyle Lawler was
 4 challenging, especially when coupled with his underlying
 5 sense of blame.
 6 We ask you, sir, to make appropriate allowances
 7 which recognise what it is to be young and human when
 8 analysing his answers and scrutinising his conduct.
 9 We have focused our submissions on issues 13 and 14,
 10 why didn't Kyle Lawler make the report, did he miss
 11 opportunities to stop Salman Abedi from murder?
 12 When considering the question of which factors were
 13 potentially causative in the sense described by your
 14 legal team that had things been different there would
 15 have been an increased opportunity to stop Salman Abedi,
 16 and in order to find that 20.50 or 22.23 or thereabouts
 17 were missed opportunities, in our submission you must
 18 find that identifying Salman Abedi as suspicious and
 19 then reporting was the only reasonable course of action
 20 for Kyle Lawler to take in the circumstances of who
 21 he was and what he knew absent of hindsight.
 22 May I turn to issue 13. Mr Lawler's evidence to you
 23 was that:
 24 "From making my observations of him and the
 25 behaviours that he was displaying wasn't enough to

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1 justify him being suspicious."
 2 And sir, we have set that out at paragraph 4 of our
 3 submissions. Evidence of Kyle Lawler's actions and
 4 behaviours we see on CCTV throughout that period of
 5 time, from 22.23 onwards, show that ultimately in our
 6 submission he did not view Salman Abedi as a suspicious
 7 person.
 8 We do say, sir, contrary to the arguments you have
 9 heard, it was not obvious that Salman Abedi was
 10 suspicious. On Monday of this week, Mr Atkinson Queen's
 11 Counsel said this:
 12 "The families submit, again as a starting point to
 13 these closing submissions, that Salman Abedi was
 14 obviously suspicious and out of place in the City Room."
 15 It was by way of example, Mr Atkinson said, the
 16 conclusion of the two experts, reached by them having
 17 considered objective factors against the background of
 18 their considerable security experience. We sound two
 19 points of caution about that statement.
 20 First, the experts relied upon factors that
 21 Kyle Lawler could never have known about and, sir,
 22 we have set those out in detail in our submissions at
 23 paragraphs 30 to 43. One example being that
 24 Salman Abedi had been in the City Room on more than one
 25 occasion for prolonged periods of time.

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1 Secondly, Colonel Latham and Dr BaMaung formed the
2 conclusions that they did on the basis of their
3 experience, which was considerably more than that of the
4 18-year-old Kyle Lawler.

5 Our issue 13 submissions are set out in detail, sir,
6 at paragraphs 14 to 54. I don't propose to read those
7 out, but may I just deal with three principal reasons
8 why we say it was not obvious that Salman Abedi was
9 suspicious at the time at which Kyle Lawler saw him.

10 First, as we say in paragraph 12, identifying
11 suspicious behaviour is not always easy. For example,
12 it wasn't obvious to anyone in the days leading to
13 22 May, including the vastly experienced former police
14 officer Mr Lavery, who did not spot Salman Abedi in the
15 City Room a few steps away from him intently observing
16 the queue, a known hallmark of hostile reconnaissance.
17 It takes practice and experience to spot and have the
18 confidence to go with a gut feeling. A person's
19 decision-making process must be viewed against the
20 circumstances that they knew at the time when they were
21 called to make the assessment and the environment within
22 which they were working.

23 Secondly, sir, in our submission, it is instructive
24 to test whether Kyle Lawler's assessment was
25 a reasonable one against the judgement of other people

1 who saw or who could have seen Salman Abedi on
2 22 May 2017. The detail of that submission is found at
3 paragraphs 44 to 54. In summary, some of those people
4 had experience of spotting suspicious people:

5 Mr Drysdale, for example. Some were members of the
6 public: Mr Hatfield, Mr Wild, Ms Whitley, Mr McGuffie,
7 Mr McCallum. Some were familiar with working in the
8 City Room: the workers from Serco, Mr Hussain, the
9 JD Williams security officer and the anti-bootlegging
10 operatives and other stewards, such as Mr Atkinson.

11 Some were in closer proximity to Salman Abedi than
12 Kyle Lawler and some spoke to him. Many saw him dressed
13 in black, wearing headwear, a coat, a rucksack and
14 hiding. Yet in the busy City Room that night only
15 a very few people regarded Salman Abedi as suspicious:
16 Mr Wild, Ms Whitley and Mr Hatfield. And sir, noting
17 that these were members of the public who were
18 unfamiliar with what were common sightings in the
19 City Room to whom a young man with a rucksack was
20 unusual, whereas to those who were familiar with the
21 City Room it was a common sighting and not a factor
22 indicating suspicion.

23 Those who were familiar with the City Room used
24 language such as "strange", "out of place", "unusual"
25 and "hiding" to describe Salman Abedi, but not

1 suspicious. And we note that "out of place" was
2 a phrase that Mr Atkinson Queen's Counsel used to
3 describe, as he said, "the obviously suspicious
4 Salman Abedi" when he began his submissions.

5 Mr Wild, Ms Whitley and Mr Hatfield have described
6 being concerned by the bomber's presence and appearance
7 in the City Room, yet Mr McGuffie, who saw the same man
8 in the same place at about the same time as Mr Wild was
9 not concerned and he told you, sir, he did not find
10 Salman Abedi to be suspicious.

11 Kyle Lawler had a bad feeling, he told you, but he
12 did not have the evidence to justify it. Neal Hatfield
13 said he had a really bad feeling. It is a matter of
14 fact, not criticism, that Mr Hatfield, who thought
15 instinctively that Salman Abedi was a bomber, remained
16 in the City Room despite his concerns, his bad feeling,
17 as did Mr Wild and Ms Whitley. This, sir, is a matter
18 for you that may be a more accurate reflection of their
19 level of concern at the time.

20 Thirdly, the information known to Kyle Lawler to
21 inform his assessment of Salman Abedi did not suggest
22 that he was a suspicious person and that detail is to be
23 found at paragraphs 30 to 32 of our submissions. He
24 didn't speak directly to Mr Wild, so he was unable
25 himself to assess the level of concern of Mr Wild or to

1 ask him questions about what he had seen. All he had to
2 go on was the information he received second-hand from
3 Mr Agha some 9 minutes after Mr Agha had been told and
4 where Mr Agha was relying upon relaying what he could
5 recall from memory.

6 Kyle Lawler had not, for example, been told that the
7 bomber had been to the City Room on the days before
8 22 May. He did not hear anyone else at all all evening
9 report anything suspicious. He knew that the pre-egress
10 check was done twice, as he heard this on the radio, but
11 nothing untoward had been reported. He understood that
12 the pre-egress check to include the mezzanine, the area
13 where he then was to watch the bomber.

14 Importantly, his colleague Mr Agha did not behave in
15 a way either in the content of what he said or in his
16 manner to appear concerned. It was not an emergency to
17 him. Putting all of that together, in our submission,
18 sir, a finding that Salman Abedi was suspicious was not
19 the only and obvious assessment Kyle Lawler could have
20 made. His ultimate opinion that Salman Abedi was not
21 suspicious was the same as a number of others on that
22 night.

23 Sir, the detail of those submissions, as I have
24 said, is set out more extensively in our written
25 document.

1 Notwithstanding this, if you take the view that it
2 should have been obvious at 22.23, we submit that
3 Kyle Lawler, whatever his inexpert view was of his
4 training and his experience, was not a person adequately
5 equipped with the tools to make an accurate assessment.
6 Four points, if I may.

7 First, identifying terrorists or even suspicious
8 people was not his primary function. His was to tell
9 people, "You can't take food and drink into the arena",
10 "Don't sit there", and, "The car park is over there",
11 and so on.

12 Secondly, he'd never seen a suspicious person
13 before. He'd never been called upon, even in a training
14 environment, to make an assessment. This was his very
15 first time. Inexperience and lack of relevant knowledge
16 can be illustrated by his reaction to seeing
17 Salman Abedi nervous and fidgeting. He initially
18 thought that the man looked calm, just waiting like
19 everybody else in the area. He saw the man fidget with
20 his hands and look nervous, but then relaxed when they
21 stopped watching him. As he said:

22 "He was fidgeting but it wasn't anything out of the
23 ordinary that would strike me as suspicious and the man
24 did not run away or make any effort to move."

25 In their first report, Colonel Latham and Dr BaMaung

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1 took the view that:

2 "In our opinion, when a previously calm individual
3 becomes fidgety immediately upon realising that security
4 staff are paying attention, that behaviour, in the
5 circumstances described, would amount to suspicious
6 behaviour."

7 That in our submission is a good example of how the
8 experienced are able to identify some suspicious
9 behaviours because to the inexperienced Kyle Lawler the
10 transient nerviness of the man on the mezzanine when
11 watched by security seemed to him to be understandable
12 and innocent. It highlights the danger of analysing the
13 conduct of Mr Lawler not from his 18-year-old shoes but
14 from those of the far more experienced experts.

15 Third point, sir, training. We have heard a lot
16 about training over the last few months and the last few
17 days and you have our written submissions at
18 paragraphs 17 to 20. One point in our submission that
19 has not been properly addressed is the identification by
20 Colonel Latham and Dr BaMaung of the lack of practical
21 on-the-job training.

22 Mr Lawler was 16 when he did his initial training,
23 18 on the night. As Colonel Latham said:

24 "Practical training I believe is indispensable and
25 the method that I have been taught to use is: explain,

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1 demonstrate, imitate, practice."

2 You may think, sir, you don't need an expert to tell
3 you that.

4 Whether it was industry standard or not,
5 Mr Middleton was not, for example, on the bridge for
6 a period of time or on the grey doors talking, asking
7 questions of his staff, encouraging. He was in the
8 interior of the arena for most of the time and close to
9 the City Room doors for the rest.

10 There was none of the type of practical training
11 suggested by Colonel Latham and whilst Kyle Lawler may
12 have worked at the arena many times before, he had no
13 experience of being confronted with a situation of
14 a potentially suspicious person either in training or in
15 reality. In short, he had no opportunity to put the
16 theory into practice.

17 Fourth point, sir, our paragraphs 21 to 26.

18 A further unanswered point is what a steward was to do
19 when receiving a report from a member of the public.
20 Report without investigation? That was not the evidence
21 of Mr Rigby and Ms Stone. They expected him to
22 investigate. What if the steward formed a different
23 conclusion? Was he to ignore his own assessment as
24 someone who knew the environment in favour of the
25 opinion of a member of the public? It is not clear and

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1 was not part of the training or briefing. This scenario
2 appears to have been overlooked.

3 Colonel Latham and Dr BaMaung have found that Agha
4 and Lawler should have been specifically and clearly
5 told in briefings about what to do if a member of the
6 public informed them about suspicious behaviour. It is
7 not clear that happened.

8 The lack of understood clear procedures and
9 following those on reporting suspicious behaviour
10 generally was also evident from other young stewards'
11 responses. It may be, sir, that that is a consequence
12 of the lack of practical training. Mr Couper-Phillips,
13 for example, wrote what he had seen on his briefing
14 sheet and handed it in, but did not upwardly report what
15 he thought was suspicious behaviour at the time, and
16 Mr Bailey in evidence criticised him for that.

17 Dimitar Arabadzhiev, whose statement you have, saw
18 two instances of suspicious behaviour. He was going to
19 confront one individual but did not. He meant to write
20 it down, but forgot. He didn't tell anyone about it
21 either.

22 Had Mr Lawler been clearly told, "If a member of the
23 public tells you something, you must report it, it
24 doesn't matter what you think", that would have in fact
25 been a much easier way forward for him. He would not

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1 have had the agony of the decision—making, worrying he
 2 might offend someone, the pressure of making a decision
 3 before the show was to end.
 4 As Colonel Latham said, and we have set this out at
 5 paragraph 66, it is very difficult in a situation where
 6 you're presented with doing something which might stop
 7 an Ariana Grande concert, you don't want to make the
 8 wrong call.
 9 I turn to issue 14. We have identified at
 10 paragraphs 56 to 62 seven points as to why the opinion
 11 of Colonel Latham and Dr BaMaung should be rejected on
 12 this issue.
 13 Kyle Lawler did not see Salman Abedi at 20.50,
 14 neither did Robert Atkinson who was with him.
 15 Fundamentally, if you accept that the two factors of not
 16 fitting the profile and carrying a rucksack are
 17 meaningless anywhere except for in the arena and in the
 18 queue to get into the arena, so meaningless on the
 19 bridge or in the City Room, then what is described as
 20 a missed opportunity by Kyle Lawler and Robert Atkinson
 21 at around 20.50 on the bridge to spot Salman Abedi
 22 should not be characterised as such.
 23 Indeed, sir, Dr BaMaung appeared to agree with the
 24 carrying of the rucksack in the City Room as not being
 25 of concern when he first gave evidence. Mr Greaney

1 Queen's Counsel said this:
 2 "Question: Doctor, if Salman Abedi had walked from
 3 the tram station, with his backpack on, up the stairs to
 4 the walkway, across the walkway, into the City Room,
 5 then down the Fifty Pence staircase and to the
 6 Trinity Way tunnel and away, on that journey you would
 7 not have expected a steward to have regarded him as
 8 suspicious or challenged him in any way?
 9 "Answer: No."
 10 Finally, this: kyle Lawler will never escape from
 11 the fact that he was one of the last people to see
 12 Salman Abedi. He will always wish he made different
 13 choices and blame himself. That is the price of
 14 hindsight. It is easy for us to see now with all that
 15 we know what he and others, such as Mr Drysdale and
 16 Ms Merchant with their spider—senses, as described by
 17 Colonel Latham, could not see, that the man they judged
 18 not suspicious was in fact the Manchester Arena bomber.
 19 Sir, those are our suspicions on chapter 7.
 20 SIR JOHN SAUNDERS: Thank you very much. I'm very grateful.
 21 Mr Greaney.
 22 MR GREANEY: Sir, finally, so far as the chapter 7 closing
 23 submissions are concerned, we will hear from Mr Williams
 24 on behalf of Mohammed Agha.
 25

1 Submissions by MR WILLIAMS
 2 MR WILLIAMS: Thank you, sir. You will have read, I know,
 3 carefully the written submissions that were previously
 4 provided and so (inaudible: distorted) much in summary
 5 and in overview, rather than trawling all those same
 6 points again. Before I get into the meat of this short
 7 submission, can I flag up one matter, and it's expressly
 8 on the instructions of Mr Agha, that he wishes to convey
 9 his most sincere condolences to the families of those
 10 deceased. He wanted that to be said and heard by them
 11 and it is meant most sincerely.
 12 Moving on to the substance then of my submissions.
 13 You will have seen from my note that the first issue
 14 that I move to is that of the credibility of Mr Agha as
 15 he gave his evidence. It's dealt with prior to in my
 16 written submission at paragraph 18, and I will deal with
 17 that and also with the issue of the grey doors, and both
 18 matters I shall deal with particularly in relation to
 19 what has been said in these closing oral submissions and
 20 particularly those by Mr Laidlaw Queen's Counsel today.
 21 If I understood what he was saying correctly, and
 22 I'm willing to be corrected if I'm wrong, but
 23 I understood him to be saying that the speaking note
 24 relied upon today and in your possession being provided
 25 to all the parties, that hasn't reached me or my

1 solicitor if that is the case. So I'm responding, as
 2 I heard it, as it were, and you have seen in my short
 3 note that I provided to you what I hope are accurate
 4 quotes from what was said orally today. If they are
 5 inaccurate, I apologise for it, but it was as
 6 (inaudible: distorted).
 7 (Inaudible: distorted) friend said on behalf of
 8 ShowSec today was that Mr Agha may not have completed
 9 the training, the online training he was referring to,
 10 with the diligence that ShowSec could expect. He went
 11 on to say that if Mr Agha had defeated ShowSec's ability
 12 to ensure online training was done properly. He also
 13 said if (inaudible: distorted) if Mr Agha deliberately
 14 spent as little time as possible on the training.
 15 So it's incumbent upon me to deal with those matters
 16 in these closing submissions. I suppose it's better
 17 that ShowSec have drawn back from their suggestion some
 18 months ago that there had been cheating, and we now at
 19 least have this softening of approach, but the
 20 accusation is still made.
 21 The accusation is essentially, given the evidence
 22 that Mr Agha made to you, the suggestion is essentially
 23 that you are being invited to decide whether Mr Agha had
 24 lied on oath. Obviously, that's a very serious
 25 accusation to make.

1 That accusation is persisted with notwithstanding
2 the developing disclosure as it attaches to the online
3 training. You will recall how the documents were
4 provided piecemeal. Initially we had the schedule and
5 it related to Mr Agha alone, and then some few weeks
6 later a wider schedule was provided, which included
7 other members of staff.

8 When making an accusation of dishonesty, lack of
9 candour, not telling the truth when giving evidence, my
10 learned friend Mr Laidlaw, in relation to ShowSec's own
11 witnesses, invited you to say that there must be cogent
12 evidence, and I would support that submission that there
13 must be cogent evidence, and perhaps it gives rise to
14 questions of sauce for the goose and sauce for the
15 gander, in my respectful submission, that if my learned
16 friend is to invite you to follow that particular path
17 then it would really require some cogent evidence
18 indeed.

19 Our submission is that the documentation you were
20 provided with does not show that Mohammed Agha simply
21 clicked on and skipped across videos and did not
22 complete his training properly. Counsel to the inquiry,
23 quite properly, asked him the questions directly. He
24 refuted the suggestion that he had cheated, had clicked
25 on directly, and said that whilst he couldn't remember

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1 the video specifically -- and I'm talking of Eyes Wide
2 Open at the moment as an illustration (inaudible:
3 distorted) passage of time, he certainly had not simply
4 clicked forward.

5 We maintain that position. That is our basic
6 position in relation to the records. However, my
7 learned friend Mr Laidlaw has suggested some other
8 course. What we say about that is the corollary must be
9 that if the records demonstrate that Mr Agha did simply
10 click on and not watch the Eyes Wide Open video, then
11 that must also be the case for other witnesses. And in
12 particular, two significant and senior members of staff,
13 Mr Middleton and Mr Rigby. If that is correct, then
14 that's indicative of a wider problem, a problem with
15 ShowSec itself, a systemic problem that Mohammed Agha
16 should not be isolated, nor scapegoated for.

17 I would like to, please, if I may, just briefly
18 illustrate the point, and I hope in advance of my
19 speaking two documents were flagged up for you, sir,
20 that I was going to refer to. The first is
21 {INQ037083/1}. If you have that before you, it should
22 be the Squire Patton Boggs letter of 4 November 2020
23 written on behalf of ShowSec.

24 SIR JOHN SAUNDERS: I'm afraid I don't. I am sorry, I don't
25 have the document, but just read it out for me and

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1 I will obviously look at it afterwards.

2 MR WILLIAMS: What I will do, sir, is I'll go quite slowly
3 and hopefully be clear as to the parts I'm referring to,
4 and you'll then be able to take a note and look at it at
5 your leisure later.

6 MR GREANEY: Sir, if it helps I believe that Mr Lopez can
7 probably share the document on our screens, but I'll
8 leave it to Mr Williams to decide whether that's the
9 most helpful way of dealing with it.

10 SIR JOHN SAUNDERS: I have now got it on the screen. It's
11 helpful to have it on the screen, thank you.

12 MR WILLIAMS: From the first page then, sir, you can see the
13 source of the letter. It's dated 4 November and it
14 speaks of the spreadsheet. You see, after the bullet
15 point list of the people that it refers to, the first
16 paragraph:

17 "The spreadsheet attached was created by Marked
18 Improvement."

19 And you have read and we have heard how it was an
20 independent third party that were assisting ShowSec.
21 It's saying that:

22 "Various matters should be taken into account [the
23 lower half of the paragraph] when considering the data
24 and the weight that can be placed on it."

25 If we can turn to the second page, please, Mr Lopez,

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1 I'd be very grateful {INQ037083/2}. Four paragraphs in,
2 there's a paragraph that begins:

3 "The caveats with this are, first, that the database
4 back-ups are snapshots of a particular point in time,
5 that the database was constantly changing as user
6 records were updated by the system and/or course content
7 was added or edited by ShowSec's learning and
8 development team.

9 "Secondly, the code in the system also evolved over
10 time, as with any web-based system, in response to bugs
11 being reported/fixed and any enhancements
12 requested/implemented. Marked Improvement can identify
13 when major changes are implemented, an example being the
14 introduction of a test in the counter-terrorism at
15 events module in December 2016, but minor changes would
16 not necessarily be documented."

17 Then this, the following paragraph in relation to
18 column F:

19 "Completed date shows the date and time on which the
20 page of a particular ShowSec module was last accessed by
21 the user."

22 So the last access:

23 "The purpose of the spreadsheets with the completed
24 sections and the timestamp columns was to give an
25 indication of time spent on a module, but as the page

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1 view timestamp was updated, if a user returned to that
 2 page it is possible that a user might have spent longer
 3 working through a module than appears at first sight.
 4 Therefore the spreadsheet may not show how long in total
 5 a user spent on the page. It is possible to estimate
 6 the time that an individual spent on a page on the last
 7 occasion they accessed it by comparing the completed
 8 date entries of the different pages within a particular
 9 module. However, the data does not and cannot show on
 10 how many other occasions, if at all, a user had
 11 previously accessed the module. As a result, the data
 12 may show the first and only time that an individual
 13 accessed the module or the last of two or more occasions
 14 on which the individual accessed it. It also follows
 15 that if an individual had spent a substantial portion of
 16 time on a particular module and had then returned to it
 17 for a much shorter time on a subsequent occasion, only
 18 the latter would be recorded."

19 If we can turn to the following page {INQ037083/3},
 20 please, Mr Lopez. On the following page you see, sir,
 21 it then moves on to column E, and the third paragraph,
 22 last sentence:

23 "It is not possible to determine whether users
 24 watched the videos in full, in part or at all, or indeed
 25 when they watched them as they were able to do so

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1 offline from the e-learning platform."

2 And the finishing paragraph:

3 "In summary, it is impossible to determine from the
 4 spreadsheet, with certainty, for how long or on how many
 5 occasions any of the individuals whose record times have
 6 been disclosed accessed the modules."

7 So that is, sir, a very large caveat to be attached
 8 to the Excel spreadsheets and I would like now, please,
 9 if I may, and if Mr Lopez is able to assist, to then
 10 move to those Excel spreadsheets. The reference is
 11 {INQ037084/1}. If it is not possible to bring it up,
 12 what I can do, sir, is take you through it, you not
 13 being able to see it, but I'll go slowly.

14 I don't see anything appearing on my screen, so
 15 presumably Mr Lopez is not able to pull that up. No
 16 matter. If it's satisfactory for you, sir, I'll go
 17 through it slowly and hopefully you will be able to take
 18 a note.

19 When you do come back to consider this document
 20 then, please, sir, you will see, it's an Excel
 21 spreadsheet and along the bottom of the spreadsheet it
 22 has the different names for the different people to
 23 which it relates. We were all taken, quite properly, to
 24 the tab that related to Mr Agha. I'm just going to use
 25 one part of it as an illustration for the point that I'm

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1 making and it's the part relating to the Eyes Wide Open
 2 video. You will remember Mr Greaney Queen's Counsel
 3 referred to that particular portion and pointed out that
 4 the video was some 12 minutes or so long.

5 SIR JOHN SAUNDERS: The spreadsheet has now come up on my
 6 screen.

7 MR WILLIAMS: Thank you, it's now up on mine as well, sir.
 8 What I'm focusing on is lines 105 and 106. I think
 9 Mr Lopez is interacting with the sheet. Yes, 105 and
 10 106 I think is now available to you.

11 What you can see at 105 and 106, it is part of
 12 module 14, and you can see "14" just before the words
 13 "Counter-terrorism at events (CTE)".

14 If we read across we see, "Eyes Wide Open, acting on
 15 suspicious behaviour", and beneath that the word
 16 "complete".

17 And if we look across at the times, Eyes Wide Open
 18 is timed at 15.54.37. The complete is 15.57.28. As
 19 I recall it, the suggestion put by Mr Greaney was that
 20 perhaps that had the potential for demonstrating that
 21 12 minutes or so had not been spent watching the video.
 22 And of course that would be a natural question to ask
 23 because at that time we did not have the caveats and the
 24 explanations. And it was a suggestion adopted with
 25 enthusiasm by my learned friend Mr Laidlaw.

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1 What I would like to do then is turn to the tab
 2 in relation to David Middleton, if Mr Lopez is able to
 3 help with that, at lines 90 and 91. Again, you see it's
 4 module 14, "Counter-terrorism at events", "Eyes Wide
 5 Open" and "Complete". The times there are 09.34.04 and
 6 09.34.14.

7 That's a 10-second gap between the two. So if this
 8 document is to be used in the way that Mr Laidlaw was
 9 potentially putting it forward to be used as, then
 10 Mr Middleton has spent 10 seconds watching that video.

11 If we could move to the tab for Mr Rigby, please,
 12 Thomas Rigby, it's lines 56 and 57.

13 At 56 and 57, sir, you see again module 14,
 14 "Counter-terrorism at events", "Eyes Wide Open" and
 15 "complete", and reading across, 16.02.55 and 16.09.17.
 16 So again, if we are to use that particular
 17 interpretation, maybe half or slightly more than half of
 18 the video was watched by Thomas Rigby.

19 I have finished with the document, thank you very
 20 much, Mr Lopez.

21 My short point, sir, is that we do not support this
 22 usage or interpretation of the document at all given the
 23 caveat, but if it is to be used in that way then it must
 24 be used fairly and examined across the various members
 25 of staff, and we know that Mr Middleton and Mr Rigby are

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1 very senior members of staff. It seems highly unlikely
2 that they would simply click through a video,
3 particularly not 10 seconds worth of video, and if you
4 are to be urged to interpret the document in this other
5 way than this is what they must have done and it's
6 indicative of some sort of systemic widespread problem
7 which, as I am submitting to you, Mr Agha must not be
8 isolated and scapegoated for.

9 But I will move on now, sir, if I may.

10 SIR JOHN SAUNDERS: Before you do, can I just -- this again
11 may be an entire lapse of memory on my part, so please
12 forgive me if it is. My recollection is that Mr Agha
13 himself accepted that he might not have paid as much
14 attention to the training as he should have. Would I be
15 right in saying that?

16 MR WILLIAMS: Well, I'm not sure that's the phrase that he
17 exactly --

18 SIR JOHN SAUNDERS: No, no, it certainly wouldn't be the
19 phrase, no. That's a general recollection.

20 MR WILLIAMS: What I can accept on his behalf is that the
21 mode in which he was accessing the training, using
22 a mobile phone, and if you look at some of the hours at
23 which he was accessing it, is not conducive to the good
24 digestion of that information. That doesn't seem to be
25 anything that was monitored at the time by ShowSec.

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1 SIR JOHN SAUNDERS: Thank you.

2 MR WILLIAMS: I will move on if it assists you, and you have
3 seen in my note, to the grey doors. Again it was
4 suggested today that Mr Agha has not told you the truth
5 in relation to the grey doors. That's in relation to
6 his evidence that Mr Middleton did not tell him where
7 the grey doors were or what his duties were and he had
8 to ask Dimitri, his colleague. Mr Laidlaw in reply to
9 that says, well, that member of staff's statement is
10 silent on the issue. Well, that's correct, it is silent
11 on the issue, but to be fair, that statement taken from
12 a member of staff was taken a very long time ago and
13 there's no suggestion that he was asked about it either
14 way because at the time it was not a known issue for the
15 police to be investigating, so it's just silent, one
16 can't draw an inference from it one way or the other if
17 one is to be fair. That's my respectful suggestion.

18 Mr Middleton did give evidence about it and he was
19 for saying that he did tell Mr Agha that he was to be
20 working on the grey emergency doors. We know this was
21 the first shift for Mr Agha as an SIA, so whilst he'd
22 been generally security staff, he had not been an SIA
23 before and we know that profiling is an SIA-accredited
24 activity, so it's the first time he would be profiling
25 in the proper sense. He's been told, according to

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1 Mr Middleton, that he's to be on the doors, and that
2 does not mean that Mr Agha is lying to you, and I will
3 turn to reliability in a moment.

4 Mr Middleton said that he did tell him to stay
5 at the emergency doors and not to leave them and he also
6 confirmed in questioning that he did not say "except for
7 emergencies". So there was no get-out clause, no
8 caveat, no softening of the instruction to Mr Agha,
9 he was to stay at those (inaudible: distorted) evidence.

10 I move on to reliability and the question of
11 reliability and there are a number of factors there.
12 One is one has to be realistic and remember that these
13 events will have been deeply traumatic for Mr Agha.
14 They have had their effect upon him, as they would do
15 anybody in that position. There has been the normal
16 passage of time and you know the mental health
17 difficulties that Mr Agha has faced as a consequence of
18 being involved in these events.

19 There has been some criticism of Mr Agha that his
20 account has changed over the life of this inquiry and
21 that is true to a limited extent. The way in which it
22 has changed is around his timings. He has had the
23 benefit, once he had representation, of going to the
24 police station and being allowed to go through the CCTV
25 with the help of the police officers. He was then able

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1 to pin down the correct times. But he can perhaps be
2 forgiven for having got the times and durations wrong
3 in the first place. It's certainly not an indication of
4 dishonesty or anything like that. One has to be
5 realistic about these matters.

6 The mental health problems that he has suffered are
7 very significant. I am not going to mention them in any
8 detail at all, but you, sir, have read the reports and
9 I do invite you to take that very much into account
10 because it affects his ability to draw on the memories
11 and then to give an account to you.

12 There is, on top of that, the pressure of the
13 prospect of being scapegoated. You may well know
14 through the inquiry legal team of the efforts that the
15 media have made to contact Mr Agha, the way he has been
16 doorstepped, he has been stopped in the street, both
17 prior to and post giving his evidence, and he has
18 received a number of threats such that he's now left the
19 family home.

20 One can only imagine the effect of those sorts of
21 pressures on a man of his young years. I commend him to
22 you, as I did in writing previously, that whatever his
23 failings in memory or perception are, he has done his
24 honest best to assist you, to assist the inquiry, and to
25 assist the families in having a better understanding of

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1 what took place that night that so affected them and
 2 their loved ones.
 3 I move forward then into the nub of the incident
 4 insofar as Mr Agha is concerned. In my writing and in
 5 this oral closing, I have characterised it as before
 6 Wild and after Wild because in my submission there are
 7 different considerations for each of those parts of the
 8 story.
 9 Before Mr Wild speaks to Mr Agha there is the
 10 consideration of audience profiling. He's on the grey
 11 doors and he's looking at members of the public within
 12 the City Room.
 13 You have heard ample evidence that audience
 14 profiling, properly so considered, is fairly specific.
 15 It relates to those people who are seeking entry into
 16 the arena. It's not an exercise that one can simply
 17 apply broadly to the whole public. So the question of
 18 whether somebody may or may not fit the expected
 19 audience profile, young girls or parents accompanying
 20 them, the focus is very much on the queue outside the
 21 City Room access doors or within the arena itself
 22 because this is, at the end of the day, a public space.
 23 So before Mr Wild speaks to Mr Agha, those are part
 24 of the proper context. There's been ample evidence that
 25 travellers will come and wait. People on trains, buses,

1 trams, will come and wait in this area, either to get on
 2 to transport themselves or to meet people coming off
 3 transport, and more than one witness has spoken of that.
 4 So that, I would suggest, is part of the common context
 5 of that room, and also backpacks, large bags, we have
 6 heard that they were relatively common items. So none
 7 of those matters in and of themselves should be expected
 8 to have caused alarm and suspicion in Mr Agha's mind
 9 because he knows all of those things as being general
 10 context for that room.
 11 In the experts' agreed document, towards the end of
 12 chapter 7, they also introduced the additional factor of
 13 wearing headgear. I put that in with clothing, wearing
 14 headgear. I invite you, sir, to name it as what it was.
 15 It was a baseball cap and I dare to suggest that there's
 16 absolutely nothing unusual about a young man in his 20s
 17 wearing a baseball cap, be it a warm May evening or not.
 18 It's just not suspicious in the slightest. I do invite
 19 you, sir, to approach all of the evidence with the lens
 20 of common sense and that there is nothing suspicious
 21 about a baseball cap, worn day, night, sunny or cold.
 22 What I do suggest is that there is a common strand
 23 of a shared view that all of the security staff, the
 24 anti-bootlegging staff, Mr Drysdale, the merchandising,
 25 Ms Merchant, none of those people saw him, Mr Abedi, as

1 being suspicious. Mr Drysdale had a good look at him,
 2 did not regard him as suspicious in the sense of
 3 potentially being a terrorist. Ms Merchant made
 4 reference to the fact that he was praying in a public
 5 space and she made some derogatory comments about it in
 6 her evidence but she did not see it as suspicious or
 7 indicating that he might be some sort of fundamentalist
 8 Islamist terrorist, as he turned out to be.
 9 So it is a shared view across those people who
 10 worked in that area that the various elements that are
 11 said to have arisen or should have arisen to suspicion
 12 were relatively common items and it didn't raise
 13 suspicion for any of those people. And if it didn't
 14 raise suspicion for any of those people, my respectful
 15 submission is it's rather unfair to suggest that it
 16 should have done in Mr Agha's mind and that he should
 17 not be judged differently from all those others.
 18 What is interesting is that some members of the
 19 public did regard Abedi as suspicious. Perhaps that's
 20 because they don't have that contextual information,
 21 they don't know that it's relatively common for people
 22 to come in with a large bag, et cetera, and that's why
 23 concern was raised in their mind. The concern was in
 24 particular raised in the mind of Mr Wild, who is to be
 25 commended for having come forward in the way that he

1 did. You have in mind the information that was given to
 2 Mr Agha and how. Mr Agha said it was said to him in
 3 a relatively calm way, it wasn't said in a panicky way
 4 to him, and others said that Mr Wild left his partner
 5 in the City Room and left for 6 minutes and then
 6 returned, which perhaps again is not indicative of panic
 7 or some such.
 8 Mr Agha is on those grey doors, not able to leave
 9 them, he does not have a radio, he has not been
 10 supervised by Mr Middleton. Mr Middleton did not come
 11 out and say, "I know it's your first time on the doors,
 12 how is it going? Have you got any concerns?" Nothing
 13 like that. So Mr Agha simply relied on his own
 14 perception of the situation. You will have in mind his
 15 age and his lack of experience in that specific role.
 16 ShowSec have misstated Mr Agha's position within
 17 this case. You will recall Mr Agha's evidence. Prior
 18 to being spoken to by Mr Wild, he did not have a concern
 19 about Abedi. Once he had been spoken to by Mr Wild, he
 20 then did start to form a concern and he told you how he
 21 had started to think about it, make connections in his
 22 mind, and he took some time to think about it. He then
 23 formed a view that he needed to communicate it in some
 24 way.
 25 It is perhaps unfortunate that ShowSec have

1 mischaracterised Mr Agha's position at this particular
2 point in time and made such strong submissions that they
3 have against him, whether inadvertently that is because
4 he's no longer employed by ShowSec, but there is a very
5 different tone, you might think, from that that was
6 applied to Mr Lawler, who is still employed by them, but
7 maybe there's nothing to that.

8 Mr Agha formed a concern arising from that which
9 Mr Wild had said to him and then reviewing the position
10 and thinking it over, but he did not regard it to be an
11 emergency. So he took actions which are proportionate,
12 in his view, to a concern. He raised his hand briefly,
13 I entirely accept, on a number of occasions. He
14 explained how he didn't want to cause alarm, draw undue
15 attention to himself, draw attention from Abedi. Some
16 few minutes passed by and then Mr Lawler came and he
17 then reported it to Mr Lawler.

18 At that point of reporting to Mr Lawler, he then
19 complied with the procedure. He had reported it to
20 somebody who had a radio and then could pass it on up
21 the chain of command. He was told by Mr Lawler that
22 that would be done. So any criticism thereafter by any
23 other parties perhaps is a little unfair after that
24 point.

25 They had been referred, Mr Agha and Mr Lawler, very

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1 much all of a piece, but there are different
2 considerations because Mr Agha, once he had formed the
3 concern, made his efforts by raising his hand, then
4 after that report it had to Lawler, he completed his
5 duty as it were, he completed that act.

6 Whether the arm-raising was sufficient is a matter
7 for you. Mr O'Connor, I think it was, said, well, he
8 could have raised his arm and kept it raised. It was
9 also said that he could have sent Mr Wild over to
10 Mr Middleton. He could have said words to the effect
11 of, "I can't leave here, but please go and speak to that
12 gentleman, he will be able to help you". And they are,
13 I accept, very practical commonsense suggestions.

14 But the fact that Mr Agha did not take those
15 particular courses of action does not mean that he
16 failed. He was a young man trying to put his training
17 into practice in the first time that he'd ever come
18 across that situation and doing it in a proportionate
19 way to the situation as he perceived it to be.

20 You might wonder, and the experts certainly did
21 raise this question, whether the training was sufficient
22 insofar as it didn't have any role play or face-to-face
23 element, something that would have allowed somebody like
24 Mr Agha, or any of the other young staff, to develop
25 decision-making skills that would equip them to such

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1 a situation, something that would have refined or
2 improved his judgement.

3 You'll recall that Colonel Latham spoke of judgement
4 that's gained through experience. Well, unfortunately,
5 this was the first night that Mohammed Agha had
6 performed as an SIA on the grey doors, so he had no
7 time, no time at all, to develop that experience.

8 It was also suggested that he should have been given
9 a radio because he was positioned at a fixed place and
10 that's something else that perhaps you might want to
11 consider.

12 So in conclusion, sir, what I am submitting is that
13 you've been invited to consider whether there was an
14 inadequacy of response by Mr Agha in that moment
15 surrounding his conversation with Mr Wild and I have
16 said what I have said about it and you will form
17 a judgement. But if you do form a judgement that there
18 is some inadequacy there, I would urge you to say that
19 in fairness, that inadequacy, if so found, is a symptom
20 of the wider systemic failings and it is not of itself
21 a cause.

22 In my submissions, what we are seeking to say
23 is that if one approaches the evidence with an attitude
24 of learning so as to assist the inquiry and to assist
25 the families of the deceased and those who were injured,

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1 and you feature Mr Agha's role into the jigsaw of
2 considerations and work towards prevention of
3 repetition, then those last two considerations, whether
4 there should be role play or face-to-face training, and
5 whether fixed positions should have a radio, those two
6 questions and the answers to them might assist you when
7 approaching the question with an attitude of learning.

8 It only falls to me to finish and to repeat, if
9 I may, the condolences to the families of the deceased.

10 Thank you, sir. If you have any questions, I'm
11 happy to --

12 SIR JOHN SAUNDERS: I don't think I have. Thank you very
13 much for your submissions.

14 Mr Greaney.

15 MR GREANEY: Could I just pick up on two points that arise
16 out of the submissions? The first is to deal with the
17 recollection that you had as to what Mr Agha had said
18 about his training. The relevant reference is
19 transcript Day 24, I believe, and for your note it's
20 pages 63 to 64 {Day24/63:1}. We can't get this on the
21 screen at the moment, but it's just a very short passage
22 that I will read out. It was a passage during the
23 course of the questioning of counsel to the inquiry:

24 "Question: We agreed earlier, didn't we, Mr Agha
25 that training is obviously important in terms of

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1 spotting suspicious characters and addressing
 2 a terrorist threat?
 3 "Answer: Yes."
 4 "Question: And the extent to which you should have
 5 been better supervised in your training is an issue
 6 that's not for you but we can agree, I think, that
 7 certainly ShowSec made available to you materials that
 8 were capable of informing you about terrorist threats,
 9 didn't they?
 10 "Answer: Yes."
 11 Then, sir, this question and answer which is what
 12 you had in mind, I believe:
 13 "Question: And do you think it's fair to say that
 14 if you had attended to your studies properly you would
 15 have been at any rate better informed on the night of
 16 the attack?
 17 "Answer: Yes."
 18 Sir, the second point, which is something that
 19 Mr Williams might want to address now or he might want
 20 to address it in writing in due course, we believe he
 21 addressed you on the basis that there had been
 22 a concession made by Mr Agha during the course of his
 23 evidence that he had viewed the training materials
 24 (inaudible: distorted) mobile telephone but for our part
 25 we certainly recall that Mr Lawler said that that was

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1 his position, we didn't recall that Mr Agha had
 2 expressed that position, and our researches over the
 3 course of the last half hour have not identified that
 4 anywhere in the transcript of the evidence of Mr Agha.
 5 So we would just invite Mr Williams to reflect upon
 6 whether that does or does not form part of the case of
 7 Mr Agha.
 8 Sir, unless Mr Williams want to say anything else at
 9 this stage, as we have indicated he may prefer to reply
 10 to those observations in writing, I can see Mr Williams
 11 has reappeared. I don't want to shut him out,
 12 of course.
 13 SIR JOHN SAUNDERS: Mr Williams.
 14 MR WILLIAMS: I am going to take the opportunity to reflect
 15 on those. I'm grateful to my learned friend Mr Greaney
 16 for flagging them up. You'll be better assisted I think
 17 if I look at the transcript and reflect on it.
 18 SIR JOHN SAUNDERS: Certainly, thank you very much,
 19 Mr Williams, that would be a help.
 20 MR GREANEY: That seems to us to be a sensible approach, and
 21 we raise these points of course just to help. We've now
 22 reached the end of all of the closing submissions on
 23 chapter 7. That's as much as we can or need to do today
 24 and we will resume, as everyone knows, the chapter 10
 25 evidence on Monday morning, when there will be an

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1 in-person hearing in Manchester that at least some of
 2 us, may I put it this way, will be able to attend.
 3 SIR JOHN SAUNDERS: Thank you, Mr Greaney. Can I just say
 4 to all those who made submissions, first of all they've
 5 been extremely helpful and, secondly, I am very grateful
 6 for the timekeeping and the only reason why we have gone
 7 over at all is because I was not available for the whole
 8 time yesterday, so thank you very much for that.
 9 MR GREANEY: Thank you very much indeed, sir.
 10 SIR JOHN SAUNDERS: I will now leave unless anyone wants me
 11 for anything.
 12 MR GREANEY: I don't believe so, thank you.
 13 (4.42 pm)
 14 (The inquiry adjourned until Monday, 1 February 2021)

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I N D E X

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 2 (continued)
 3 Submissions by MR HORWELL1
 4 Submissions by MR LAIDLAW22
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