Manchester Arena Inquiry
Volume 2: Emergency Response

Report of the Public Inquiry into the Attack on Manchester Arena on 22\textsuperscript{nd} May 2017

Chairman: The Hon Sir John Saunders
November 2022
Manchester Arena Inquiry
Volume 2: Emergency Response

Volume 2-la
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Preface

Volume 2 of my Report is concerned with the emergency response to the explosion at the Manchester Arena (the Arena) on 22nd May 2017. As I set out in Volume 1, at 22:31 that day, a suicide bomber detonated his device in a publicly accessible area adjacent to the Arena bowl, called the City Room (the Attack). He did so as a concert by the singer Ariana Grande came to an end. The bomb killed twenty-two people who had attended the concert or were waiting outside for those who had, and injured many many more.

The Inquiry’s terms of reference require me to assess the impact of any inadequacies in the planning and preparation by the emergency services, and in the emergency response. This includes whether any inadequacies undermined the ability of the response to save life or contributed to the extent of the loss of life.¹

For this reason, most of Volume 2 is focused on what went wrong on the night of 22nd May 2017. That does not mean that I have ignored the evidence of what went well.

The heroism shown by very many people that night is striking. Considerable bravery was shown by members of the public who were visiting the building, those who were

¹ See Appendix 1 in Volume 1
employed to work at the Victoria Exchange Complex and personnel from the emergency services.

I have seen the terrible footage from the CCTV and body-worn video cameras of the scene of devastation in the City Room. The description of that area as being like a “war zone” was used by a number of witnesses. That is an accurate description.

To enter the City Room or remain there to help victims required great courage. Nothing I say in this Volume of my Report is intended to diminish that fact. I pay tribute to all those who selflessly went to the aid of others.

In addition to the individual acts of courage, there were some parts of the emergency response that worked well. Notwithstanding the concerns I expressed in Volume 1 about the conduct of some in the period before the explosion, British Transport Police (BTP) officers who were present in the Victoria Exchange Complex at the time of the explosion responded immediately and rushed to the City Room. More BTP officers from elsewhere mobilised urgently. Greater Manchester Police (GMP) also mobilised a very significant number of firearms officers and unarmed officers. There were more than sufficient rank and file police officers from both GMP and BTP to assist with the response.

I am satisfied that the way in which the firearms officers acted meant that, had there been a threat from

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2/71/16-72/6, INQ012286/2, INQ005866/2, INQ004984/2, INQ006661/6, INQ024259/3, INQ006024/3, INQ003647/2
marauding terrorists with firearms, it would have been neutralised very quickly. I was impressed by the professionalism of those officers.

Similarly, while I have concerns about many aspects of the command of the emergency services, there was much evidence of collaboration by junior police officers. There was also ingenuity and initiative displayed, such as when, due to the unacceptable failure to make stretchers available to those in the City Room, makeshift platforms were used to carry people out.

I have no doubt that lives were saved by the emergency response. There were many grave injuries sustained. Without the care of members of the public, those who worked at the Victoria Exchange Complex and emergency services personnel, more lives would have been lost. While I am critical of the emergency response overall, I recognise that, at an individual level, many people did their jobs to a high standard and were a positive influence on the outcome. There will be some who owe their lives to those who worked tirelessly to assist them.

During the Inquiry, many have acknowledged that mistakes were made in the aftermath of the explosion. I have been concerned with analysing why those mistakes were made and what can be done to prevent them happening again. I have also been concerned with analysing whether, when things went well, they could have been done better.
It may be inevitable that when a sudden and very shocking event happens, such as the detonation of a bomb, things will go wrong. People panic. Courageous people rush in to do what they can to help, and there is a risk that nobody stands back to consider what is the best way to organise the response.

By no means all the mistakes that were made on 22nd May 2017 were inevitable. There had been failures to prepare. There had been inadequacies in training. Well-established principles had not been ingrained in practice.

Why was that? Partly it was because, despite the fact that the threat of a terrorist attack was at a very high level on 22nd May 2017, no one really thought it could happen to them. This was the case even though such a high-profile concert in a very large arena might obviously attract the attention of a terrorist intent on killing and injuring as many people as possible. Maybe it is also because, fortunately, this sort of tragic event is rare.

Looked at overall, and objectively, the performance of the emergency services was far below the standard it should have been. GMP did not lead the response in accordance with the guidance that it had been given or parts of its own plans. Greater Manchester Fire and Rescue Service (GMFRS) failed to turn up at the scene at a time when they could provide the greatest assistance. North West Ambulance Service (NWAS) failed to send sufficient paramedics into the City Room. NWAS did not use
available stretchers to remove casualties in a safe way, and did not communicate their intentions sufficiently to those who were in the City Room.

The purpose of Volume 2 of my Report is to analyse why these problems occurred. It is not to apportion blame but rather to scrutinise whether systems worked, whether individuals were able to perform in accordance with their training and, if they did not, to understand why. It is only through careful analysis that we can learn from errors and failures to prevent repetition. That is why this Volume is so long and so detailed.

I have criticised a large number of people whom I consider to have made mistakes on the night. Some of those criticisms may seem harsh, particularly given the situation that those individuals were faced with. They were trying to do their best. I do understand the enormous pressures that they were acting under. They had to do many things in a short time and it may not be surprising that things went wrong. I am not unsympathetic to them. But I need to identify mistakes where they have been made because otherwise there is no prospect of preventing them in the future. Safeguards need to be put in place to try and prevent, as far as we can, mistakes being made due to the stress caused by being involved in an appalling event such as this.

At the centre of my Inquiry is the terrible loss of twenty-two lives. Each family and each person at the Arena has a deeply personal story to tell about the impact of the
Attack on them. My Report cannot change what has happened. My intention is to uncover what went wrong and find ways of improving practices so that no one has to suffer such terrible pain and loss again.

Volume 2 is divided into two sub-volumes, Volume 2-I, comprising Parts 9 to 16, and Volume 2-II, comprising Parts 17 to 21 and the Appendices. It is laid out as follows:

- **Part 9** remembers each of those who died. They are at the heart of the Inquiry and it is appropriate that Volume 2, which deals with their deaths, begins by remembering who they were.

- **Part 10** is a narrative summary of the emergency response and what went wrong with it. It does not set out my reasoning, which comes in later Parts. So far as is possible, it sets out events in a chronological order.

- **Part 11** considers the overarching framework in place in 2017 for an emergency response. This includes the relevant legal provisions and the guidance documents that applied on 22nd May 2017.

- **Part 12** addresses the preparedness of a number of organisations: the Greater Manchester Resilience Forum; BTP; GMP; NWAS; North West Fire Control (NWFC); and GMFRS. Part 12 also deals with two particular areas of preparedness, which apply across the emergency services in Greater Manchester: the
setting up of a multi-agency control room talk group; and multi-agency exercising, in particular one called Exercise Winchester Accord, which took place almost exactly a year before the Attack.

- **Part 13** considers the police services emergency response to the Attack: that of BTP, GMP and Counter Terrorism Policing Headquarters. Along with the ambulance and fire and rescue services discussed in Parts 14 and 15, these organisations represented the state’s immediate response to the Attack. In this Part, I summarise the help BTP and GMP police officers sought to provide to those who died.

- **Part 14** considers the ambulance service emergency response to the Attack from NWAS. In this Part, I record the help NWAS personnel sought to provide to those who died.

- **Part 15** considers the fire and rescue service emergency response to the Attack from NWFC and GMFRS.

- **Part 16** deals with a number of other organisations that were present on the night of the Attack and whose staff went to help. The principal focus is on SMG, the Arena operator, and on the organisation that SMG contracted to provide healthcare services, Emergency Training UK (ETUK). Part 16 also considers the response of: Showsec, the crowd management and security company retained by SMG; employees of TravelSafe, which provided security to
parts of the railway network; and Network Rail. Part 16 concludes with a section that sets out the important contribution that members of the public made to the response. In this Part, I identify the members of the public and staff working in the Victoria Exchange Complex who tried to help those who died.

- **Part 17** sets out the effect of the explosion. It includes a record of the accounts that some of those who survived gave me.

- **Part 18** is focused on the twenty-two who died. It sets out in relation to each of them, in summary form, what happened from the point of the explosion. I heard detailed, and often traumatic, evidence in the hearings about the experience of each of those who died. I only set out in this Part the details that I think are necessary to record the circumstances of their deaths. It also deals with the question of whether any of those who died might have been able to survive had the emergency response been better.

- **Part 19** reviews the stages and investigations that have preceded this Inquiry. I draw out ways in which investigations following mass casualty incidents may be improved in the future.

- **Part 20** is concerned with a period that, during the course of the Inquiry, was termed ‘the Care Gap’. This is the inevitable period of time between an incident that causes injury and the arrival of the emergency services, particularly the ambulance
service. I explain why change needs to occur in order to both narrow and fill that Care Gap. I make recommendations that seek to achieve this.

- **Part 21** sets out my conclusions, lists the recommendations made across the course of this Volume and specifies those recommendations that I shall monitor.
The twenty-two who died

Alison Howe
Angelika Klis  Marcin Klis
Chloe Rutherford  Liam Curry
Courtney Boyle
Eilidh MacLeod
Elaine McIver
Georgina Bethany Callander
Jane Tweddle
John Atkinson
Kelly Brewster
Lisa Lees
Martyn Hakan Hett
Megan Joanne Hurley
Michelle Kiss
Nell Jones
Olivia Paige Campbell-Hardy
Philip Tron
Saffie-Rose Roussos
Sorrell Leczkowski
Wendy Fawell
Part 9
Remembering those who died

9.1 Twenty-two people lost their lives on 22nd May 2017. The responsibility for their deaths lies with SA and HA.

9.2 Those individuals who were killed have always been at the heart of this Inquiry. The evidence has shown them to be irreplaceable, unique people who lit up the lives of those around them. The evidence has also shown the devastation their loss has caused to families and friends. It has brought home to everyone involved in this Inquiry, and watching the hearings, how important it is to protect and preserve life.

9.3 Evidence was given about each person who died, through the words of those who loved them, through pictures of them at some of their happiest moments and through song. I heard about their personalities, their strengths and their aspirations.

9.4 What follows is a summary of that evidence. For each individual, I have tried to capture something of who they were as a person. I also set out how they came to be in the City Room at 22:31.
9.5 In this Part, I do not go past the point of explosion. In Part 18 in Volume 2-II, I return to each person in relation to what happened after the bomb was detonated.
Alison Howe was the mother of Sasha and Darcie and the stepmother of Lewis, Jack, Jordan and Harris. Her husband was Stephen Howe. Her parents were Sue and George Cann. She was 44 years old at the time of her death on 22nd May 2017.

Stephen described how he first met Alison. He told her almost immediately that he loved her and would marry her one day. He turned out to be right. As a result, they ended up sharing a family,
which brought them so much love and happiness. One of Alison’s friends told me that Alison and her husband Stephen had something special and that he gave her a fabulous life. 8

9.8 Alison was adored by her family and loved as a wife, stepmother and mother. 9 Family was her life. 10 I heard how close she was to her mother, with whom she spent so much time, constantly laughing and enjoying a “beautiful relationship”. 11 Alison had a positive, engaging personality and gave love generously to those in her life.

9.9 Alison’s “Super Six” 12 children wrote a poem in which they told their mum how much they loved her. They thanked her for her love and kindness. 13 Her husband proudly gave Alison credit for the way she had brought up their children and for the strength they had received from her. 14 She was a force for good. 15
Events of 22\textsuperscript{nd} May 2017

9.10 Alison attended the Arena that night with her friend, Lisa Lees, and their daughters.\textsuperscript{16} Their daughters went to watch the concert. Alison and Lisa returned to collect them afterwards.\textsuperscript{17} Together, they entered the City Room at 22:27:01 from the direction of Manchester Victoria Railway Station.\textsuperscript{18}

\textsuperscript{16} 152/3/23-24
\textsuperscript{17} 152/4/1-11
\textsuperscript{18} 152/4/8-9
Angelika and Marcin Klis

9.11 Angelika and Marcin Klis were born in Poland.\textsuperscript{19} Marcin was 42 years old at the time of his death on 22\textsuperscript{nd} May 2017. Angelika was 39 when she died.\textsuperscript{20}

9.12 Angelika and Marcin met in Poland in the early 1990s and fell in love. In 1996, they married. They had two daughters: Aleksandra and Patrycja.\textsuperscript{21} By 2007, the family had moved to England.\textsuperscript{22}

\textsuperscript{19} 6/1/20-21, 150/103/8-10
\textsuperscript{20} 150/103/11-13
\textsuperscript{21} 6/1/25-2/3, 150/103/14-17
\textsuperscript{22} 6/2/8-9, 150/103/18-19
9.13 Angelika and Marcin were devoted to their children, as well as each other. I heard how they would dedicate time to being together as a family. Angelika loved lying in the sunshine and being with her daughters, shopping and going for massages. Marcin loved photography and rock music. They travelled together and took holidays in Rome, Egypt and Poland. Spending time as a family is what made them both happiest.

9.14 Aleksandra and Patrycja described Angelika and Marcin as their best friends and spoke of their “amazing parents”. They remember that their love for each other was incredibly strong and that, “they were so in love, as if they were teenagers without a care in the world … They were soulmates and they didn’t want to be without each other.”

Events of 22nd May 2017

9.15 Angelika and Marcin and their daughters arrived at the Arena that night as a family. Angelika and Marcin left their daughters there, having arranged
to meet up after the concert. They spent a few hours in Manchester City Centre together. Photographs and footage taken from the evening show just how in love and how happy they were.

9.16 Angelika and Marcin returned to the City Room at 22:23 and remained standing with their arms around one another. They were holding each other at the point of the detonation.

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31 150/104/22-24  
32 150/105/14-17  
33 150/105/16-23
9.17 Chloe Rutherford was the daughter of Lisa and Mark Rutherford and the sister of Scott. She was 17 years old at the time of her death on 22nd May 2017.

9.18 Liam Curry was the son of Caroline and Andrew Curry and the brother of Zack. He was 19 years old when he died.

9.19 Both of them showed outstanding promise in their young lives. Chloe had an early love of theatre and thrilled audiences in stage performances while at school. She went to college to study
music performance, where she discovered a love of songwriting.\textsuperscript{39} Chloe expressed herself through writing lyrics and performing her own music, often raising money for charity.\textsuperscript{40} Liam excelled in sports, particularly cricket, for which he shared a passion with his father.\textsuperscript{41} He went on to study sports science at college and then university.\textsuperscript{42}

9.20 Liam and Chloe were two very happy teenagers. They had been dating since 2014, after meeting at a cricket club.\textsuperscript{43} Their relationship blossomed on what Liam’s mother described as the “QWERTY keyboard of love.”\textsuperscript{44}

9.21 During their three years together, they supported each other as they continued their education and made decisions about their careers. Also, just a few months before the Attack, they dealt with the devastating loss of Liam’s father, Andrew.\textsuperscript{45} Chloe was described as being Liam’s “rock” during this time.\textsuperscript{46}

9.22 Liam had decided that he wanted to join the police.\textsuperscript{47} Chloe had secured an apprenticeship

\footnotesize{\textsuperscript{39} 7/22/15-23  \\ \textsuperscript{40} 7/22/11-24  \\ \textsuperscript{41} 7/13/18-23, 7/14/18-19  \\ \textsuperscript{42} 7/23/8-16  \\ \textsuperscript{43} 7/19/11-15, 154/95/17-18  \\ \textsuperscript{44} 7/19/15-16  \\ \textsuperscript{45} 7/25/21-23, 154/97/16-19  \\ \textsuperscript{46} 7/26/16-17, 154/97/19-22  \\ \textsuperscript{47} 7/28/16-20, 154/96/10-11}
with a local travel agency.\textsuperscript{48} She was thrilled about this. In the months that were to follow the Ariana Grande concert,\textsuperscript{49} they had trips to Majorca and New York planned.\textsuperscript{50}

9.23 I heard about the joy they brought to one another and their families. They were described as being at their best when together.\textsuperscript{51} They had so much in their lives to look forward to.\textsuperscript{52} Their families were in no doubt that they would have married and had a family.\textsuperscript{53}

**Events of 22\textsuperscript{nd} May 2017**

9.24 Liam and Chloe attended the concert that night as just one of many special occasions in their lives. I heard that they were staying overnight in Manchester and spent time before the concert shopping and having dinner together.\textsuperscript{54} They sent pictures to their families from their seats in the Arena.\textsuperscript{55}

9.25 They entered the City Room together at 22:30:49.\textsuperscript{56}
9.26 Courtney Boyle was the daughter of Deborah Hutchinson and Robert Boyle. She was the sister of Nicole.⁵⁷ Courtney was 19 years old at the time of her death on 22⁰ May 2017.⁵⁸

9.27 Many spoke of Courtney’s positive, caring nature.⁵⁹ That, together with her witty, funny personality, made her very popular.⁶⁰ She put others first and made sure that Nicole and Deborah kept smiling when times were tough.⁶¹ Courtney was intelligent. She achieved her

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⁵⁷ 150/114/3-5
⁵⁸ 150/114/7-8
⁵⁹ 5/83/11-15
⁶⁰ 5/85/9-12
⁶¹ 5/84/18-19, 5/85/15-23
dream of going to university to study criminology and psychology. Deborah recalls that Courtney was the happiest she had ever seen her. She simply loved her life. Courtney achieved first-class honours at the end of her first year. She was awarded a posthumous honorary degree from her university in July 2017.

9.28 Courtney loved music, and it was through music that she met her boyfriend Callum, at Leeds Festival. They had the best time of their lives together. For Callum, Courtney “made the good times great and the bad times bearable.” He described how lucky he felt to have met Courtney.

9.29 Courtney was an enormous part of the lives of all her family. Her aunt, uncle and cousins described their special close bond and told of some of their happiest memories together. Courtney adored her sister. They were best friends and Nicole told of how Courtney was her
protector.\textsuperscript{72} Nicole wants to ensure that Courtney is forever remembered as a girl who “\textit{shone so brightly in any place she was and still does today}”.\textsuperscript{73}

\textbf{Events of 22\textsuperscript{nd} May 2017}

\textbf{9.30} Nicole had a VIP ticket to the concert. Courtney, her mother Deborah, Deborah’s partner Philip Tron, and his mother June Tron took Nicole to the Arena that evening.\textsuperscript{74} While Nicole attended the concert, Courtney and her family enjoyed a meal together in Manchester.\textsuperscript{75} Courtney was very excited about her forthcoming trip to Amsterdam with Callum.\textsuperscript{76}

\textbf{9.31} Courtney kept in contact with Nicole throughout the show.\textsuperscript{77} As they returned to the Arena to collect Nicole, Deborah remembers the laughter she shared with Courtney as they sat in the car.\textsuperscript{78} Courtney and Philip left the car and went to collect Nicole, entering the City Room together at 22:22:11.\textsuperscript{79}
Eilidh MacLeod

9.32 Eilidh MacLeod was the daughter of Marion and Roddy MacLeod and the sister of Shona and Laura.\textsuperscript{80} She was 14 years old at the time of her death on 22\textsuperscript{nd} May 2017.\textsuperscript{81}

9.33 Eilidh was a happy girl with a great sense of fun and humour.\textsuperscript{82} She was a much-loved middle sister and very family orientated.\textsuperscript{83} I heard how close she was to her sisters, with whom she

\textsuperscript{80} 153/57/3-4
\textsuperscript{81} 153/57/7-8
\textsuperscript{82} 4/20/1-8, 153/57/13-19
\textsuperscript{83} 4/26/14, 153/57/12-13
shared so much laughter.\textsuperscript{84} She was a “shining light” in her family’s life.\textsuperscript{85}

9.34 Eilidh was popular at school.\textsuperscript{86} As her mum Marion said, “It wasn’t hard to love Eilidh. She loved everything about her life.”\textsuperscript{87} Her friends remember her beautiful personality and how she made them laugh with her sense of humour and infectious laugh.\textsuperscript{88} Eilidh enriched the lives of many.\textsuperscript{89}

9.35 Eilidh loved music, which was an enormous part of her life.\textsuperscript{90} She was a talented bagpipe player.\textsuperscript{91} I heard how proud her family were when she enjoyed success at the World Pipe Band Championships in August 2016.\textsuperscript{92} I have no doubt that Eilidh would have achieved anything she set her mind to.\textsuperscript{93} As her mother said, “The world was her oyster.”\textsuperscript{94}

\begin{itemize}
\item \textsuperscript{84} 4/20/10-21, 153/58/2-7
\item \textsuperscript{85} 153/58/1
\item \textsuperscript{86} 153/58/22
\item \textsuperscript{87} 4/21/5-6, 153/59/17-18
\item \textsuperscript{88} 4/32/17-20, 153/59/1-4
\item \textsuperscript{89} 153/68/11-12
\item \textsuperscript{90} 153/58/8-9
\item \textsuperscript{91} 153/58/9-11
\item \textsuperscript{92} 4/22/11-20, 153/58/15-17
\item \textsuperscript{93} 153/68/11-12
\item \textsuperscript{94} 4/21/7-8, 153/59/20
\end{itemize}
Events of 22nd May 2017

9.36 Eilidh was extremely excited that her countdown to the concert was finally over.95 She and her mother travelled from Scotland to Manchester. They stayed in a hotel the night before the concert.96

9.37 Earlier that day, they enjoyed a trip to the Trafford Centre to spend quality time with Eilidh’s godmother.97 The group had a lovely time together, enjoying lunch and shopping, while Eilidh talked about the concert excitedly.98 Marion dropped Eilidh and her friend off at the Arena.99 When she was seated, Eilidh made a video call to her mum. Marion recalls how happy Eilidh was.100

9.38 Eilidh and her friend entered the City Room at 22:30:49.101
9.39 Elaine McIver was the daughter of Patricia and Frank McIver and sister of Paul and Lynda. Her partner was Paul Price. Elaine was 43 years old at the time of her death on 22nd May 2017.

9.40 Elaine was the love of Paul’s life. They met in the autumn of 2014. Paul told of their shared love of music and plans for the future together. They had just had an offer accepted on a house,
which they were very excited about.\textsuperscript{108} They had spoken of travelling, including to Australia, New Zealand and Canada.\textsuperscript{109} Paul felt that they had a long future ahead of them and that they “were finally going to live happily ever after”.\textsuperscript{110}

9.41 Elaine’s family spoke about her personality. She was described as having a “lust for life”,\textsuperscript{111} a massive heart and personality, and being a leader with a “strong sense of fairness and justice”.\textsuperscript{112} With these qualities, it is perhaps no surprise that she became a police officer, a career she loved.\textsuperscript{113} Her sister Lynda spoke of how proud she was to be Elaine’s sister and that she was “the best person anyone would wish to know”,\textsuperscript{114} the family’s favourite.\textsuperscript{115}

9.42 Her family made it clear that Elaine would not want to be remembered as a victim.\textsuperscript{116} I have no doubt it is the joy and love she brought to her family and friends that will be remembered above all.

\begin{itemize}
\item \textsuperscript{108} 9/64/5-8
\item \textsuperscript{109} 9/67/13-17
\item \textsuperscript{110} 9/68/12-14
\item \textsuperscript{111} 156/41/5
\item \textsuperscript{112} 156/43/1
\item \textsuperscript{113} 156/41/22-23
\item \textsuperscript{114} 156/42/19-20
\item \textsuperscript{115} 156/42/18
\item \textsuperscript{116} 156/41/8
\end{itemize}
Events of 22\textsuperscript{nd} May 2017

9.43 Paul and Elaine travelled to Manchester that evening to take Paul’s daughter and her friend to the concert.\textsuperscript{117} While the concert was on, they walked around Manchester and, before having a meal, they had a drink in an open-air pub, where a man was playing the piano.\textsuperscript{118} Paul’s memories are of them speaking about the new house\textsuperscript{119} and that it was a beautiful evening.\textsuperscript{120}

9.44 Paul and Elaine returned to the Arena at around 22:00\textsuperscript{121} to collect Paul’s daughter. They entered the City Room from the direction of Manchester Victoria Railway Station at 22:06:23.\textsuperscript{122} They waited together in the City Room for the girls to return, listening to the sound of the concert ending.\textsuperscript{123}

\begin{itemize}
\item \textsuperscript{117} 9/65/12-15
\item \textsuperscript{118} 156/54/17-23
\item \textsuperscript{119} 9/65/25-66/1
\item \textsuperscript{120} 9/65/22
\item \textsuperscript{121} 156/45/23-24
\item \textsuperscript{122} 156/46/1-2
\item \textsuperscript{123} 156/56/10-18
\end{itemize}
Georgina Bethany Callander was the daughter of Lesley and Simon Callander and the younger sister of Daniel and Harry.\textsuperscript{124} She was 18 years old at the time of her death on 23\textsuperscript{rd} May 2017.\textsuperscript{125}

Georgina was an Ariana Grande \textit{“supafan”}\textsuperscript{126} and had met her once before 22\textsuperscript{nd} May 2017.\textsuperscript{127} Music and travel brought Georgina a great deal of happiness and her bedroom wall was covered in concert tickets and pictures of places she had visited.\textsuperscript{128} Much of that travelling had been with
her mother Lesley, from whom she was “inseparable”. They had travelled to many places, including both the east and west coasts of America, Italy, France and every theme park in the UK.

9.47 Georgina achieved a lot in her 18 years, showing skill in both ballet and taekwondo in her younger years. She achieved distinctions in all of her exams and was awarded a place to study paediatrics at university. This career choice reflected Georgina’s passion for caring for others. In her brother Daniel’s words, “From an early age Georgina wanted to help people … She was like a ray of sunshine on the darkest of days. If you were feeling down she would help you through it.” I have no doubt that she would have gone on to help countless people.

9.48 Georgina’s parents both spoke of their memories of her beautiful smile and her unmistakable and infectious laughter. Her brother Harry reflected on the happy memories that will always be with the family. He said, “I know in my heart of hearts

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129 6/51/22
130 6/37/20-25, 6/38/7-12
131 7/3/10-14
132 7/7/18-20
133 6/51/7-10
134 6/50/25, 6/51/25-52/2
135 6/30/25, 6/54/15-16, 7/5/11-19, 7/8/5-6
what she wanted for us is to all live, laugh
and love as she did.”

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9.49 Georgina travelled to Manchester on 22\textsuperscript{nd} May 2017 with her mother Lesley, and they booked into a local hotel where they spent time getting ready for the evening together. Georgina attended the concert that night with a friend and, before it started, they visited the merchandise stalls trying to find Georgina the perfect T-shirt.

9.50 As the concert was ending, Georgina and her friend left their seats and walked through the doors to the City Room at 22:30:51. Her friend recalls Georgina smiling back at her as she began to run across to a merchandise stall.

\begin{itemize}
\item 136 6/55/6-8
\item 137 155/5/10-12
\item 138 155/5/13-6/2
\item 139 155/6/10-11
\item 140 155/6/17-19
\end{itemize}
Jane Tweddle

9.51 Jane Tweddle was the mother of Harriet, Lily and Isabelle Taylor, the daughter of Margarette and Alan Tweddle and the sister of Paul.\textsuperscript{141} She was 51 years old at the time of her death on 22\textsuperscript{nd} May 2017.\textsuperscript{142}

9.52 Jane was a much-loved mum, daughter, sister, auntie and friend.\textsuperscript{143} She was her daughters’ “warrior mum”, teaching them to be kind and to stick together.\textsuperscript{144} She filled the home with love and laughter.\textsuperscript{145} Her daughters remember that,
when they asked what time it was, their mother would reply, “It’s the time of your life, never forget it.” Jane’s outlook on life continues to inspire them.

9.53 Jane was extremely close to her family. I heard of Jane’s “special and comical” relationship with her mother Margarette, who remembers Jane’s smile, laughter and love of life. Jane was a much-loved aunt. She provided a second home for her nieces and nephews, who knew her door was always open. Jane’s brother, Paul, knows that her strength, love and laughter will always live on in her close-knit family.

9.54 Jane was cherished and trusted by the young people whose lives she touched while working at a high school. Her daughters remember that she was a “perfect listener … and source of strength and support” to many of the children she helped through her work.

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146 151/27/25-28/2
147 10/14/23, 151/27/10-11
148 10/13/17-19
149 151/27/12-13
150 10/14/2-4
151 151/27/13-15
152 10/15/1-2, 151/27/17-19
153 10/15/7-8, 151/27/21-24
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9.55 Jane travelled to the Arena with her friend Joanne Aaron, whose daughter was attending the concert. Jane and Joanne Aaron were due to pick Joanne’s daughter and her friend up afterwards.

9.56 While they waited for the concert to finish, Jane and Joanne Aaron enjoyed a meal and coffee together in Manchester. Joanne Aaron recalls that they had a good night together. They discussed plans for the future and Jane spoke about her daughters and what they were up to.

9.57 Jane and Joanne Aaron entered the City Room at 22:23:45.
9.58 John Atkinson was the son of Daryl and Kevin Price and brother of Laura, Stacey and Amy.\textsuperscript{160} John was 28 years old at the time of his death on 23\textsuperscript{rd} May 2017.\textsuperscript{161}

9.59 John was very bright. He had a Mensa IQ score of 137 at eight years old.\textsuperscript{162} By the age of 25, he had passed all his NVQs and reached management level.\textsuperscript{163} He chose a career working with young adults with autism and behavioural difficulties, which he loved.\textsuperscript{164} His working life was
spent helping those in care. His kind and generous nature was evident for all to see. His sister Laura remembers John as “the most thoughtful, loving, caring” man she had ever known. His mum told of his generosity and kindness.

9.60 John was a fitness fanatic, who loved music, dancing and life in general. He was the centre of his family’s world, and was described as their “heart and soul”. I heard that his smile would light up the room and that he had an “addictive” personality. He loved everyone and everyone loved him. He adored his sisters and nephews, and hoped to one day provide foster care for children. His parents remember “his laugh, his humour, his personality, his love for his family, his thoughtful ways”.

9.61 John was kind, generous and made people laugh. There is less laughter in the world without him.
Events of 22\textsuperscript{nd} May 2017

9.62 John received tickets to the Ariana Grande concert as a Christmas present and attended with his lifelong friend, Gemma O’Donnell.\textsuperscript{177} Gemma recalls that the concert was really good and they had a lovely time together.\textsuperscript{178}

9.63 Having been to the Arena before, John knew that it would take them a little time to get out of the car park and so they left shortly before the concert ended.\textsuperscript{179} John and Gemma entered the City Room at 22:30:48.\textsuperscript{180}

\begin{itemize}
  \item [177] 158/6/9-13
  \item [178] 158/6/19-20
  \item [179] 158/6/21-24
  \item [180] 158/7/1-3
\end{itemize}
Kelly Brewster

9.64 Kelly Brewster was the daughter of Kim and Kevin Brewster and the sister of Claire and Adam.181 Her partner was Ian Winslow.182 She was 32 years old at the time of her death on 22nd May 2017.183

9.65 Kelly’s family described her as “a funny, intelligent, very opinionated woman who knew what she wanted and had a thirst for life”.184 She lived life to the full.185 Her adventurous spirit saw her travel across the world, including solo trips to

181 154/2/10-11
182 154/2/13
183 154/2/17-18
184 5/97/21-24, 154/2/21
185 5/111/22-23
Australia and America, where she made many friends and came back with many happy memories.\(^{186}\) Kelly always had stories to tell about her travels and her hopes for the places she would visit in the future.\(^{187}\) In her 32 years, she did more than many do in a lifetime.\(^{188}\)

9.66 Kelly’s family and friends meant the world to her, and the close bond with her sister Claire was evident. I heard of the many precious times they spent together.\(^{189}\)

9.67 Kelly met Ian at her 30\(^{th}\) birthday party.\(^{190}\) Her family remember that it was clear from their first meeting that they were made for each other.\(^{191}\) They would leave little notes around the house to say how much they loved each other, and both shared a passion for travel.\(^{192}\) Their last trip was to Disneyland Paris, a perfect surprise planned by Kelly for Ian and his daughter, who now hold their memories of that trip very dear.\(^{193}\)

9.68 On the morning of 22\(^{nd}\) May 2017, Kelly and Ian had an offer accepted on their new home. They were excited about their plans for the future,


\(^{187}\) 5/103/16-18

\(^{188}\) 5/113/15-16

\(^{189}\) 154/3/6-7

\(^{190}\) 5/103/19-25, 154/3/23

\(^{191}\) 5/105/5-6, 154/3/23-4/1

\(^{192}\) 5/104/6-20, 154/4/2-3

\(^{193}\) 5/104/24-105/4, 154/4/6-9
including growing their family.\textsuperscript{194} Kelly’s family and friends said that Kelly was the happiest she had ever been,\textsuperscript{195} and that she and Ian “\textit{were the true definition of soulmates}” who would have been together forever.\textsuperscript{196}

Events of 22\textsuperscript{nd} May 2017

9.69 Kelly attended the concert with her niece, and her sister Claire Booth.\textsuperscript{197} On the journey, Claire remembers hearing Kelly speak to Ian on the phone and that they were “\textit{so happy and excited}” about the house that it was infectious.\textsuperscript{198} It set the mood for the evening.

9.70 Kelly, Claire and Claire’s daughter all enjoyed the concert.\textsuperscript{199} It was still dark in the Arena bowl and Ariana Grande was saying goodnight as they left their seats.\textsuperscript{200} Together, they entered the City Room at 22:30:53.\textsuperscript{201}
Lisa Lees was the daughter of Ivan and Elaine Hunter, and sister of Lee. She was married to Anthony Lees and was the mother of Lauren and India. She was also a grandmother. She was 43 years old at the time of her death on 22nd May 2017.

Lisa was a very positive person. She was always singing and dancing, and made every situation fun. Anthony described Lisa as “funny, exciting,
full of laughter, full of life”. She was dedicated to her career and put 110 per cent into her work. It gave her family so much pride to see her set up an award-winning business providing holistic therapies to terminally ill children. It was one of Lisa’s greatest achievements. She later returned to college to teach the next generation of beauticians, to pass on her skills.

9.73 Her daughters spoke of Lisa with great love and warmth. She was their best friend. She would tell them that they could achieve anything if they put their minds to it, and they should “always believe”. Her positive attitude lives on through her children. India aspires to be just like her mum. Lauren plans to help her mother’s memory live on in her own children and to be there for her sister and family.

9.74 As Lisa’s mother said, Lisa touched so many lives with her love and compassion. Her
infectious laugh and her ability to light up a room\textsuperscript{217} will never be forgotten.

Events of 22\textsuperscript{nd} May 2017

9.75 Lisa attended the Arena that night with a friend, Alison Howe, and their daughters.\textsuperscript{218} Their daughters went to watch the concert. Lisa and Alison returned to collect them afterwards.\textsuperscript{219} Together, they entered the City Room at 22:27:01 from the direction of Manchester Victoria Railway Station.\textsuperscript{220}
9.76 Martyn Hett was the son of Figen Murray and Paul Hett and the stepson of their respective partners, Stuart Murray and Kath Hett. He was a brother to Daniel, stepbrother to Matt and Emma and half-brother to Louise and Nikita. Martyn was 29 years old at the time of his death on 22nd May 2017.

9.77 Martyn had an instantly engaging personality. His mother spoke of his “incredible passion for life” and “catching charisma”. I saw some of it for myself, in videos and images shared by his
family. Martyn was a larger-than-life character. He lived his life at 100 miles an hour, but equally took the time to make whoever he was with know that they mattered. He had so many friends and displayed such compassion for others. Many of Martyn’s friends made videos detailing their memories of him and spoke of how he was a joy to be around, that he was always there for the good times and the bad, and was “deeply kind and empathetic”. He brought people together and allowed them all to shine.

9.78 His humour, love of drama and talent for film-making propelled him into the limelight, as he amassed over 10,000 followers on Twitter. He also made a number of television appearances. I heard of his impact even on those who had never met him, and how he touched people’s lives. One of them said, “Life is full of negatives. Don’t be another one. Be more Martyn.” #BEMOREMARTYN became a hashtag in the aftermath of the announcement of Martyn’s death.

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225 5/3/6
226 5/3/19-22
227 5/13/12-17, 156/3/13-19
228 156/4/13-18
229 5/14/11, 156/4/18-20
230 5/9/16-17
231 5/31/4-10
232 5/32/21-22
233 5/31/22-32/8
9.79 Martyn’s mother told how she struggled to condense into a few minutes “a life so colourful and vibrant and packed with adventure”\textsuperscript{234} I can understand that. Martyn’s friends and family are right to be proud of him. His future was very bright.

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9.80 Martyn attended the concert that night with three of his closest friends: Paul, Chris and Stuart\textsuperscript{235} They were celebrating Paul’s birthday and Martyn’s upcoming trip to America\textsuperscript{236} I heard and saw for myself, in a short video clip taken that night, how happy Martyn was. He was standing up, singing and dancing from the first song\textsuperscript{237} Martyn left his seat near the end of the show and was seen to enter the City Room at 22:28:42\textsuperscript{238}

\textsuperscript{234} 5/2/14-16
\textsuperscript{235} 156/7/1-3
\textsuperscript{236} 156/7/3-4
\textsuperscript{237} 156/7/12-13
\textsuperscript{238} 156/8/13-14
Megan Joanne Hurley

9.81 Megan Hurley was the daughter of Michael and Joanne Hurley and the sister of Bradley.\textsuperscript{239} She was 15 years old at the time of her death on 22\textsuperscript{nd} May 2017.\textsuperscript{240}

9.82 Megan had a real talent for sport. She competed for her school in running and was a strong swimmer.\textsuperscript{241} She loved spending time on a jet ski with her dad.\textsuperscript{242} She loved history, but also had a creative side and chose photography and graphic design as two of her GCSEs.\textsuperscript{243}

\textsuperscript{239} 153/2/20-21
\textsuperscript{240} 153/2/23-24
\textsuperscript{241} 5/37/21-22, 5/39/23-25
\textsuperscript{242} 5/39/21-22
\textsuperscript{243} 5/37/19-38/4, 5/40/5-6
9.83 I heard about Megan’s surprising maturity and that she had “a very gentle, quiet nature that everyone was endere by”.244 Family friends commented that Megan “was the daughter that you hoped your own daughters would turn into”.245 She was family orientated and idolised all her cousins.246 Her parents felt that, given her caring nature, she would make an amazing midwife.247 She had also been considering a career in physiotherapy, or perhaps becoming a vet because of her love of animals.248

9.84 Megan’s bond with her brother Bradley was commented upon by many. Some spoke of being “in awe” of their relationship,249 and that they were like best friends, with a “sort of secret language”, which saw them laughing hysterically at things no one else understood.250

9.85 I heard from many people who loved Megan. They spoke of her beautiful and infectious smile251 and how it was easy for her to make others feel happy.252 It is said that she made and kept friends easily253 and I can see why.

244 5/38/17-19, 5/44/3-4, 5/75/14-17
245 5/48/24-25
246 5/40/17-21
247 5/41/2
248 5/41/1-6
249 5/52/7-8
250 5/49/7-11, 5/53/19-20
251 5/51/5-6, 5/52/25, 5/54/5-6, 5/57/25, 5/60/15, 5/62/17, 5/68/18-19, 5/76/3-4
252 5/64/4-7, 5/65/12-17, 5/66/20-24, 5/67/17-21
253 5/36/14-17
Events of 22nd May 2017

9.86 Megan loved Ariana Grande and received a ticket to the concert as a Christmas present. Bradley bought a ticket so that he could go with her. Megan was so excited in the lead-up to the concert that she would share videos and pictures with Bradley, counting down to the date.

9.87 On the day of the concert, Megan and Bradley spent time getting ready together, joking and taking photographs. There was a happy atmosphere in the Hurley home and they were both excited about the night ahead. After being dropped off by their parents, Megan and Bradley bought T-shirts before finding their seats. Megan and Bradley spent the concert singing, dancing and taking photographs together, having a wonderful night. They left their seats after the encore and walked together, holding hands and laughing, to the City Room. They entered the City Room at 22:30:49.
Michelle Kiss was the daughter of Christine and Mick and sister to Nichola. She was the much-loved wife of Anthony (Tony) Kiss, and mother to their three children. Michelle was 45 years old at the time of her death on 22nd May 2017.

Michelle and Tony were childhood sweethearts. Tony described her as his “guiding light” from the first moment they met. He remembers their first date as if it was yesterday: the pure happiness he felt and how Michelle’s beautiful smile made her face light up. In 1995, they got married on a beach in Barbados, surrounded by close family.
and friends. By 2004, their family was complete. They were soulmates and their love story endured for 30 special years.

9.90 Michelle loved and embraced life. Tony described her as having “an aura of love and positivity that glowed with each of her smiles.” Michelle’s family described her as the “hub” of her family. They remember her devotion to her husband and children and how she loved them beyond measure. Family was the most important part of Michelle’s life. She was loving, selfless and a natural homemaker, with the ability to bring people together. Tony and Michelle were the proudest of parents and so very happy.

9.91 Her children will always remain a living tribute to her work as a mother. Tony knows Michelle would be so proud to see in them the same love and drive that she was blessed with.

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269 8/17/23-25
270 8/26/13-14
271 8/21/6-9
272 8/16/11-12, 151/20/5
273 8/18/11-12
274 8/25/18
275 151/22/2-3
276 8/33/20-21, 151/21/10
277 8/18/2-9, 151/20/17
278 8/19/17-18
279 8/22/19-25, 151/26/7-9
Events of 22\textsuperscript{nd} May 2017

9.92 Michelle attended the Arena with her friend Ruth Murrell, to drop off their daughters at the concert.\textsuperscript{280} Michelle and Ruth went into Manchester City Centre together while the concert was on, before returning to the Arena to collect their daughters.\textsuperscript{281} Michelle and Ruth entered the City Room at 22:18:43.\textsuperscript{282}
Nell Jones was the daughter of Jayne and Ernie Jones and sister of Sam, Joe and William. She was 14 years old at the time of her death on 22nd May 2017.

Nell was gifted in very many ways. She excelled in English and maths and was placed on the “gifted and talented register”. She was described as a “sheer delight” to teach and a “fabulous role model for others to look up to”.

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283 152/22/20-21
284 152/22/23-24
285 8/3/9-11
286 8/3/24-25
287 8/4/3-4
Alongside her academic ability, Nell had a passion for drama. She shone on stage and loved entertaining others. She had a “bright, bubbly, vibrant personality” and she put her heart and soul into every performance she gave. She stood out as a star right from the start.

A number of Nell’s friends told of the fun times they had shared: shopping, trips to the park, trying to ice-skate, birthday meals out; every story filled with joy and happy memories for them. Nell was described as the fun one in the friendship group, with a “wicked sense of humour.” Her best friend said, “If I searched the world over I would never find a friend as loyal, caring, funny or as full of life as Nell was. She was one in a million and she will live in my heart forever.” Nell’s parents are right to be very proud of her.

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Nell was not a huge Ariana Grande fan, but was so excited to be going to the concert that night.
with a friend.\textsuperscript{295} Her mother Jayne had given her some money to spend at the merchandise stalls and told her to have a lovely time.\textsuperscript{296} Nell’s friend recalls how much they enjoyed the concert and that they were singing and dancing from the very first song.\textsuperscript{297} They left after the final song and entered the City Room at 22:30:43.\textsuperscript{298}
9.98 Olivia Campbell-Hardy was the daughter of Charlotte Hodgson and Andrew Hardy. She was a much-loved stepdaughter, sister and granddaughter. She was 15 years old at the time of her death on 22nd May 2017.

9.99 Olivia was a happy, determined girl who had packed so much into her 15 years. I heard many amusing stories about Olivia from her family: from her arrival at the school prom dressed head-to-toe in blue, riding on a blue
scooter,\textsuperscript{303} to the way she would speak in “\textit{dinosaur language}”\textsuperscript{304} and do Judge Rinder impressions.\textsuperscript{305} Anything she did, she made funny.\textsuperscript{306} She was always making people laugh and made an impact on everyone she met.\textsuperscript{307} Olivia didn’t just walk into a room; she would make an entrance.\textsuperscript{308} In addition to her loud and boisterous side, Olivia was gentle and caring and would “\textit{fight for the underdog}”.\textsuperscript{309} She always put others before herself.\textsuperscript{310} She made the world a better place.\textsuperscript{311}

9.100 Olivia was a talented singer and had a promising future ahead of her.\textsuperscript{312} She loved performing with her primary school choir, with her great-grandma ‘Larlar’\textsuperscript{313} and even auditioned for \textit{Britain’s Got Talent}.\textsuperscript{314} Her mother recalls her singing at a family wedding aged 11, and reducing grown men to tears.\textsuperscript{315} Her father recalls how proud he was when she sang at her Grandad Steve’s
60th birthday party.\textsuperscript{316} She dreamed of performing in the West End, of finding fame and getting a house in New York.\textsuperscript{317}

9.101 Olivia was clearly special and loved by all of her family.\textsuperscript{318} I have no doubt that, with her determination and sense of humour and the support of those who loved her most, Olivia would have made a success of a life in music or in anything else she chose to do.\textsuperscript{319}

**Events of 22nd May 2017**

9.102 Olivia was a fan of Ariana Grande and had been offered a ticket by her friend.\textsuperscript{320} They were extremely excited in the lead-up to the concert.\textsuperscript{321} After school, they got the tram into Manchester and had something to eat before going into the Arena.\textsuperscript{322} Olivia’s friend spoke of the fun they had at the concert, “singing along” and “messing about” together.\textsuperscript{323} He said Ariana Grande “was fantastic. We loved her.”\textsuperscript{324}
9.103 Olivia was in contact during the concert with her mum, who told Olivia that she loved her.\textsuperscript{325} Olivia and her friend left their seats after the encore and entered the City Room at 22:30:51.\textsuperscript{326}
Philip Tron was the son of June and Keith Tron and father of Olivia. He was the twin brother of Rachel and the brother of Andrew, Michael and Victoria. Philip was 32 years old at the time of his death on 22nd May 2017.

Philip was a larger-than-life character. He was a joker, hugely likeable and had “the most recognisable big smile”. He was a “family-loving guy” who would get the older generation...
up on the dancefloor at family functions, even those in wheelchairs, and twirl them around the floor. Family was the most important thing to Philip and, above all, he wanted to find the right partner, settle down and have more children.

I heard much about Philip’s practical skills. There was not a job that he would not try to do and he became the “go-to person” for family and friends needing jobs carried out. His sister Vicky joked that Philip was a “jack of all trades and master of none”.

In 2016, Philip’s practical skills led him to secure a job at a water conservation company, which involved working with his hands and suited him perfectly. He had previously worked at the Gateshead Arms pub, where he was remembered for his “smile and cheeky grin” when talking to customers and for being “a great source of one-liners”.

His happy-go-lucky character meant that he had many friends. I heard that Philip had a reputation for practical jokes and also for shying

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333 7/35/3-6
334 7/42/24-43/2
335 7/39/8-9
336 7/39/8-13
337 7/48/13
338 7/41/1-8
339 7/40/10-21
340 7/35/18-19, 7/34/24-25
away from buying a round of drinks, much to the amusement of his family. His friends reflected that “heaven has a new Geordie ambassador. He’ll be waiting up there to greet you and even get you a pint, but it’ll be your round!” Philip’s spirit of fun has left his loved ones with many happy memories. He will live on through those.

Events of 22nd May 2017

9.109 Philip had attended the Arena with his ‘mam’ June, girlfriend Deborah Hutchinson and Deborah’s daughters Courtney and Nicole Boyle. Nicole had a ticket to the Ariana Grande concert and they were dropping her off. They spent time in Manchester shopping and sightseeing, and while Nicole was at the concert, the rest of the group went out for dinner.

9.110 They returned to the car after their meal, where they waited for the concert to finish. June recalls she was having a jokey argument with Philip because he had written rude words in her quiz book. This kind of prank was typical of Philip, and as he and Courtney left to collect

341 7/45/16-20
342 7/48/6-9
343 151/11/9-11
344 151/7/17-19
345 151/7/20-21
346 151/7/21-25
347 151/8/4-6
348 151/8/6-8
Nicole, June remembers laughing with him. Philip and Courtney entered the City Room at 22:22:11 from the direction of Manchester Victoria Railway Station.
Saffie-Rose Roussos

9.111 Saffie-Rose Roussos was the daughter of Lisa and Andrew Roussos.\textsuperscript{351} She was the younger sister of Ashlee Bromwich and Xander Roussos.\textsuperscript{352} Saffie-Rose was eight years old at the time of her death on 22\textsuperscript{nd} May 2017.\textsuperscript{353}

9.112 Saffie-Rose was a girl with a very bright future ahead of her. Although quiet in class, from a young age “she came alive when she could dress up and role play”.\textsuperscript{354} Later, at school discos, that quiet little girl “became confident whilst dancing

\textsuperscript{351} 174/6/15-16
\textsuperscript{352} 174/6/18-20
\textsuperscript{353} 174/6/21-22
\textsuperscript{354} 9/38/22, 9/39/18-23, 9/40/6-8
and singing”. She had a love of gymnastics. I heard how she was full of energy and would constantly be practising gymnastic routines, jumping on her pogo stick and even climbing telegraph poles. She found joy in everything she did and brought a great deal of happiness to those around her.

9.113 Saffie-Rose had bravery and strength. “Couldn’t do it’ wasn’t Saffie’s style” and the bangs and injuries that came from the backflips and somersaults never stopped her. All she ever wanted was a “cuddle and kiss” to make things better.

9.114 Lisa remembers her daughter as being a “pure, gentle, beautiful soul who touched people’s hearts with her kindness and infected people with her smile”. Her father described her as “perfection” and remembers “her beauty, big brown eyes and smile” and how spending time with her felt like “magic”. She had a way with people who were drawn to her amazing magnetic
personality.\textsuperscript{363} She was so loved by her family and friends.

Events of 22\textsuperscript{nd} May 2017

9.115 Saffie-Rose received tickets to the Ariana Grande concert as a Christmas gift.\textsuperscript{364} She was ecstatic to receive the tickets, to finally be going to see her “idol” along with Lisa and Ashlee.\textsuperscript{365} She would talk about it all the time, “it was just the conversation of every day” at home.\textsuperscript{366}

9.116 On 22\textsuperscript{nd} May 2017, Saffie-Rose returned from school and got ready for the concert.\textsuperscript{367} She wore an Ariana Grande Dangerous Woman Tour T-shirt and carried her Ariana Grande handbag.\textsuperscript{368} Andrew recalls waving Saffie-Rose, Lisa and Ashlee off and that he had never seen Saffie-Rose so excited.\textsuperscript{369} She was “on cloud nine”.\textsuperscript{370}

9.117 Ashlee recalls having a good time at the concert and dancing with Saffie-Rose.\textsuperscript{371} Lisa told of watching Saffie-Rose “jumping up and down” and “dancing all the way through” the concert. She spoke of how lovely it was to watch Saffie-Rose

\textsuperscript{363}9/45/4-6
\textsuperscript{364}174/145/7-13
\textsuperscript{365}174/145/17-146/10
\textsuperscript{366}174/146/2-6
\textsuperscript{367}174/11/1-2
\textsuperscript{368}174/11/2-4
\textsuperscript{369}174/11/9-11
\textsuperscript{370}174/11/12-13
\textsuperscript{371}174/11/23-25
and Ashlee dance together and how happy Saffie-Rose was. 372

9.118 They left their seats at the end of the concert. 373 Saffie-Rose, holding her mother’s hand, entered the City Room from the concourse area at 22:30:45. 374
Sorrell Leczkowski

9.119 Sorrell Leczkowski was the daughter of Samantha Leczkowski and the sister of Sebastian and Sophie. Sorrell was 14 years old at the time of her death on 22\textsuperscript{nd} May 2017.

9.120 Sorrell was a happy, positive and caring girl. She would “light up the room as she entered, singing and dancing”. Her independent spirit emerged from an early age. I heard of her powers of persuasion, even from the age of two,
her sarcastic wit and her no-nonsense approach to life.\textsuperscript{380}

9.121 Sorrell had a large, but close friendship group at school.\textsuperscript{381} Samantha agreed with the deputy head’s assessment that Sorrell was “the roots and trunk and her friendships were the branches”\textsuperscript{382}. She held everyone together and was a natural leader.\textsuperscript{383}

9.122 Sorrell’s family all adored her.\textsuperscript{384} She was family orientated and loved it when everyone came together.\textsuperscript{385} Her family recall many happy memories together on holidays and days out.\textsuperscript{386} She spent a lot of time with her grandparents learning to cook, doing craft projects on her nana’s kitchen table and laughing at her grandad’s “silly jokes”\textsuperscript{387}

9.123 Sorrell was creative, talented and ambitious.\textsuperscript{388} She had a clear plan for her future.\textsuperscript{389} Her heart was set on an eight-year course in architecture at Columbia University in New York. She was
unafraid of all the hard work that lay ahead. Sorrell was so certain of the path she would follow that she told her mother they would celebrate her 60th birthday together in New York. Sorrell was awarded a posthumous honorary membership of the Barnard and Columbia Architecture Society, in light of her achievements.

9.124 Sorrell’s mother was so proud of Sorrell, whom she regarded not only as her daughter but also her best friend. Sorrell considered her mum to be her “rock”. Sorrell should have had a “long, fun-filled life ahead of her” and, with her drive and determination, would have achieved so much.

Events of 22nd May 2017

9.125 Sorrell had attended the Arena with her mum and nana Pauline, to drop off her sister Sophie and her friend for the concert. Sorrell then went into Manchester with her mum and nana. They shopped and had dinner together before returning to the car to wait for the concert to draw

390 153/70/2-5
391 4/49/4-11, 153/70/6-9
392 4/47/22-25
393 4/46/7-8, 4/48/1, 4/49/21-23
394 4/49/12-13
395 4/45/9
396 153/71/3-7
to an end.\(^{397}\) While in the car, Sorrell helped Pauline and Samantha play a word game.\(^{398}\)

They entered the City Room at 22:17:56, where they waited for Sorrell’s sister and her friend.\(^{399}\) Pauline and Samantha recall how Sorrell was singing, dancing and making them laugh.\(^{400}\)
9.127 Wendy Fawell was the daughter of Julia and Michael Tiplady and the sister of Andrew. She was mother to Adam and Charlotte.\textsuperscript{401} Wendy was 50 years old at the time of her death on 22\textsuperscript{nd} May 2017.\textsuperscript{402}

9.128 Wendy was a fun person who had a great deal to live for.\textsuperscript{403} Her family told of how Wendy loved socialising and spending time with family and friends.\textsuperscript{404} She was “the life and soul of a party”\textsuperscript{405}
and loved having people around her. She was a brilliant cook. Her family recall amazing Christmas dinners and that Wendy would host barbecues with enough food to feed an army. “This was Wendy at her best: looking after everyone, making sure they were having a good time.”

9.129 Wendy loved being a mum to Adam and Charlotte, who “were always paramount in her thoughts and deeds”. She was a wonderful mother. Her caring nature meant she tried to mother everyone and “gave so much of herself”. Her mother, Julia, told of Wendy’s love of Elvis Presley and the “wicked sense of humour” she had inherited from her.

9.130 I heard much about Wendy’s love of children, not just her own but also those she worked with. In recent years, she was a dinner lady and worked at a before and after school club. For Wendy, working with children was her dream.
Not only that, but she had a great talent for it.\textsuperscript{418} She took to it like “a duck to water” and passed her qualifications “with flying colours”.\textsuperscript{419} She was kind, compassionate and had a fun personality, which meant that children enjoyed spending time with her.\textsuperscript{420} Her family can be proud of the person Wendy was. She gave so much to enrich the lives of others.

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9.131 Wendy had driven to Manchester with her daughter, her friend Caroline and Caroline’s sons.\textsuperscript{421} The children were all going to the Ariana Grande concert, and Wendy and Caroline dropped them off before enjoying a meal together in Manchester City Centre.\textsuperscript{422}

9.132 Wendy and Caroline returned to the Arena to collect their children, entering the City Room from the raised walkway at 22:30:24.\textsuperscript{423} Wendy and Caroline separated in the City Room in order to ensure that they did not miss their children in the crowds.\textsuperscript{424}
Part 10
What went wrong

Introduction

10.1 Significant aspects of the emergency response on 22\textsuperscript{nd} May 2017 went wrong. This should not have happened. Some of what went wrong had serious and, in the case of John Atkinson, fatal consequences for those directly affected by the explosion.

10.2 In this Part, I will look at the key events in the chronology of the emergency response on the night of the Attack and the areas in which I have found the response to be inadequate. I do so by reference to the first two hours of the response. For the first hour, the golden hour, I will set out the problems as they developed by reference to 20-minute periods.

10.3 There are a number of things this Part will not do. It will not be an exhaustive review of everything that went wrong. It will not be a complete recitation of what people did or did not do. It will not set out the analysis or evidence by which I have reached the conclusions I have. All of that is deliberate.
10.4 In the Parts that follow, I have provided comprehensive footnotes, following the approach I set out in Appendix 4 in Volume 1 of my Report. In this Part, I have intentionally limited the footnotes only to direct quotations. That is because I am often summarising findings based on a substantial body of evidence and footnoting is impractical. The reader should look to subsequent Parts in this Volume of my Report for the detail that provides the evidential basis for the conclusions I set out in this Part. A plan of the Victoria Exchange Complex can be found at Figure 37 in Part 13.

10.5 There are two introductory matters before I turn to the key events. First, I will introduce four key phrases which are used in Volume 2. Second, I will briefly explain key concepts relevant to an emergency response in 2017.

Key phrases

Golden hour

10.6 The first hour of an emergency response will determine its overall success. As a recognition of this period’s importance, some emergency responders refer to it as ‘the golden hour’. In my Report, the term will be used to refer to the period from 22:31 to 23:30. In using this term,

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1 93/6/3-25, 94/141/23-142/2, 148/95/19-21, 131/36/16-21, 177/240/14-19, 188/58/6-18
I recognise that one hour is an arbitrary period of time. The time it takes to respond will be dependent on many factors, as determined by the incident itself. However, ‘the golden hour’ is a useful way of communicating the urgency with which the emergency services should be acting from the start.

**Grip**

10.7 The aim for the commanders in the golden hour should be to gather information and decide what needs to be done, putting in place structures that bring order to the inevitable chaos as quickly as possible. Where there is a threat, this should be swiftly contained and neutralised. There should be a concentrated focus on rescuing victims as quickly as possible. For those who are critically injured, minutes or seconds can count. Witnesses described the process of bringing order to the chaos by using the word ‘grip’: commanders needed to ‘grip the situation’ or ‘grip the incident’. In my view, ‘grip’, used in this way, efficiently communicates what was required. I shall use it in this Volume of my Report.

**Muscle memory**

10.8 Another phrase commonly used by emergency responders was ‘muscle memory’. This captures the idea that a particular way of behaving has become ingrained and is instinctive. To create
‘muscle memory’ requires effective training and exercising. I shall use this phrase in this Volume of my Report.

The critical period of the response

10.9 Finally, I shall use the phrase ‘the critical period of the response’. Unlike ‘the golden hour’, which can be applied to all Major Incidents, this period is specific to events on the night of the Attack. It covers the time from the explosion to the removal of the final living casualty from the City Room: 22:31 to 23:39. This period should have been shorter than it was.

Key concepts

10.10 The framework under which the emergency services were expected to operate in 2017 was called the Joint Emergency Services Interoperability Principles or ‘JESIP’. I will outline this in more detail in Part 11.

10.11 JESIP’s origin can be traced back to the Prevention of Future Deaths report by Lady Justice Hallett, following the inquests into the deaths caused by the terrorist attack on 7th July 2005. That report, and others which followed, identified that there were repeated failures by the emergency services to work together effectively. Despite this, many of the problems that JESIP
was created to resolve recurred on 22\textsuperscript{nd} May 2017.

10.12 By 2017, JESIP was well established. There had been at least two years for the emergency services operating in the Greater Manchester area to understand what was required of them and to ensure that their personnel knew how to implement JESIP.

10.13 The overarching aim of any response to an emergency is saving lives and reducing harm. This should be the most important consideration throughout every decision-making process.\textsuperscript{2} The five main principles for achieving this, known as the \textit{“Principles for joint working”}, were: communication, co-location, co-ordination, shared situational awareness and joint understanding of risk.\textsuperscript{3}

10.14 There were significant failures in relation to each of these principles for joint working on the night of the Attack.

10.15 The core guidance document for the application of JESIP in practice was the \textit{Joint Doctrine: The Interoperability Framework} (the Joint Doctrine). The Joint Doctrine set out how an emergency response should be structured. I set out below a summary of four aspects of that structure.

\textsuperscript{2} INQ004542/16
\textsuperscript{3} INQ004542/5
First, the declaration of a Major Incident. A Major Incident was defined within the Joint Doctrine as “an event or situation with a range of serious consequences which requires special arrangements to be implemented by one or more emergency responder agency.” Every responder agency should declare a Major Incident as early as is justified by the information it has. Every responder agency that declares a Major Incident should communicate that fact to all other responder agencies “as soon as possible.”

Second, METHANE messages. The METHANE message provides a structure into which key information is placed. It allows for information to be shared in a recognised format: “M/ETHANE is a structured and consistent method for responder agencies to collate and pass on information about an incident.” METHANE is a mnemonic, with each letter standing for a different piece of information to be gathered and relayed. I set out what METHANE stands for in Figure 23 in Part 11.

Third, the three levels of command: Strategic, Tactical and Operational. These levels are sometimes described as Gold, Silver and Bronze. The Strategic/Gold Commander sets the strategic
direction, co-ordinates and prioritises resources. The Tactical/Silver Commander interprets the strategic direction, develops the tactical plan and co-ordinates activities and assets. The Operational/Bronze Commander executes the tactical plan, commands his or her service’s response and co-ordinates actions.

10.19 Fourth, there are two key locations that are central to a successful multi-agency response: the Rendezvous Point (RVP) and the Forward Command Post (FCP).

10.20 The RVP is a single place to which all responding agencies should travel and co-locate. The RVP needs to be identified and then communicated as early as possible. The RVP brings all the responders together in a single place. It reduces the risk that each responder agency will operate on its own, rather than together.

10.21 The FCP is the place where commanders at the scene from each responder agency meet as soon as possible. It should be a jointly agreed location. Co-locating commanders is essential. When commanders are co-located, they can perform the functions of command, control and co-ordination face to face.
The first 20 minutes

First 999 calls

10.22 By 22:30, the Ariana Grande concert was nearly over. Members of the 14,500-strong audience had already begun to make their way out of the Arena, many via the City Room. Just one minute later, SA walked towards the departing crowd and detonated his deadly device. He did so near to the exit doors from the Arena concourse. He intended to kill and injure as many people as possible.

10.23 At 22:31:52, Greater Manchester Police (GMP) received the first of many 999 calls from the public. Those calls started to reveal the horror of what had happened. A member of the public in the City Room made that first emergency call. He said that there had been an explosion, in the foyer near the old McDonald’s restaurant. He said that 30 or 40 people were injured.

10.24 At 22:32, North West Ambulance Service (NWAS) received its first 999 call. It was in similarly stark terms: a bomb had gone off near the box office. A graphic description was given of the impact it had caused.

10.25 Many other 999 calls followed. Not all the emergency calls were as clear. A small number referred to shooting or gunshots. The situation
was chaotic. That was not surprising. JESIP expected the emergency services to be able to respond to such an incident. It provided the framework for a multi-agency response. JESIP should ensure that the chaos of an unfolding incident is gripped as soon as possible.

BTP officers at the Victoria Exchange Complex

10.26 Four British Transport Police (BTP) officers were in Manchester Victoria Railway Station. They heard the bomb go off. They immediately made their way to the City Room. As they did, they encountered some of those affected by the explosion. Showing considerable courage, the first three BTP officers entered the City Room fewer than two minutes after the explosion.

10.27 Those first officers reported to BTP Control what they could see and hear. The lights in the City Room were on. There were many casualties. Police Constable (PC) Jessica Bullough messaged BTP Control from the City Room at 22:33 to confirm that a bomb had been detonated. She requested ambulances. BTP Control confirmed that multiple ambulances were being requested and contact was being made with GMP.

10.28 Three minutes after the explosion, four BTP officers were in the City Room. Seven minutes after the explosion, nine BTP officers were in the
City Room or on the raised walkway. Some brought first aid bags with them. During this time, the first person from Emergency Training UK (ETUK), the Arena’s event healthcare provider, entered the City Room. Together with the BTP officers and members of the public, they began to try to assist casualties.

10.29 BTP officers were also sharing their situational awareness with BTP Control. It was the start of what should have been an effective, co-ordinated multi-agency response to the Attack. Unfortunately, that is not what happened.

**GMP Control**

10.30 The GMP Force Duty Officer (FDO) on the night of the Attack was Inspector Dale Sexton. He was based in GMP Control. This was some distance from GMP Headquarters (GMP HQ). His role was to take initial command of an incident such as the Attack until other commanders assumed command. This meant that, until he handed each of them over, he held a number of command roles simultaneously. Inevitably, this placed him under a considerable amount of pressure.

10.31 At 22:34, Inspector Sexton became aware of an incident at the Arena. At that point, he became the Tactical/Silver Commander and the Strategic/Gold Commander for the incident. When he deployed firearms assets, he also
became the Initial Tactical Firearms Commander and the Strategic Firearms Commander.

10.32 Inspector Sexton quickly became overburdened by the number of tasks he had to undertake. This had a direct impact on the effectiveness of the emergency response. It affected who received information, what resources were made available and the decisions of other commanders.

10.33 Inspector Sexton made a significant mistake in the early stages: he failed to declare a Major Incident. This omission was duplicated by other GMP commanders during the critical period of the response. It was not rectified until nearly 01:00 the following morning.

North West Fire Control

10.34 At about the same time that Inspector Sexton became aware of the Attack, North West Fire Control (NWFC), which provided the control function for Greater Manchester Fire and Rescue Service (GMFRS), was informed by GMP Control of “an explosion in the city centre”.

10.35 The NWFC Control Room Operator created an entry on the NWFC system in readiness to mobilise GMFRS resources straight to the scene of the Attack. That mobilisation order was not given by NWFC, as a supervisor intervened and

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7 INQ001231/2
decided that the GMFRS duty National Interagency Liaison Officer (NILO) should be consulted before any mobilisation took place.

**BTP Control and Major Incident declaration**

10.36 BTP had a similar role to GMP’s FDO. BTP called that position ‘the Force Incident Manager’. At 22:35, the Force Incident Manager, Inspector Benjamin Dawson, declared himself in command of the incident. Within four minutes, he declared a Major Incident. BTP communicated that declaration to NWAS at 22:41. It did not, however, communicate it to either GMP or GMFRS at any relevant stage. This was an error and an early example of many failures in communication that were to emerge across the multi-agency emergency response.

10.37 The BTP incident log reveals that BTP Control did try to contact GMP Control at an early stage. At 22:37, the BTP incident log records “still on hold with GMP”. The GMP incident log indicates that contact was made by BTP at 22:39. BTP was in the 999 queue along with many others. BTP had failed to appreciate that it did have better means of communicating directly with GMP, using a radio channel reserved for police services to contact each other.

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8 INQ002000/29
NWAS Control

10.38 At 22:36, NWAS Control called GMP Control. NWAS Control was on hold for over two minutes. When they spoke, the NWAS operator stated: “We’re 10 minutes away – we’ve got quite a lot of ambulances coming.”

10.39 Later in the call, NWAS Control stated that they had “five at least” ambulances on the way and that more were being contacted. GMP Control informed NWAS Control that there were “probably at least 20” police officers on the scene.

10.40 As the call between NWAS Control and GMP Control was taking place, another operator in NWAS Control called NWFC. NWAS Control informed NWFC that a bomb had gone off at the Arena. In that call, NWFC was not told that NWAS was in the process of deploying personnel to Manchester Central Fire Station, less than a mile from the scene, and to the scene itself.

Deployment of GMP firearms officers

10.41 At 22:36, Inspector Sexton directed the dispatch of firearms officers to the Victoria Exchange Complex. Shortly afterwards, he granted formal authority for the firearms officers to deploy with...
their weapons. This was an important and sensible step.

Mobilisation of NWAS Advanced Paramedic Patrick Ennis

10.42 NWAS Advanced Paramedic Patrick Ennis was on duty at Central Manchester Ambulance Station. He quickly became aware of the 999 calls to NWAS Control. Commendably, he decided to deploy directly to the Arena. At 22:38, he told NWAS Control that he was on his way to the scene.

The City Room shortly after the explosion

10.43 At the Victoria Exchange Complex at 22:36, BTP officers were doing their best to help the casualties.

10.44 Situation updates were provided to BTP Control from the City Room. However, none of the BTP officers in the City Room declared a Major Incident. None of the BTP officers in the City Room provided a METHANE message. This was due to a failure by BTP to prepare them adequately for the situation they were confronted with.

10.45 BTP officers worked alongside members of the public, SMG and Showsec staff and ETUK. ETUK was contracted by SMG to provide healthcare services at the Arena for the concert. There were
14 people on duty from ETUK on 22nd May 2017. A number of those ETUK employees entered in the minutes following the explosion. They showed courage in doing so.

10.46 However, ETUK had not adequately prepared to deal with a Major Incident response. There were not enough staff with necessary clinical qualifications, skills and experience on duty. Some staff were not sufficiently qualified to provide healthcare at events. ETUK’s Major Incident Plan expected ETUK to provide a METHANE message to NWAS. This would have given NWAS situational awareness at an early stage. ETUK failed to do this.

10.47 Overall, ETUK’s provision of a healthcare service on the night of the Attack was inadequate.

Rendezvous Points

10.48 GMP Inspector Michael Smith understood the need to grip the unfolding response. He was notified about the Attack by GMP Control at 22:34. He acted with impressive speed. Within minutes, he started to make his way to the Arena. As he did so, at 22:36, he informed GMP Control that the RVP should be “the … parking area outside the Cathedral”.\(^{12}\) This RVP was recorded on the GMP incident log as the “Cathedral car...
park”. It was passed on to NWFC at 22:40. It was also given to GMFRS by GMP Control much later, at 23:54. It was never used by any agency.

10.49 At 22:40, Inspector Smith contacted GMP Control again. Having heard that there was already a GMP officer on scene, Inspector Smith said he wanted all officers to go to the scene directly. Inspector Smith intended this to be understood as the new RVP. It was not passed on as such to NWFC and GMFRS.

10.50 Before the arrival at the scene of Inspector Smith, BTP Sergeant David Cawley was one of two Sergeants present. One of his first actions was to reject a request made at 22:40 by a BTP Sergeant in Liverpool for an RVP. Sergeant Cawley said that it was not possible to identify an RVP because of the need to focus on treating casualties. This was an error. It was his responsibility as a supervising officer to assess the situation and to identify how best to co-ordinate the response on the ground with the resources he had. It is a difficult thing to do. It requires training and experience. A multi-agency RVP was urgently required. It was an important step that would have helped to co-locate resources for the emergency response.
10.51 NWAS had decided that Manchester Central Fire Station would be used by its ambulances as an RVP. NWAS Control informed BTP Control of this decision about the RVP at 22:41.

10.52 Three minutes later, at 22:44, BTP PC Carl Roach declared an RVP at the Fishdock car park. This was an area on the Corporation Street side of the Victoria Exchange Complex. The BTP incident log records that the RVP should be passed on to GMP. I have seen no evidence that this RVP was ever communicated by BTP to GMP or NWAS. This RVP was never used by any emergency service during the critical period of the response.

10.53 In the first quarter of an hour after the Attack and thereafter, there was substantial confusion over the location of an RVP. Each emergency service chose its own. In some cases, this was passed on to other agencies. In others, it was not.

10.54 There should have been a concerted effort to agree a multi-agency RVP where all the emergency services could co-locate.

10.55 At the time of the Attack, the emergency services operating in Greater Manchester were in the process of setting up a radio talk group that allowed the control rooms for each emergency service to communicate with each other directly and simultaneously. It should have been
operational by 22nd May 2017, but it was not. One of the issues it would have helped to resolve was a multi-agency RVP.

**GMP duty Superintendent**

10.56 Temporary Superintendent Arif Nawaz was GMP’s duty Superintendent that evening. In this role, known as Night Silver, he was expected to become the Tactical/Silver Commander in the event of a Major Incident. GMP Control notified Temporary Superintendent Nawaz about the Attack at 22:39. He was told that 20 to 30 people had been injured.

10.57 Temporary Superintendent Nawaz decided to check the incident log and find a copy of the GMP contingency plan for the Victoria Exchange Complex. Given the important role he had to play, he should have delegated this task to someone else.

**NWAS Tactical Commander and the Hazardous Area Response Team**

10.58 At the same time, NWAS Control contacted Annemarie Rooney, the NWAS on-call Tactical Commander. She was told that there were reports of a bomb explosion at the Arena. At 22:39, Annemarie Rooney told NWAS Control, “[W]e need to get HART.” HART stands for
Hazardous Area Response Team. HART is an NWAS specialist resource with training and equipment that enable it to work in hazardous areas.

10.59 NWAS Control had known since 22:32 that a bomb had been detonated. The need for HART should have been identified before 22:39. The sooner HART is notified of an event such as a bomb explosion the better. NWAS had two six-person HART crews on duty that night: one covering Cheshire and Merseyside (the C&M HART crew) and one based in Greater Manchester (the GM HART crew). At the time Annemarie Rooney spoke to NWAS Control, the GM HART crew were closest to the Victoria Exchange Complex.

10.60 Annemarie Rooney took some other important steps. At 22:41, she telephoned Consultant Paramedic Daniel Smith. In that call, they agreed that he would travel to the scene. She also spoke to Neil Barnes, the NWAS on-call Strategic Commander for Greater Manchester. Neil Barnes asked for a further update when a METHANE message was available. The situation required him to be more proactive. It was already apparent that a complex, multi-agency response was required, and quickly.
GMFRS duty NILO contact with NWFC

10.61 At 22:40, NWFC informed the GMFRS duty NILO, Station Manager Andrew Berry, of the Attack. He decided to discuss what was happening with the FDO. Although now out of date, Station Manager Berry was informed of the Cathedral car park RVP declared by Inspector Smith three minutes earlier. Station Manager Berry rejected that RVP because he was not confident that it was safe.

10.62 Instead, Station Manager Berry directed NWFC to mobilise GMFRS resources to Philips Park Fire Station, three miles from the Victoria Exchange Complex. He should not have done this. Station Manager Berry’s rejection of the Cathedral car park RVP set in motion a series of events that resulted in GMFRS not arriving at the Victoria Exchange Complex until over two hours after the Attack occurred.

10.63 The effect of Station Manager Berry’s decision to mobilise to Philips Park Fire Station was that the fire appliances at Manchester Central Fire Station drove away from, not towards, the incident. While driving away from the incident, the Manchester Central fire appliances drove past ambulances travelling in the opposite direction.

10.64 At the same time that PC Roach was declaring an RVP at the Fishdock car park, the BTP Senior
Duty Officer Chief Inspector (CI) Antony Lodge contacted the BTP divisional commander for the area in which the Arena was located, Chief Superintendent Allan Gregory. Chief Superintendent Gregory made his way to the BTP control room in Birmingham. In due course, he would take over from Inspector Dawson as the BTP Silver Commander, but that was not until 23:34.

Arrival of GMP firearms officers at the Victoria Exchange Complex

10.65 The first firearms officers arrived at the Victoria Exchange Complex eight minutes after the explosion. Initially, the FDO was told that reports of an explosion were a false alarm and that it was nothing more than fireworks. It quickly became apparent that that was wrong. By 22:41, a GMP firearms officer outside the Arena, PC Lee Moore, updated the FDO that there were “major casualties”.

10.66 The FDO authorised an emergency search at 22:42. This was a specialist tactic that involved locating and neutralising any threat. At about the same time, PC Lee Moore again confirmed to GMP Control that there were casualties. He indicated that it was believed a ball bearing
device had caused them. He ended his radio message, “Operation Plato, Operation Plato”.16

10.67 At 22:43, a pair of firearms officers, one of whom was PC Lee Moore, entered the City Room from the raised walkway. Approximately one minute later, they emerged onto the Arena concourse, having crossed the City Room. During their walk through the City Room, they conducted a “raw check” for any gunmen who might be present.17 No such threat was identified by them. Two minutes later, those two firearms officers had joined three other firearms officers at the doors to the City Room on the Arena concourse.

NWAS Major Incident declaration

10.68 At 22:46, NWAS became the second emergency service, after BTP, to declare a Major Incident at the Victoria Exchange Complex. The declaration was not shared with any other emergency service despite the requirement that it should be.

10.69 Following the declaration, a series of calls were made to notify local hospitals of the Major Incident declaration, giving approximate casualty numbers. NWAS records indicate that, by 23:00, six hospitals had been informed of the Major Incident declaration.
GMP Tactical Firearms Commanders

10.70 Around the same time as the NWAS Major Incident declaration, GMP’s CI Mark Dexter was notified about the Attack. He placed himself on duty and immediately began making his way to the Arena. En route, CI Dexter spoke to Temporary CI Rachel Buckle. Temporary CI Buckle was the on-call Tactical Firearms Commander. They agreed that CI Dexter would travel to the Victoria Exchange Complex to take up the Ground Assigned Tactical Firearms Commander role. They further agreed that Temporary CI Buckle would travel to GMP HQ to take up the Tactical Firearms Commander role.

10.71 The Ground Assigned Tactical Firearms Commander role is a firearms role. However, in the absence of any tactical command of the unarmed officers at the scene, CI Dexter also assumed the role of Tactical/Silver Commander for those officers following his arrival at the scene. He arrived at 23:23. In the 52 minutes before that, there was no GMP Tactical/Silver Commander at the scene. There needed to be.

Arrival of NWAS Advanced Paramedic Patrick Ennis at the Victoria Exchange Complex

10.72 By 22:46, Patrick Ennis was on Station Approach outside the Victoria Exchange Complex. At 22:47, he asked for at least four ambulances to go to
“Victoria Station”. He entered the Victoria Exchange Complex at 22:50 and updated NWAS Control that the best access was via Hunts Bank.

10.73 GMP PC Grace Barker approached Patrick Ennis as he entered the station. She informed him: “Every NWAS. They want every NWAS there … At the booking office which is just … upstairs.” Patrick Ennis began to make his way to the City Room.

**GMP Operation Plato declaration**

10.74 At 22:47, Inspector Sexton declared Operation Plato. In 2017, Operation Plato was the emergency services’ designation for the response to an attack by a marauding terrorist with a firearm. Although, as it turned out, there were no armed terrorists within the Arena or wider area, this was a reasonable decision. There had been some reports of gunshots.

10.75 In 2017, there was a focus within counter-terrorism on such attacks because of incidents elsewhere in the world. Inspector Sexton could not discount the possibility that a Marauding Terrorist Firearms Attack was under way. That was understandable.

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18 INQ015047T [Note: ‘Victoria Station’ is incorrectly transcribed as ‘Gurriers Station’ in the transcript]

19 76/77/25-79/22
10.76 The next step for Inspector Sexton was crucial. He should have ensured that the declaration of Operation Plato was communicated to the other emergency services. The GMP plan required this. Inspector Sexton failed to do this. The burden of his responsibilities as FDO meant that he overlooked it.

10.77 GMP had no contingency plan for this, despite knowing that the FDO role was likely to come under enormous pressure during an incident such as the Attack. As a result, no one prompted Inspector Sexton to communicate the declaration of Operation Plato or checked whether he had done so.

10.78 The failure to communicate the Operation Plato declaration had significant consequences. It affected the ability of the emergency services to work together by jointly understanding the risks.

10.79 Communication was not the only failure in relation to Operation Plato. The declaration of Operation Plato required zones to be applied. The purpose of the zones is to ensure emergency responders are protected from any terrorists who may be present. There was a substantial failure by GMP at every level of armed command in relation to the zoning of the Victoria Exchange Complex during the golden hour.
Arrival of GMP Operational/Bronze Commander at the Victoria Exchange Complex

10.80 At about the same time as the declaration of Operation Plato, Inspector Smith entered the City Room. He assumed the role of GMP Operational/Bronze Commander, a role that he performed to a high standard. At 22:47, Inspector Smith contacted GMP Control. He directed that a GMP officer should meet the arriving paramedics.

10.81 The GMP radio operator then broadcast: “Any staff, please, start making to the booking office.”\(^{20}\) This was a reference to the City Room. The GMP incident log was updated to the effect that all available officers should go there.

10.82 At 22:50, Inspector Smith radioed GMP Control stating, “The booking hall is the seat of the explosion. It’s not the Arena itself.”\(^{21}\) By this time, Inspector Smith knew what he was dealing with. He knew this because he was in the City Room. He could see for himself. He had immediate, direct access to those already on the scene.

Intervention of NWAS Consultant Paramedic Daniel Smith

10.83 At the same time, Consultant Paramedic Daniel Smith radioed NWAS Control. At that time, he

\(^{20}\) INQ018514T/14
\(^{21}\) INQ018644T/9
was travelling to the Victoria Exchange Complex. He told NWAS Control to maintain the RVP at Manchester Central Fire Station pending his arrival at the scene.

10.84 By 22:50, there were two ambulances on the forecourt of Manchester Central Fire Station. A third ambulance arrived there at 22:53, a fourth at 22:56, a fifth at 22:59 and a sixth at 23:02. This intervention by Daniel Smith was an error. It was made at a time when Daniel Smith was not part of the command structure. It would not be until 23:00 that NWAS Control issued an instruction to the ambulances at Manchester Central Fire Station to deploy to the scene.

**GMP firearms officers’ ‘spiky bubble’**

10.85 As unarmed police officers, personnel from ETUK and members of the public continued to assist casualties, GMP firearms officers worked quickly to secure the City Room. Two officers had already done a raw check. A second sweep of the City Room was undertaken. At 22:46, firearms officer PC Edward Richardson entered the City Room. By this point, he was the Operational Firearms Commander. This placed him in operational command of the firearms officers within the Victoria Exchange Complex.

10.86 By 22:48, the firearms officers were confident that there was no firearms terrorist threat in the
City Room. They could not be sure that there was not a secondary device, although there were no obvious signs of one, and they had not checked all of the Arena for gunmen. PC Richardson deployed firearms officers to create a “spiky bubble” around the City Room. This resulted in firearms protection on the Arena side of the City Room and the railway station side of the City Room.

10.87 By 22:50, the City Room had been secured by firearms officers against any marauding terrorist with a firearm. There was also nothing positively to indicate the presence of a secondary device.

Further contact between GMFRS duty NILO and NWFC

10.88 At 22:48, Station Manager Berry spoke to NWFC. He said that he could not reach the FDO. In contrast to what the firearms officers in the City Room knew, he was told that, in addition to there being over 60 casualties, there were reports of an active shooter.

10.89 Station Manager Berry was not told that ambulances were being deployed and that the police were on the scene, with more officers on the way. By this time, Station Manager Berry had mobilised the GMFRS Marauding Terrorist
Firearms Attack specialists to Philips Park Fire Station. The GMFRS response had already diverged from the other emergency services. The requirements of JESIP were not being met.

**NWAS Tactical Advisors/NILOs**

10.90 Jonathan Butler and Stephen Taylor were the NWAS Tactical Advisors/NILOs on the night of 22nd May 2017. At 22:49, Jonathan Butler was contacted by NWAS Control and mobilised to the scene. He lived approximately 45 minutes from Manchester City Centre.

10.91 Immediately after his call with NWAS Control, Jonathan Butler contacted Stephen Taylor. It was agreed that Jonathan Butler would travel to the scene and Stephen Taylor would provide cover from home while he did so. This was a sensible arrangement. Stephen Taylor then tried on numerous occasions to contact the FDO. Like the GMFRS officers, he could not get through.

**GMP Tactical/Silver Commander and Operation Plato**

10.92 At 22:50, Temporary Superintendent Nawaz spoke to the FDO, Inspector Sexton. In this conversation, Temporary Superintendent Nawaz became the GMP Tactical/Silver Commander. He was told that Operation Plato had been declared. Temporary Superintendent Nawaz had no idea what Operation Plato was. He did not
reveal this critical lack of knowledge. Instead, he gave the impression that he did know what Operation Plato was. Temporary Superintendent Nawaz should have asked the FDO to explain what Operation Plato meant.

10.93 Temporary Superintendent Nawaz was responsible for the unarmed officers at the scene and developing a tactical plan. He could not do this without knowledge of a central aspect of the police response. Temporary Superintendent Nawaz kept from everyone that he did not know what Operation Plato was.

10.94 Because of his lack of understanding of Operation Plato, Temporary Superintendent Nawaz was not competent to perform the role of Tactical/Silver Commander of the response on the night of the Attack.

GMFRS duty NILO’s departure for Manchester

10.95 At around 22:48, Station Manager Berry decided to set off from his home to Philips Park Fire Station. This was a journey of more than 20 miles. In the course of it, he became lost due to diversions. At the time he set off, he was not to know that he would encounter the difficulties he did.

10.96 However, it should have been obvious to Station Manager Berry that his geographical location meant that a substantial amount of time would be
spent driving, rather than being devoted to developing and advancing the GMFRS response. The GMFRS response was already significantly out of step with that of BTP, GMP and NWAS. Travelling at such a critical time was not going to improve that.

10.97 Station Manager Berry should have given his undivided attention to progressing the GMFRS response to the incident. He had great difficulty contacting the FDO. It is a striking feature of the evidence that he made no attempt to contact the NWAS NILOs. Nor did he make any effort to contact BTP, despite the Attack occurring within a transport hub.

10.98 Instead, he spoke only to NWFC and GMFRS officers during his drive to Manchester. In the course of these conversations, he learned nothing new about the incident. These conversations served to recycle existing knowledge about what had happened, not to increase his situational awareness.

10.99 The NILO role was not a command role. However, for reasons I will give when I consider the second hour of the emergency response, Station Manager Berry was effectively in charge of the GMFRS response throughout the entire time he was driving.
BTP Control’s request for a METHANE message

10.100 Inspector Dawson, on behalf of BTP, was still trying to gain an understanding of what was happening at the scene. He made a number of requests for a METHANE message to be provided to him. At 22:50, he tried again and broadcast a request over the radio for someone to provide a METHANE message. Sergeant Cawley agreed to provide one, but was not able to communicate it to Inspector Dawson for another seven minutes.

10.101 By 22:50, a METHANE message should have been provided to BTP Control and then disseminated to all other emergency services.

The City Room at 22:50

10.102 By 22:50, more unarmed officers were arriving in the City Room. A minute earlier, seven officers from the Tactical Aid Unit had run into the Victoria Exchange Complex. They made their way towards the City Room. Their help was desperately needed but the real urgency in the City Room was for paramedics.

10.103 With no tactical plan from Temporary Superintendent Nawaz, Inspector Smith formed his own plan. He decided that, first, the casualties needed expert treatment and evacuation. That was the priority. Second, once lives had been
saved, steps needed to be taken to preserve the area as a crime scene.

10.104 Inspector Smith communicated the need for ambulances within seconds of arriving in the City Room at 22:48. He repeated the request again at 22:50 and 22:51.

10.105 No one had yet zoned the City Room for the purpose of Operation Plato. By 22:50, the City Room was in fact a cold zone. In 2017, under the national Operation Plato guidance, a cold zone was an area where it was assessed that there was no immediate threat to life from a terrorist armed with a firearm. By 22:50, the GMP firearms officers were confident in their assessment that no such threat existed in the City Room.

10.106 That did not mean that the City Room was entirely safe for those responding. However, it had been assessed by Inspector Smith to be “safe enough” for non-specialist emergency responders and members of the public to be in. Not only should this have been the view across the emergency services, based on the available information, but it was in fact correct, as is now known for certain.

End of the first 20 minutes

10.107 Within 20 minutes of the explosion, a concerted effort had been made by those at the scene to
ensure that the City Room was secure from further threat and to help the casualties in that location.

10.108 However, a great deal had already started to go wrong. Only BTP and NWAS had declared a Major Incident. Neither declaration was shared with all the other emergency services. There was no clear multi-agency RVP and there had been no discussion about an FCP. GMFRS had rejected the GMP RVP and decided to muster on its own, some distance from the Victoria Exchange Complex. NWAS Control had not deployed to the scene ambulances that were close by.

10.109 Despite efforts by Inspector Dawson, no METHANE message had been passed from the scene. ETUK also failed to pass a METHANE message to NWAS.

10.110 Operation Plato had been declared by GMP, but not communicated to other emergency services or the unarmed GMP officers. No consideration had been given by GMP to the zoning of the scene as required under Operation Plato.

10.111 Had the response proceeded as it should have, GMFRS would have had personnel at, or very close to, the Victoria Exchange Complex by 22:50. This could have been achieved had any one of the following been done.
10.112 First, this could have been achieved through the use of the multi-agency control room talk group, had it been progressed to an operational stage more quickly than it was. The system in operation on the night of the Attack involved each emergency service making a call to another emergency service and waiting to be connected in order to pass on information. Inspector Smith made a request at 22:40 for all officers to come straight to the scene. If all the control rooms had been communicating with each other on a single radio channel, this information could have been disseminated to all other emergency services at that time.

10.113 Second, this could have been achieved through a METHANE message passed to NWFC in the first 15 minutes stating that GMFRS was required at the scene. Realistically, at this stage, this could only have originated from BTP officers or ETUK.

10.114 Third, it could have been achieved through the duty NILO initially accepting the GMP RVP, or through the duty NILO accepting the GMP RVP once he found that he could not get through to the FDO.

10.115 As it was, another 1 hour and 45 minutes would have to pass before GMFRS had any personnel on the scene.
The second 20 minutes

Message from GMP Control to NWAS Control

10.116 At 22:51, GMP Control told NWAS Control that “all available ambulances” were needed.\(^{23}\) The “exact location”\(^{24}\) was identified to be “the booking office which is over the bridge to the main entrance”.\(^{25}\)

10.117 NWAS Control did not act immediately to notify all ambulances allocated to the incident that they should go straight to the Victoria Exchange Complex. A number of ambulances had been sent to Manchester Central Fire Station. The message deploying them to the scene was not given until 23:00.

Further GMFRS NILOs mobilised

10.118 At 22:52, Station Manager Berry called NWFC and asked to mobilise three more NILOs. The extra NILOs requested by Station Manager Berry were not contacted by NWFC for at least 14 minutes. The GMFRS response was being severely hampered by delays and failures in communication.

10.119 The call by Station Manager Berry was an opportunity for NWFC to share its knowledge that

\(^{23}\) INQ015139T/1
\(^{24}\) INQ015139T/1
\(^{25}\) INQ015139T/1
ambulances were being deployed to the scene and that police officers were already there. This information was not shared. Station Manager Berry remained of the view that there was a risk that a Marauding Terrorist Firearms Attack was under way. GMFRS resources continued to be directed away from the scene, out of step with the other emergency services.

NWAS Advanced Paramedic Patrick Ennis’s first entry into the City Room

10.120 Patrick Ennis entered the City Room at 22:53. On that first visit to the City Room, he was there for nearly seven minutes. During this time, he spoke to Inspector Smith and ETUK personnel.

10.121 A minute after he entered the City Room, Patrick Ennis sent a METHANE message to NWAS Control. This was the first METHANE message sent by anyone. In the message, Patrick Ennis confirmed that it was a Major Incident and stated that there were at least 40 casualties and 10 deceased. He thought there were at least a dozen casualties in the P1 priority level of most seriously injured. He confirmed that ambulances were still needed at Hunts Bank.

10.122 NWAS Control replied to confirm that “everyone is now making their way to Hunts Bank”.
However, for a number of ambulances already sent to Manchester Central Fire Station, it was to be another 12 minutes before they set off from that location to the Arena.

10.123 The METHANE message did not identify that GMFRS personnel were not present or that they were needed. NWAS did not share the METHANE message with BTP, GMP or NWFC. This compounded the earlier failure by NWAS to share its Major Incident declaration.

**Arrival of the GMP ‘can-do’ team in the City Room**

10.124 Two minutes after the arrival of Patrick Ennis, GMP officers from the Tactical Aid Unit, led by Sergeant Kam Hare, entered the City Room. Inspector Smith was grateful for their presence. He described them as a “can-do team”. These officers, like their BTP counterparts already present in the City Room, had received only basic first aid training.

10.125 Sergeant Hare directed his team to work in pairs and to give first aid. Reflecting his belief at the time, he reassured them that paramedics were on the way. That was not the case. The police officers did all they could, but they did not have

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27 103/24/11-25/3
the training of paramedics and there was a limit to what they could achieve.

**Police explosives detection dogs**

10.126 Just before the arrival of Sergeant Hare and his team, the Operational Firearms Commander, PC Richardson, made a request for explosives detection dogs. He made further requests for this to the FDO at 22:54 and 23:00. It was not until 23:47 that a BTP explosives detection dog arrived, 75 minutes after the explosion. A GMP explosives detection dog arrived only later.

10.127 The early attendance of explosives detection dogs would have enabled prompt confirmation that there was no secondary device in the City Room. It would have helped with the management of risk. It is very difficult, in circumstances such as existed in the City Room, to get that confirmation without the assistance of explosives detection dogs.

**NWFC and the NWAS “Bronze Commander”**

10.128 At 22:55, NWFC was informed by GMP Control that NWAS had a “Bronze Commander” on the scene. This was a reference to Patrick Ennis, who Inspector Smith had mistaken for the NWAS Operational Commander. This information was passed on to only one GMFRS officer, who failed to register it. It was not passed on to any other GMFRS officer that night.
10.129 Two minutes after this call, Station Manager Berry spoke to NWFC. He was not given this information. Had it been shared with Station Manager Berry at this point, he may have changed the course he had set GMFRS on. This was another example of a failure to ensure situational awareness for a multi-agency emergency response.

Operation Plato and the City Room

10.130 By 22:55, Operation Plato had been running for eight minutes. Throughout most of this time, the City Room was secured against armed attackers by a significant number of well-organised firearms officers.

10.131 No one save for the firearms officers knew of the declaration of Operation Plato. Given the relevance of this to the deployment forward of emergency responders, this lack of knowledge on the part of the emergency services generally was significant.

10.132 The Operational Firearms Commander, PC Richardson, and the Operational/Bronze Commander, Inspector Smith, never spoke to each other. This is despite the fact that they were both in the City Room from 22:49. Inspector Smith was not told by anyone that Operation Plato had been declared for most of the golden hour.
10.133 Even if Inspector Smith had been told of the declaration during the early stages of the response, he would not have known what it meant because GMP had not given him any training about Operation Plato.

GMP Tactical/Silver Commander and GMP Headquarters

10.134 At around the time that Patrick Ennis was doing his first checks in the City Room, Temporary Superintendent Nawaz spoke to Assistant Chief Constable (ACC) Deborah Ford, who was the GMP Strategic/Gold Commander and Strategic Firearms Commander. She directed him to go to GMP HQ.

10.135 GMP was the lead agency and needed to ensure that it had a sufficient command presence at the scene both to organise its own officers, unarmed and armed, and to co-ordinate with the other agencies.

10.136 Temporary Superintendent Nawaz’s departure to GMP HQ, without any other officer being sent to act as Tactical/Silver Commander at the scene, left a command vacuum at the Victoria Exchange Complex. This meant that important elements of the multi-agency response were missed. No FCP was set up. Setting up an FCP was principally the responsibility of GMP. This, in turn, meant that there was no opportunity for shared situational
awareness and joint assessment of risk by commanders at the scene.

GMP Force Duty Officer telephone line

10.137 By 22:57, the FDO was struggling to manage the different roles that he was required to fulfil. No action cards were available, which could have been used to delegate tasks from the FDO to others in the control room. It was difficult for anyone to reach the FDO. Answering the FDO telephone line in particular was not a good use of the FDO’s time.

10.138 A large number of people, including members of the press, were trying to make contact with GMP via the FDO line. This was bound to cause problems. Inspector Sexton instructed David Myerscough, a member of police support staff who had been a GMP radio operator since 2014, to answer the FDO line. Through no fault of his own, this was not a role David Myerscough had the skills and knowledge to perform. He was out of his depth.

BTP METHANE message

10.139 Between 22:58 and 23:03, Inspector Dawson talked Sergeant Cawley through the elements of METHANE. This was the second METHANE message of the night.
10.140 Inspector Dawson explained that this was so that he could co-ordinate and get support to the scene. In the course of receiving the METHANE message, Inspector Dawson stated: “[W]e’re just going to get as many ambulances and fire and all that to you as we can.”

10.141 Despite the time spent obtaining this information and recording it in the BTP incident log, the METHANE message was not passed on to any other emergency service. It should have been. The passing on of a METHANE message is an essential part of the sharing and development of each emergency service’s situational awareness.

10.142 This had the most significant impact on GMFRS. At the time the BTP METHANE message was being passed from the scene, GMFRS was mustering at Philips Park Fire Station. If BTP had passed on the METHANE message to NWFC, it could have been relayed to Station Manager Berry. It was to be another 70 minutes before GMFRS considered it sufficiently safe to deploy firefighters to the scene.

Halfway through the golden hour

10.143 Halfway through the golden hour, there was still no common RVP and not one person involved in the response had even mentioned an FCP. No
one in command roles in the other emergency services had recognised that GMFRS had decided to mobilise to a fire station three miles from the Victoria Exchange Complex.

10.144 GMP had an Operational/Bronze Commander in the City Room. The person who was to be the first NWAS Operational Commander, Daniel Smith, had just arrived at the Victoria Exchange Complex and was about to take up that role. There was no Bronze Commander for BTP. None of the BTP, GMP or NWAS Tactical/Silver Commanders had produced a tactical plan or communicated it to their Operational Commanders.

10.145 The two METHANE messages had not been shared with the other emergency services. Only one paramedic had been into the City Room.

Appointment of NWAS Operational Commander

10.146 Consultant Paramedic Daniel Smith arrived at the Victoria Exchange Complex at 22:59. He was not part of NWAS’s planned command structure for the night. Shortly after he arrived, he took up the role of NWAS Operational Commander.

10.147 There was an urgent need for paramedics to triage and provide life-saving treatment to the injured in the City Room.
10.148 At 23:01, the only personnel Daniel Smith had immediately available for deployment were a doctor, a Senior Paramedic, two paramedics and a student paramedic. He chose to send the two paramedics and the student paramedic to Trinity Way. He did so on the basis that a police officer had told him there was at least one critically ill patient on Trinity Way. These NWAS personnel should not have been deployed until Daniel Smith had a better understanding of what was happening, particularly in the City Room. Only then could he assess where the paramedics could make the greatest contribution.

10.149 As those he had deployed to Trinity Way were leaving, Daniel Smith was approached on the station concourse by Patrick Ennis who had left the City Room at 23:01. In the course of the short conversation that ensued, Patrick Ennis informed Daniel Smith that there were police officers, members of the public, event healthcare staff and security staff in the City Room, helping casualties. He told Daniel Smith that people were in urgent need of medical attention and that there had been fatalities. They did not discuss whether the City Room was a safe place for non-specialist paramedics, like Patrick Ennis, to work. They should have.

10.150 One of those immediately available to Daniel Smith was Derek Poland. Derek Poland was a
Senior Paramedic. He was also one of the two on-call Operational Commanders. He had been mobilised to the scene in that capacity. Derek Poland volunteered to go into the City Room to support Patrick Ennis. Daniel Smith instructed him to stay on the station concourse.

**NWAS Advanced Paramedic Patrick Ennis’s second entry to the City Room**

10.151 At the conclusion of his conversation with Daniel Smith, Patrick Ennis returned to the City Room. He re-entered the City Room at 23:05. Daniel Smith did not direct Patrick Ennis to go back to the City Room, Patrick Ennis went voluntarily. Patrick Ennis’s expectation was that more paramedics would follow him. In the event, only two did, 10 minutes later.

10.152 Patrick Ennis had SMART Triage Tags in a bag in his vehicle. SMART Triage Tags allow casualties to be labelled with their priority level once they have been assessed. Patrick Ennis did not take these SMART Triage Tags with him into the Victoria Exchange Complex. He did not ask anyone to retrieve them for him or ask to use anyone else’s set once he was within the City Room.

10.153 As a result, when he commenced triage on his return to the City Room, Patrick Ennis had no clear and reliable method for identifying each
casualty in terms of the priority level he had assessed them to have.

**NWAS Operational Commander’s risk assessment of the City Room**

10.154 Daniel Smith decided that non-specialist paramedics should not be deployed into the City Room. He wrongly believed that he was prohibited from deploying any non-specialist paramedics into the City Room.

10.155 Daniel Smith made this decision within a very short period of time of his arrival. He did not go up to the City Room to see the position for himself. He had not discussed it with Patrick Ennis. He did not attempt to find or speak to the GMP Operational/Bronze Commander.

10.156 Had Daniel Smith spoken to either Patrick Ennis or Inspector Smith about paramedics working in the City Room, he would have been told by both of them that they regarded it as a safe enough area to work in.

10.157 Daniel Smith should have sought to improve his situational awareness and conduct a joint risk assessment before making such an important decision.

**BTP command**

10.158 At 23:05, Chief Superintendent Gregory spoke to ACC Robin Smith, who was at home in the south
of England. ACC Smith was the on-call Gold Commander for BTP that night. Chief Superintendent Gregory informed ACC Smith that he was making his way to the BTP control room in Birmingham and that, once there, he would undertake the role of Silver Commander.

10.159 Chief Superintendent Gregory was rightly concerned about the lack of a BTP Bronze Commander. He concluded that the role of Bronze Commander needed to be undertaken by someone of seniority. As a result, his focus was not on finding a more junior officer to fulfil the role of Bronze Commander for BTP as quickly as possible. This was an error on his part.

10.160 Chief Superintendent decided to appoint Superintendent Edward Wylie as Bronze Commander. Superintendent Wylie was the sub-divisional commander for the Pennine sub-division. He was based in Manchester. Chief Superintendent Gregory called Superintendent Wylie at 23:08. Superintendent Wylie did not answer his telephone.

10.161 Having failed to get through to Superintendent Wylie, Chief Superintendent Gregory did not try to find out who of those already present at the Victoria Exchange Complex might take charge of the BTP response until a more senior officer arrived. He should have done so.
Manchester Central Fire Station

10.162 At 23:06, NWFC was informed by one of the fire crews who had left Manchester Central Fire Station and travelled to Philips Park Fire Station that ambulances were arriving at their home station as they departed. This was important information that NWFC failed to act upon. It was not passed on to Station Manager Berry.

10.163 At the time NWFC was being informed of this, those ambulances at Manchester Central Fire Station began to leave in convoy for Hunts Bank. The first ambulance in the convoy arrived at the Victoria Exchange Complex two minutes later.

NWAS C&M HART crew

10.164 At about the same time, the Team Leader of the C&M HART crew, Ronald Schanck, spoke to NWAS Control. It was agreed that the C&M HART crew would mobilise to Manchester. The C&M HART crew should have been mobilised to respond approximately 30 minutes before this time.

NWAS evacuation plan from the City Room

10.165 The staircase leading from the raised walkway to the station concourse presented a formidable obstacle to injured casualties being evacuated from the City Room. It was a challenge even for those injured who could walk. For those unable to walk, it was a danger. Daniel Smith was by now
wearing an Operational Commander tabard and was located by the War Memorial entrance to the station. This gave him a viewpoint of the staircase.

10.166 From 23:07, Daniel Smith saw casualties being brought down from the City Room on makeshift stretchers. He could have had no idea when these materials would run out. He did not know what stretchers were available in or around the City Room. It did not occur to him to arrange to use the stretchers in the ambulances, which had begun to arrive in numbers at 23:08. The use of improvised stretchers was the product of the ingenuity of the police officers, members of the public and Victoria Exchange Complex staff. This should not have been necessary.

10.167 Daniel Smith believed that the evacuation was going well, and so he thought that he did not need to do anything further. He should have realised that the system for evacuation needed to be improved. Moving casualties in this way was a risk to them. It was painful for many. It risked making injuries worse. Although the stretchers in the ambulances ideally required training to use, they were significantly preferable to what was in fact used, even when used by those without training. The NWAS evacuation plan was inadequate.
Aside from the issue of stretchers, the evacuation plan was hampered by the fact that, between 23:05 and 23:15, there was only one paramedic in the City Room: Patrick Ennis. At 23:06, the first HART operative, Lea Vaughan, arrived at Hunts Bank. A minute later, two more HART operatives, Simon Beswick and Christopher Hargreaves, arrived. The arrival of the GM HART crew offered another opportunity to deploy medical resources into the City Room, where help was most needed.

**NWAS Casualty Clearing Station**

The first two casualties arrived at the Casualty Clearing Station at 23:07. One was on a makeshift stretcher; one had been assisted on foot down the raised walkway steps. By 23:10, there were four casualties in the Casualty Clearing Station. A total of 38 casualties were treated in the Casualty Clearing Station before being transported onwards to hospital.
GMFRS duty NILO and the METHANE messages

10.171 The NWAS or BTP METHANE messages were not shared with NWFC. Consequently, NWFC did not have them to share with Station Manager Berry. Station Manager Berry stated in evidence that, had he received either of these messages, GMFRS would “have responded straightaway”. I accept this evidence. It stands as a very clear example of the importance of METHANE messages being shared. It is also the reason why responsibility for GMFRS’s failure to attend within the first two hours does not rest solely with NWFC and GMFRS.

10.172 Because he was so far away, Station Manager Berry should have remained at home and mobilised another officer who lived closer to go to the scene. This should have been standard procedure.

GMP Tactical/Silver Commander’s arrival at GMP Headquarters

10.173 Temporary Superintendent Nawaz arrived at GMP HQ at about 23:10 and entered the room where the commanders were to be based. He was the first to arrive but, within a short time, many others joined him. By this time, Temporary Superintendent Nawaz had made no effective command decisions to influence what was
happening at the Victoria Exchange Complex. He still did not know who the GMP Operational/Bronze Commander was. They would not speak for nearly another 25 minutes.

**End of the second 20 minutes**

10.174 By 23:10, one paramedic had been triaging for five minutes in the City Room. Alongside members of the public and others at the Victoria Exchange Complex, unarmed GMP officers and BTP officers continued their efforts to help the injured. With the exception of the firearms officers, who had ballistic protection, none of those working in the City Room was wearing personal protective equipment.

10.175 Inspector Smith was providing effective command to the unarmed police officers in the City Room. However, the responsibilities of that role meant that another senior officer was required to ensure that the JESIP requirements were being met. Someone needed to review the whole scene.

10.176 In particular, there was a need for an FCP, where commanders could co-locate and communicate. This would have allowed them to share situational awareness and jointly assess risk. From this, they could have co-ordinated their efforts most effectively.
10.177 Before the end of this period, if the mistakes I have identified above had not been made, NWAS and GMFRS would have been in a position to deploy resources into the City Room.

10.178 The failure to dispatch the ambulances already at and travelling to Manchester Central Fire Station meant that there were fewer resources available to the NWAS Operational Commander in the first five minutes of his command than there should have been.

10.179 The NWAS Operational Commander made his command decisions without reference to the superior situational awareness of GMP and BTP. His risk assessment was that the City Room was not safe enough for non-specialists to work in. By contrast, both GMP and BTP considered the City Room safe enough for specialists, non-specialists, employees of civilian organisations and members of the public to operate in.

10.180 As for GMFRS, its crews were mustered at Philips Park Fire Station in another part of the city.

The final 20 minutes

The City Room at 23:11

10.181 By about 23:11, there were a substantial number of highly motivated police officers from GMP and BTP in the City Room. The unarmed officers
were doing their best to assist casualties. This included by helping to carry them out. There were a significant number of members of the public and Victoria Exchange Complex staff offering their assistance.

10.182 At 23:12, Patrick Ennis approached Inspector Smith in the City Room. Patrick Ennis explained that the Casualty Clearing Station was being set up on the station concourse. This gave greater impetus to the evacuation of casualties. Between 23:12 and 23:42, when the last casualty arrived in the Casualty Clearing Station, 33 casualties were evacuated from the City Room. All but six of them were evacuated on makeshift stretchers.

10.183 The need for paramedics in the City Room was now acute. At 23:13, Sergeant Hare could be heard on video saying to another officer, “Paramedics mate, they need to be coming in droves.” At the same time, three HART operatives were captured on CCTV on Hunts Bank, speaking to Daniel Smith.

Deployment of HART operatives at the Victoria Exchange Complex

10.184 At 23:15, two of those HART operatives, Lea Vaughan and Christopher Hargreaves, entered the City Room. They had volunteered to enter the
City Room following a briefing with Daniel Smith in which he indicated that the scene had not been declared safe. They went into the City Room not knowing what the situation was. They did so without ballistic protection.

10.185 The third member of the GM HART crew at the scene, Simon Beswick, remained behind on Station Approach. He was a HART Team Leader. He should have deployed into the City Room to provide a command presence.

10.186 As Lea Vaughan and Christopher Hargreaves were entering the City Room, the three other members of the GM HART crew were arriving on Hunts Bank. Together with Simon Beswick, these three HART operatives were tasked by Daniel Smith to set up what he termed a Casualty Collection Point. The correct decision would have been for all four to have been deployed to the City Room.

10.187 In the City Room, Lea Vaughan and Christopher Hargreaves began to assist Patrick Ennis with the triage process. Both Simon Beswick and Daniel Smith stated in evidence that they were expecting to be told by the paramedics in the City Room if more paramedics were required there. Given how much the paramedics in the City Room had to do, this was an unrealistic
expectation. Instead, Simon Beswick and Daniel Smith should have taken the initiative.

10.188 The three paramedics in the City Room needed a commander with them, such as the HART Team Leader, who could make an overall assessment of what was required and liaise with the police in the City Room. Lea Vaughan expected more paramedics to follow her into the City Room. They never came. She said in evidence that they were not needed, but in my view they were.

GMP Tactical/Silver Commander and NWAS Tactical Commander at GMP Headquarters

10.189 Annemarie Rooney arrived at GMP HQ at 23:12. Temporary Superintendent Nawaz was already there. ACC Ford arrived shortly afterwards. Temporary Superintendent Nawaz informed Annemarie Rooney that a suicide bomber was responsible for the Attack, that it was not a shooting incident. He told her that there were 20 fatalities at that time, including the bomber. This information was not passed on to Daniel Smith, who was allocating his resources at the scene on the basis that the City Room was not safe.

10.190 The conversation between Annemarie Rooney and Temporary Superintendent Nawaz did not reveal that their respective Operational/Bronze Commanders were taking a different approach to the risk in the City Room. Temporary
Superintendent Nawaz did not even know who the GMP Operational/Bronze Commander was at that stage.

10.191 The conversation was not focused, as it should have been, on how GMP and NWAS could coordinate their efforts.

10.192 Temporary Superintendent Nawaz did not look at the GMP incident log. Had he done so, he would have seen that Inspector Smith was making repeated requests for paramedics in the City Room. Accordingly, this was not something that he was able to discuss with Annemarie Rooney when they spoke at 23:15.

BTP Bronze Commander

10.193 By 23:10, no BTP Bronze Commander had been appointed. Having been unsuccessful in his attempt to contact Superintendent Wylie, Chief Superintendent Gregory contacted Superintendent Kyle Gordon. The two spoke at 23:12. Chief Superintendent Gregory directed Superintendent Gordon to travel to the scene and take up the role of Bronze Commander.

10.194 There was no appointment of a more junior officer as an interim Bronze Commander. In these circumstances, the appointment of Superintendent Gordon, who was in Blackpool at the time of this conversation, was a bad decision.
10.195 Chief Superintendent Gregory expected Superintendent Gordon’s journey would take about an hour. In fact, it took much longer. Superintendent Gordon had no access to a police vehicle or police radio. Having failed to secure a police vehicle to pick him up, Superintendent Gordon ordered a taxi to take him to the scene.

10.196 Superintendent Gordon did not arrive at the Victoria Exchange Complex until approximately 01:20. During the time he was travelling, he was unable to influence BTP actions or operational decisions. Even had the trip taken an hour, Superintendent Gordon would have arrived too late to make a meaningful contribution.

10.197 This meant that, throughout the critical period of the response, BTP did not have an on-scene Bronze Commander.

Continued evacuation of the City Room

10.198 NWAS classified casualties for treatment by three priority levels: P1, P2 and P3. P1 was reserved for the casualties in most urgent need of care. In the City Room, by 23:17, one P1 casualty had been carried into the Casualty Clearing Station on a makeshift stretcher.

10.199 Two P2 casualties had been carried into the Casualty Clearing Station on makeshift stretchers. A P2 casualty was anybody who could
not mobilise with minimal assistance. Some P1 and P2 casualties had also reached the Casualty Clearing Station without needing to be carried. A number of casualties remained in the City Room.

**GMP Tactical Firearms Commander role**

10.200 Following her agreement with CI Dexter, Temporary CI Buckle travelled to GMP HQ in order to take up the Tactical Firearms Commander role. Shortly before she arrived, at 23:10, she spoke to Superintendent Craig Thompson. Superintendent Thompson informed Temporary CI Buckle that he intended to take up the Tactical Firearms Commander role when he arrived at GMP HQ.

10.201 As a result, despite being in a position at 23:20 or shortly after to relieve Inspector Sexton of his role as Initial Tactical Firearms Commander, Temporary CI Buckle did not do so. Superintendent Thompson did not take up the Tactical Firearms Commander position until 00:18, very nearly an hour later.

10.202 GMP knew there was a risk of the FDO becoming overwhelmed. Given this, Temporary CI Buckle should have taken up the Tactical Firearms Commander role when she arrived at GMP HQ.
Redeployment of the GMP Force Duty Supervisor

10.203 In the latter part of the golden hour, the FDO was still overburdened and difficult to contact. At 23:20, this was compounded by a decision to send his Force Duty Supervisor from GMP Control. The role of the Force Duty Supervisor is pivotal in an Operation Plato situation. Inspector Sexton had an expert and experienced Force Duty Supervisor in Ian Randall that night.

10.204 Inspector Sexton made a decision that Ian Randall should travel to GMP HQ to set up the Silver Control Room. That was a mistake. Ian Randall’s replacement lacked his experience. As a result, Inspector Sexton lost a significant part of the limited support that had been available to him.

NWAS Tactical Advisor/NILO

10.205 At around this time, the NWAS NILO Stephen Taylor had still not been able to make contact with the FDO. At 23:22, he contacted NWAS Control and asked about using a multi-agency radio talk group which was monitored by GMP. This was a sensible thing to do but should have been done much earlier.

10.206 Stephen Taylor should have also sought to make contact with BTP. He did not do so. He only sought to contact GMFRS and NWFC after 01:00 on 23rd May. This is an example of a significant
communication failure that had set in to the emergency response.

10.207 There was little multi-agency communication. This was either because there was not a good understanding of the systems to do this or because insufficient efforts were made to seek information from emergency service partners where it was missing.

**Arrival of GMP Ground Assigned Tactical Firearms Commander at the Victoria Exchange Complex**

10.208 At 23:23, CI Dexter arrived at the Victoria Exchange Complex. Once there, he took up the role of Ground Assigned Tactical Firearms Commander. This role placed him in charge of what he described as the “forward-facing” part of the response.\(^3\)\(^1\) That is to say, the part of the response focused on eliminating the threat from terrorists and keeping other responders safe.

10.209 Co-ordinating the other parts of the response was not part of CI Dexter’s role. However, the command vacuum at the scene meant that CI Dexter had no choice but to involve himself in those parts of the response. It is to his credit that he did so.

\(^3\)\(^1\) 107/90/10-20
10.210 CI Dexter entered the City Room at 23:25. He spoke to Inspector Smith. He then spoke to PC Richardson, the Operational Firearms Commander. CI Dexter was the first GMP officer to give real thought to Operation Plato zoning, although his ability to do so was affected by the limits of his understanding. He was also the first senior police officer at the scene who actively sought out others in a command position.

Second NWAS METHANE message

10.211 At 23:23, Daniel Smith provided a METHANE message from the scene. Daniel Smith did not inform NWAS Control in that message that GMFRS officers were not at the scene and that they were needed.

10.212 NWAS Control did not share Daniel Smith’s METHANE message with any other emergency service. Had it been shared with NWFC, it was capable of resulting in GMFRS personnel arriving at the scene much sooner than they did.

Stalling of GMFRS response

10.213 At 23:25, the Manchester Central Fire Station Watch Manager telephoned NWFC again. He told NWFC that he was with a firefighter whose wife was a paramedic. She was at the scene. This was important information: the other emergency services were co-locating at the scene. NWFC did not pass this information on to Station
Manager Berry. It was an opportunity, over 45 minutes after the Attack, for a step back to be taken. This would have led to a realisation, even at this late stage, that GMFRS had taken a completely different approach from that of NWAS.

10.214 At 23:28, Group Manager Carlos Meakin, who had been mobilised as a second NILO, called NWFC. He repeated the information that the Manchester Central Fire Station crews had seen ambulances pulling up there as they were leaving for Philips Park Fire Station. He was told that the deployment to Philips Park Fire Station was Station Manager Berry’s decision and that NWAS was aware that GMFRS was mustering at Philips Park Fire Station.

10.215 By 23:30, GMFRS had mobilised a significant number of senior officers. The Chief Fire Officer, an Area Manager and four Group Managers were all involved in the GMFRS response. Two of the Group Managers went to Philips Park Fire Station. The other senior officers made their way to GMFRS’s Command Support Room at GMFRS HQ. Each of them had a different level of knowledge about the incident.

10.216 The primary reason why no one from GMFRS had gripped the response by 23:30 was GMFRS’s approach to incident command. GMFRS’s policy at the time was that the Incident
Commander was the most senior Fire Officer at the scene. The difficulty that policy created was seen in Station Manager Berry’s initial mobilising decision, which was that those responding should go somewhere other than the scene. That meant that, by 23:30, with no one at the scene, GMFRS did not have an Incident Commander. This was a significant gap in GMFRS policy. It was a gap that should have been identified and filled before the events of 22nd May 2017.

10.217 Those that knew of Station Manager Berry’s initial mobilising decision deferred to him, expecting him to get further information from the FDO. None of those who deferred to Station Manager Berry’s initial decision knew that he had been given an RVP near the scene by GMP and had rejected it.

10.218 By 23:30, GMFRS was still not on scene. Its response had stalled.

End of the golden hour

10.219 As the golden hour ended, there were 25 casualties in the Casualty Clearing Station. Six were P2 casualties, who had been carried out of the City Room on makeshift stretchers. There were still four P1 casualties, who needed to be carried out of the City Room to the Casualty Clearing Station. A concentrated focus on casualties is required during the golden hour.
Despite the best efforts of those working selflessly in the City Room, the emergency response had failed to achieve effective evacuation.

10.220 By 23:30, the NWAS Operational Commander did not know how many casualties would require transportation to hospital. It was not until 23:34 that Daniel Smith reported to Annemarie Rooney an accurate estimate of the number who would require transportation to hospital. He should have established this figure from the paramedics in the City Room much sooner than this. This was so he could ensure that there were enough ambulances allocated to respond.

10.221 One hour after the explosion, the full structure of a co-ordinated response was still not in place. BTP did not have a Bronze Commander on the scene. GMFRS had not started directing resources to the Victoria Exchange Complex. Only three paramedics were in the City Room, two of them for only the last 15 minutes of this period.

10.222 The FDO had not communicated his declaration of Operation Plato to other emergency services. Operation Plato zoning was only just under consideration. None of the GMP firearms commanders had reviewed the decision to declare Operation Plato at all.
10.223 None of the emergency services had gripped the response to the Attack as they should have. It would take a substantial part of the next hour of the response and beyond for that to happen.

The second hour

10.224 The second hour began with the emergency services focusing their efforts at three locations. Police officers from both GMP and BTP were in the City Room. With them, from NWAS, were three paramedics. NWAS’s focus was on the station concourse and Station Approach, where paramedics and doctors were managing 25 seriously injured casualties. GMFRS had mustered its resources three miles away.

10.225 At 23:31, many casualties remained in the City Room.

British Transport Police

Officers in and around the City Room

10.226 The activity of the BTP officers continued. A significant number of casualties still needed to be evacuated. The BTP officers in the City Room continued to do their best to help, and were assisted by others. At 23:39, the final living casualty was evacuated from the City Room. As the critical period of the response ended, there was still an enormous amount of work to
be done. That casualty arrived in the Casualty Clearing Station at 22:42.

10.227 At 23:47, a BTP explosives detection dog arrived at the Victoria Exchange Complex. This was the first time an efficient and safe means of ensuring that there were no secondary devices became available. This response time is something that needs to be improved in the future.

Bronze Commander

10.228 Shortly after the start of the second hour, Chief Superintendent Gregory relieved Inspector Dawson of his role as Silver Commander. This was the point of formal handover. However, since becoming aware of the incident, Chief Superintendent Gregory had been sharing some of the responsibilities with Inspector Dawson. He had made decisions around the appointment of the Bronze Commander.

10.229 At 23:31, there was still no BTP Bronze Commander at the scene. Fortunately for BTP, CI Andrea Graham had become aware of the Attack shortly after 23:00, put herself on duty and made her way into the centre of Manchester. By 23:56, she was at the Victoria Exchange Complex. Upon learning of CI Graham’s presence, Chief Superintendent Gregory’s plan was that CI Graham take up the role of Bronze Commander until Superintendent Gordon arrived.
10.230 CI Graham was spoken to twice about becoming Bronze Commander after she arrived at the Victoria Exchange Complex. A breakdown in communication meant that she did not end either of those calls understanding that this was her role. While she did view herself as in command of the BTP officers and she did liaise with GMP, she did not undertake the Bronze Commander duties as envisaged by JESIP. She did not liaise with the NWAS Operational Commander or take any steps around establishing an FCP.

10.231 CI Graham would have been a reasonable choice for appointment as Bronze Commander at an early stage. Her home was sufficiently close to the Victoria Exchange Complex for her to be able to get there within a reasonable period of time. The attempts to appoint her into that role only occurred after it became apparent that Superintendent Gordon’s journey was taking a long time and after she had self-deployed. At 00:30 on 23rd May 2017, Superintendent Gordon was still 40 minutes away from arrival at the Victoria Exchange Complex.

Greater Manchester Police

Officers in and around the City Room

10.232 As with BTP officers, GMP officers helping in the City Room continued their work, under the supervision of Inspector Smith.
10.233 The City Room continued to be secured by firearms officers. Other firearms officers continued their work of ensuring that all of the Arena was clear of threats.

10.234 At around 00:11 on 23rd May 2017, a GMP explosives detection dog arrived. Again, this response time is something that should be improved if possible.

Commanders at GMP Headquarters

10.235 ACC Ford, the GMP Strategic/Gold Commander, made a conscious decision to replace Temporary Superintendent Nawaz of the Tactical/Silver Commander role. She did not regard him as competent to act as Tactical/Silver Commander in an Operation Plato situation.

10.236 At 00:00 on 23rd May 2017, Temporary Superintendent Christopher Hill arrived at GMP HQ. He relieved Temporary Superintendent Nawaz of the role of Tactical/Silver Commander. Temporary Superintendent Hill did not immediately enquire whether a Major Incident had been declared. Approximately one hour after he took over as Tactical/Silver Commander, when he did become aware that there had been no declaration of a Major Incident by GMP, Temporary Superintendent Hill made that declaration.
10.237 At 00:18, Superintendent Thompson relieved Inspector Sexton of firearms command. Superintendent Thompson took up the role of Tactical Firearms Commander. This meant that Inspector Sexton had acted as Initial Tactical Firearms Commander for approaching two hours. This was too long for anyone in that role.

10.238 By 00:30, a decision had been taken to hold a Strategic Co-ordinating Group meeting. As Strategic/Gold Commander for the lead agency, this was ACC Ford’s responsibility to organise. The Strategic Co-ordinating Group meeting did not take place for nearly another four hours. It took place too late to have any impact on the immediate emergency response.

North West Ambulance Service

Operational Commander in the Casualty Clearing Station

10.239 At 23:57, Daniel Smith was relieved of the role of Operational Commander by Stephen Hynes. Stephen Hynes was a senior member of staff within NWAS. Contrary to policy, he self-deployed and, without reference to the Tactical Commander, took over from Daniel Smith.

10.240 By the time Stephen Hynes took over, the City Room evacuation effort was over. That is not to say that Stephen Hynes did not have a
challenging role to perform. He did. In the course of doing so, he was able to address some of the earlier JESIP failings.

10.241 As Operational Commander, it was Stephen Hynes’ responsibility to organise the transportation of casualties to hospital. At the point he took over, only one casualty in the Casualty Clearing Station had left for hospital.

10.242 By 00:01 on 23rd May 2017, two casualties had left the Casualty Clearing Station for hospital. There were still 36 casualties in the Casualty Clearing Station. By the end of the second hour, nine casualties from the Casualty Clearing Station had left in ambulances for hospital. There were still 29 seriously injured casualties to move. Of those 29, 11 were assessed to be the highest priority of casualty. It was not until 02:50 on 23rd May 2017 that the final casualty left the Casualty Clearing Station for hospital.

10.243 To those who experienced it, this period of time will have seemed interminable. It must not happen again.

Tactical Commander at GMP Headquarters

10.244 Annemarie Rooney was not told of the Operation Plato declaration until approximately 00:15 on 23rd May 2017. When she was told, she did not ask about Operation Plato zones. She did not
pass on the fact that Operation Plato had been declared to anyone at the Victoria Exchange Complex until after 00:30.

10.245 By the time Annemarie Rooney passed this on, a misunderstanding connected to Operation Plato had occurred involving Stephen Hynes.

**Strategic Commander**

10.246 At approximately 23:40, Neil Barnes, the NWAS Strategic Commander, was told that there was a Strategic Co-ordinating Group meeting at GMP HQ. Until that point, he had remained at home and had not spoken to the Strategic/Gold Commanders of any other emergency service.

10.247 Shortly after he was notified about the Strategic Co-ordinating Group, he set off from home. It should have been apparent to him from what he had learned of the incident at a much earlier stage that such a meeting was inevitable. He should have set off earlier than he did. Had he done so, he would have been able to speak to the GMP Strategic/Gold Commander, ACC Ford, in person sooner than he did.

10.248 The NWAS Strategic Commander made no significant or meaningful contribution to the emergency response.
Greater Manchester Fire and Rescue Service

10.249 By 23:40, Station Manager Berry had reached Philips Park Fire Station. Also present was Group Manager Ben Levy. At approximately 23:45, Group Manager Levy declared himself to be the Incident Commander. This was the right thing for him to do. This was an attempt to grip the GMFRS response. It did not have the effect that Group Manager Levy was intending.

10.250 Following Group Manager Levy’s self-appointment, Station Manager Berry got through to GMP on the FDO telephone line. He did not speak to the FDO. The person he spoke to had been asked by Inspector Sexton to answer the FDO telephone line. Through no fault of his own, that person was not competent to answer the FDO telephone line during the emergency response to a terrorist attack.

10.251 Station Manager Berry asked for the location of an FCP. During an unsatisfactory conversation, Station Manager Berry was initially told: “I think they’ve been liaising at the Cathedral.” This was a reference to the RVP, which Inspector Smith gave at 22:37, but which he superseded at 22:40. Station Manager Berry was then given a location of “the old Boddingtons car park.” Dissatisfied

32 INQ018835T/13
33 INQ018835T/15
with the information he was being given, Station Manager Berry rejected that location and said that GMFRS was going to go to Manchester Central Fire Station.

10.252 Following this call, Group Manager Levy called Chief Fire Officer Peter O’Reilly. Group Manager Levy wanted to go forward to the Victoria Exchange Complex. Chief Fire Officer O’Reilly did not realise that Group Manager Levy had appointed himself the Incident Commander. A misunderstanding between them resulted in Group Manager Levy believing that he had been told that he must not go further than Manchester Central Fire Station. GMFRS resources at Philips Park Fire Station moved forward to Manchester Central Fire Station.

10.253 At 00:12 on 23rd May 2017, Chief Fire Officer O’Reilly spoke to the NWAS Operational Commander, Stephen Hynes, whom he knew. Stephen Hynes, who did not know about the Operation Plato declaration, told Chief Fire Officer O’Reilly that the GMFRS Operation Plato specialist resources were not required. Stephen Hynes requested 12 non-specialist firefighters and a commander.

10.254 Following a debate in the GMFRS Command Support Room, Chief Fire Officer O’Reilly directed that the resources requested by Stephen
Hynes should go forward. In the course of that mobilisation, a GMFRS officer learned of the Operation Plato declaration by GMP. He did not ask about the zoning, but did pass on the fact of the declaration. This did not lead to the deployment of the Operation Plato specialist resources. It should have caused Chief Fire Officer O’Reilly to send forward the specialist firefighters.

10.255 At the end of the second hour, GMFRS resources were still seven minutes away from arriving at the scene.

Conclusion

10.256 This overview of the emergency response cannot cover in detail what happened. It is instead focused on the standards required by JESIP and the Joint Doctrine to achieve an effective multi-agency response, and where they were not met on 22\textsuperscript{nd} May 2017.

10.257 There are a number of themes in the problems that arose in the emergency response. These are set out below and will be explored in the more detailed analysis of the emergency response that follows in Parts 13, 14 and 15.

10.258 First, there was the lack of communication between emergency responders, both through
the act of physically co-locating at a single multi-agency RVP and via radio.

10.259 Second, there was the failure to have available either a multi-agency control room talk group or to set one up on the night. This would have allowed control rooms to speak to each other directly.

10.260 Third, there was the failure by the FDO to inform other emergency services of his declaration of Operation Plato or to keep it under review.

10.261 Fourth, there was the failure by the FDO and others in GMP to consider zoning the scene, following the declaration of Operation Plato, in the early stages of the response.

10.262 Fifth, there was the failure to set up an FCP. This was principally the responsibility of GMP.

10.263 Sixth, there were delays by NWAS in getting ambulances and paramedics to the scene.

10.264 Seventh, there was the failure to send all HART operatives into the City Room to assist with triage and life-saving intervention of casualties.

10.265 Eighth, there was the failure to send non-specialist paramedics into the City Room to assist with triage.

10.266 Ninth, there was the failure to get stretchers to the City Room to help evacuate the injured.
10.267  Tenth, there was the failure by GMFRS to arrive on scene and make the contribution in removing the injured that its officers could have done.

10.268  Eleventh, there was the failure of NWFC to give important information to officers in GMFRS.

10.269  Twelfth, there was the failure of anyone in a senior position in GMFRS to take a grip of the situation during the critical period of the response.
Part 11
Framework for emergency preparedness and response

Introduction

11.1 In this Part, I will set out the framework within which the emergency services were required to prepare for and respond to a terrorist attack, as at the time of the Attack. That was largely governed by the civil contingencies regime, the Joint Emergency Services Interoperability Principles (JESIP) Joint Doctrine¹ and the JESIP-badged document Responding to a Marauding Terrorist Firearms Attack and Terrorist Siege: Joint Operating Principles for the Emergency Services.²

11.2 I will also identify the relevant parts of The Purple Guide to Health, Safety and Welfare at Music and Other Events (the Purple Guide).³ This document provided important guidance to those hosting events in relation to healthcare service provision.

¹ INQ004542
² INQ008372/1
³ INQ041126
11.3 My review of the above documents is not intended to be exhaustive. It is confined to aspects relevant to the issues investigated during the Inquiry.

11.4 In Part 3 in Volume 1, I considered the licensing regime. The licensing regime is relevant to issues in Volume 2 of my Report. This is because the SMG premises licence for the Arena had provisions in it relating to first aid. I shall address these in Part 16.
The civil contingencies regime

**Key findings**

- British Transport Police, Greater Manchester Police, North West Ambulance Service and Greater Manchester Fire and Rescue Service (GMFRS) had a duty to maintain plans for a response to an emergency within Greater Manchester.

- They were obliged to consider collaborating with emergency responders when planning for an emergency and to make provision for training and exercising when planning for an emergency.

- They were obliged to co-operate in their local resilience forum and attend resilience forum meetings every six months.

- North West Fire Control was under a contractual obligation to assist GMFRS in fulfilling its obligations.

**Civil Contingencies Act 2004**

11.5 Central to the civil contingencies regime at the time of the Attack was the Civil Contingencies Act 2004 (the 2004 Act). Underpinning and complementing it were the Civil Contingencies...
11.6 Section 2(1) and Schedule 1 of the 2004 Act described a number of organisations as “Category 1 responders”.

Category 1 responders include all blue light emergency services. British Transport Police (BTP), Greater Manchester Police (GMP), North West Ambulance Service (NWAS) and Greater Manchester Fire and Rescue Service (GMFRS) were all Category 1 responders.

11.7 Section 2(1)(d) of the 2004 Act placed a legal requirement on Category 1 responders to maintain emergency plans (the emergency plans duty). The purpose of these plans included ensuring, so far as is reasonably practicable, that a Category 1 responder can perform its function to respond to, reduce, control or mitigate the effect of an emergency, if it occurs.

11.8 Under its Agreement for Services with GMFRS, North West Fire Control (NWFC) undertook to make suitable arrangements to support GMFRS in fulfilling GMFRS’s responsibilities in relation to Major Incidents and civil contingency events.
The 2005 Regulations

11.9 Regulation 4 of the 2005 Regulations required Category 1 responders in England and Wales to co-operate as part of a “local resilience forum” within their area of operation. Local resilience forums were required to meet at least once every six months. Category 1 responders had, so far as was reasonably practicable, to attend these meetings or be effectively represented at them.

11.10 Regulation 8 of the 2005 Regulations provided Category 1 responders with the option of performing the emergency plans duty jointly with another responder.

11.11 Regulation 22 of the 2005 Regulations required Category 1 responders to consider whether it would be appropriate to perform the emergency plans duty by collaborating with other Category 1 responders to maintain a multi-agency plan.

11.12 Regulation 25 of the 2005 Regulations required plans prepared under the emergency plans duty to provide for the carrying out of training and exercising. In relation to both, this is for the purpose of ensuring that the plan is effective.

8 Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, Regulation 4(4)(b)
The Joint Doctrine

Key findings

- The Joint Emergency Services Interoperability Principles (JESIP) were established in 2015 following a number of reports that consistently found failures by the emergency services to work together in response to a Major Incident.

- *The Joint Doctrine: The Interoperability Framework* (the Joint Doctrine) set out guidance essential for joint working by the emergency services.

- The version of the Joint Doctrine in force at the time of the Attack was published ten months before 22nd May 2017. There was sufficient time for it to be fully embedded.

- The Joint Doctrine set out five principles for joint working: co-location; communication; co-ordination; joint understanding of risk; and shared situational awareness.

- The most important of these is co-ordination. The other four principles should support a co-ordinated response.

- A Major Incident declaration should occur as early as possible, as it sets in train important structures, which take time to be put in place.
• A METHANE message should be issued as early as possible from the scene. It should be shared promptly with the other emergency services.

• A dialogue between the emergency services’ control rooms should be established as soon as possible.

• Frequent discussions between control rooms should include: covering what information each emergency service holds; what hazards and risks are known by each agency; and what assets have been deployed by each agency.

• Commanders at the scene should co-locate at a Forward Command Post as early as possible.

Introduction

11.13 On 6th May 2011, Lady Justice Hallett issued her Prevention of Future Deaths report following the inquests into the terrorist attacks in London on 7th July 2005 (the 7/7 attack).\(^9\) The report sets out what went wrong with the emergency response to that atrocity. This included: a lack of adequate information-sharing between the emergency services; failures in communication; basic misunderstanding between the emergency services as to their respective roles and

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operations; and difficulties resulting from the lack of a common Rendezvous Point.

11.14 Those who have followed the Inquiry will immediately recognise that, on the night of 22nd May 2017, almost exactly six years after this Prevention of Future Deaths report and nearly 12 years after the 7/7 attack, these same things went wrong again.

11.15 In 2012, after Lady Justice Hallett’s report, steps were taken to create the Joint Emergency Services Interoperability Programme. The main driver for this was the recommendation from the *Blue Light Interoperability Programme Report* in April that same year.\(^{10}\) This report recommended the formation of a joint programme to improve multi-agency working between the emergency services.\(^{11}\)

11.16 In October 2013, as part of the Joint Emergency Services Interoperability Programme, the *Joint Doctrine: The Interoperability Framework* was published.\(^{12}\) This set out what was expected of the emergency services as they worked together to respond to emergencies.

11.17 Also published in October 2013 was a review by the Cabinet Office’s Emergency Planning College

\(^{10}\) INQ024271/47  
\(^{11}\) INQ024271/47 at paragraph 4.1.2  
\(^{12}\) INQ018900
of 32 joint emergency responses between 1986 and 2010. This identified the following common causes of failure: inadequate training; ineffective communication; no system to ensure that lessons were learned and staff taught those lessons; and previous lessons/reports not being acted upon.\textsuperscript{13}

11.18 Again, the evidence heard in this Inquiry shows that those same issues recurred on the night of 22nd May 2017.

11.19 In 2015, the programme was relaunched as the Joint Emergency Services Interoperability Principles (JESIP).\textsuperscript{14} Governance was provided by an Interoperability Board with members of the emergency services and local and national governmental organisations. There was ministerial oversight of the Interoperability Board.

11.20 A year later, in July 2016, a second edition of the Joint Doctrine: The Interoperability Framework (the Joint Doctrine) was issued. It built upon the principles of the first.\textsuperscript{15} The second edition was the applicable version in the months leading up to and at the time of the Attack. When I refer to the ‘Joint Doctrine’, I am referring to the content of the second edition.

\textsuperscript{13} INQ016167/1-8
\textsuperscript{14} INQ024271/48
\textsuperscript{15} INQ004542
11.21 The review that led to the second edition concluded that it was essential for the emergency services to view JESIP training as a continual requirement.\textsuperscript{16}

11.22 The Foreword of the Joint Doctrine stated:

“This guidance remains essential to the effective interoperability of emergency services and other responder agencies and will be subject to future changes and improvements as it is tested and incorporated into business as usual. We need to make sure that the ethos of ‘working together’ becomes embedded, not only within our own organisations at every level, but within that of the other responder agencies.”\textsuperscript{17}

11.23 The Foreword went on to state that the Joint Doctrine “should be embedded in individual organisation policies and procedures and in their training and exercise programmes, for all levels of response staff”.\textsuperscript{18}

11.24 The evidence heard in the Inquiry has confirmed the importance of almost all of what is said in the Joint Doctrine. I have set out below the parts relevant to the Attack, although not necessarily in the order in which they appear in the document.

\textsuperscript{16} INQ024271/50
\textsuperscript{17} INQ004542/2
\textsuperscript{18} INQ004542/2
Principles for joint working

11.25 The five principles for joint working were introduced in this way:

“The need for a joint response is not new. The findings and lessons identified by public inquiries and inquests have highlighted cases where the emergency services could have worked better together and shown much greater levels of communication, co-operation and co-ordination.”

11.26 In light of this introduction, it is disappointing that so much went wrong with joint working on 22nd May 2017. That does not mean that there were not any good examples of joint working on the ground. But at a command level, things went badly wrong. This Inquiry comes at the end of a line of inquiries and inquests which have identified similar problems. Those inquiries and inquests made recommendations, which it was hoped would bring about change. It is clear that in Greater Manchester those recommendations did not result in JESIP being sufficiently well embedded before the Attack. If unnecessary loss of life is to be avoided in the future, it is important that a change in knowledge, culture and attitude takes place.
11.27 The principles for joint working, as presented in the Joint Doctrine, are shown in Figure 22.

**Co-locate**
Co-locate with commanders as soon as practicably possible at a single, safe and easily identified location near to the scene.

**Communicate**
Communicate clearly using plain English.

**Co-ordinate**
Co-ordinate by agreeing the lead service. Identify priorities, resources and capabilities for an effective response, including the timing of further meetings.

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

**Shared situational awareness**
Shared Situational Awareness established by using METHANE and the Joint Decision Model.

Figure 22: The principles for joint working in the Joint Doctrine

11.28 The Joint Doctrine stated: “They [the principles for joint working] will often, but not always, be followed in the order in which they are presented.” This suggests that co-location will
often be the first act guided by JESIP. I do not consider this statement to be necessarily helpful.

11.29 In many cases, communication between control rooms ought to be possible before responders are able to come together at a scene. This ought to be a priority action for every control room at an early stage.

11.30 Later in the Joint Doctrine, this very point was acknowledged: “A dialogue between control room supervisors should be established as soon as possible”\(^{22}\) and “Control room supervisors should engage in multi-agency communications and carry out the initial actions required to management [sic] the incident.”\(^{23}\) I agree with both of these statements.

11.31 Adequate communication between control rooms focused on achieving a co-ordinated response was a major failing on the night of the Attack. I am concerned that there was insufficient emphasis on the importance of immediate and ongoing contact between control rooms. This is a subject I will look at in more detail in Part 12.

\(^{22}\) INQ004542/10
\(^{23}\) INQ004542/12
Principle 1: Co-location

11.32 The Joint Doctrine stated:

“When commanders are co-located, they can perform the functions of command, control and co-ordination face-to-face. They should meet as early as possible, at a jointly agreed location at the scene that is known as the Forward Command Post (FCP). This allows them to establish jointly agreed objectives and a co-ordinated plan, resulting in more effective incident resolution. The benefits of co-location apply equally at all levels of command.”

11.33 It went on:

“Co-locating commanders and face-to-face exchanges will always be the preferred option …

…

The lead responder will suggest a location for commanders to co-locate in the early stages of a multi-agency incident when operational commanders may be travelling to the scene.”

11.34 The Joint Doctrine stated: “If there is any delay in commanders co-locating, interoperable
communications should be used to begin establishing shared situational awareness.” This statement could be better phrased. It is possible to read it as suggesting that only if there is a delay should the control rooms be used to establish shared situational awareness.

11.35 Control rooms should begin sharing information at the earliest possible stage, in parallel with commanders seeking to co-locate. Shared situational awareness is a dynamic process. An ongoing dialogue from the very start is required between control rooms. There should not be a delay to see if commanders can co-locate in a timely way. Other parts of the Joint Doctrine recognised this.

11.36 On the night of the Attack, BTP Control received accurate information from its officers at the Victoria Exchange Complex within seconds of the explosion. During the first ten minutes, the only emergency service with personnel in the City Room was BTP. BTP should have been sharing that situational awareness with the other agencies as a priority. The most straightforward way for this to occur was via a multi-agency
control room radio channel. This did not occur on the night of 22nd May 2017.\textsuperscript{31} In Parts 12 and 13, I shall provide more detail in relation to this.

Principle 2: Communication

11.37 The Joint Doctrine stated:

“\textit{Meaningful and effective communication between responders and responder agencies underpins effective joint working.}”\textsuperscript{32}

11.38 It also stated:

“\textit{Using terminology that either means different things to different people, or is simply not understood across different services is a potential barrier to interoperability.}”\textsuperscript{33}

11.39 On the night of the Attack, GMP’s Force Duty Officer (FDO) declared Operation Plato. This declaration was not communicated outside GMP during the critical period of the response, by which I mean the period from the explosion at 22:31 to the removal of the final living casualty from the City Room at 23:39.\textsuperscript{34} However, had it been communicated to GMP’s unarmed officers at the scene, including the Operational/Bronze Commander, it would have meant nothing to them as they had not been trained in what the

\begin{itemize}
\item \textsuperscript{31} 122/155/21-158/10, INQ017957/1-4
\item \textsuperscript{32} INQ004542/6
\item \textsuperscript{33} INQ004542/7
\item \textsuperscript{34} 98/119/13-120/4
\end{itemize}
declaration of Operation Plato meant, and what actions were required as a result.

11.40 There was also the potential for confusion in terms of the language used around zones. Operation Plato uses the terms hot, warm and cold to describe zones. Some NWAS personnel referred to a system used at Major Incidents that were not Marauding Terrorist Firearms Attacks, which also used the terms hot, warm and cold zones. Although the terms are identical, they mean different things within the two systems. The use of the same terms to mean different things is a practice that must stop, if it has not already. It gives rise to the possibility of misunderstanding.

Principle 3: Co-ordination

11.41 The Joint Doctrine stated:

“Co-ordination involves commanders discussing resources and the activities of each responder agency, agreeing priorities and making joint decisions throughout the incident. Co-ordination underpins joint working by avoiding potential conflicts, preventing duplication of effort and minimising risk … For effective co-ordination, one agency generally needs to take a lead role.”

35 102/10/23-13/6
36 76/162/2-166/10, 76/188/19-190/17, 77/127/8-17, 79/13/20-16/17, 81/107/16-108/8, 112/153/10-154/2, 113/133/15-141/10
37 INQ004542/7
11.42 Given that the responders on 22nd May 2017 were responding to a terrorist attack, it was widely recognised that GMP should take the lead role. This made the ability for other agencies to make contact with the FDO extremely important. It also placed a very substantial burden on the FDO.

11.43 GMP was the lead agency. GMP had two Operational/Bronze Commanders in the City Room from a very early stage: Inspector Michael Smith and Police Constable (PC) Edward Richardson. Inspector Smith was responsible for the unarmed officers and PC Richardson for the firearms officers. The fact that GMP was the lead agency meant that contact by other Operational/Bronze Commanders with the GMP Commanders at the scene was essential. BTP did not have a Bronze Commander at the scene during the critical period of the response. Neither did GMFRS. The NWAS Operational Commander was at the Victoria Exchange Complex from 23:00, but he did not try to contact the GMP Operational/Bronze Commander or Operational Firearms Commander, either directly or indirectly.
11.44 I regard co-ordination to be the most important of the principles for joint working. A fully co-ordinated response is likely to produce the best outcome. The other four principles are very important, but they are the means by which co-ordination is achieved.

Principle 4: Joint understanding of risk

11.45 The Joint Doctrine stated:

“Different responder agencies may see, understand or treat risks differently. Each agency should carry out their own ‘dynamic risk assessments’ but then share the results so that they can plan control measures and contingencies together more effectively.”41

11.46 Later, it stated:

“Commanders jointly assess risk to achieve a common understanding of threats and hazards, and the likelihood of them being realised. This informs decisions on deployments and the required risk control measures.”42

11.47 The different approaches to risk were starkly apparent on the night of 22nd May 2017 and were reflected by the locations in which each emergency service was prepared to operate.

41 INQ004542/7
42 INQ004542/17
11.48 BTP and GMP went directly to the City Room and many officers from both police services remained in the immediate vicinity of the explosion for substantial periods of time. Any risk assessment consciously performed by those officers was not until after they were in the City Room. Inspector Smith reached the conclusion that the City Room was “safe enough” after he had entered. 43

11.49 The three NWAS paramedics, including those from the Hazardous Area Response Team (HART), who went into the City Room during the critical period of the response did so voluntarily, as opposed to being deployed into that area. The remainder were deployed on the station concourse and Station Approach.

11.50 GMFRS did not consider the vicinity of the Victoria Exchange Complex to be sufficiently safe until long after the critical period of the response had ended. 44

11.51 The police, NWAS and GMFRS each made their own risk assessments separately. They each reached different conclusions. This was unsurprising because they each had different levels of situational awareness. Had a joint assessment of risk occurred, it is likely that there would have been much closer alignment between

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43 103/1/6-19
44 185/61/7-65/15

174
the responders as to which areas were safe enough to work in.

**Principle 5: Shared situational awareness**

11.52 The Joint Doctrine stated:

> “Shared situational awareness’ is a common understanding of the circumstances, immediate consequences and implications of the emergency, along with an appreciation of the available capabilities and the priorities of the emergency services and responder agencies.”

11.53 It is a striking fact that, on the night of the Attack, those at the scene did not regard it as significant that GMFRS was not present. The only realistic reason for this is that there was insufficient realisation on the part of GMP, BTP and NWAS of the important contribution that GMFRS could have made on the night. GMFRS’s specialist capabilities included its Specialist Response Team, which was trained and equipped to work alongside HART in an Operation Plato warm zone. In addition, all firefighters were trained in rescue and first aid. The addition of the rescue capability of GMFRS would have resulted in the safer and faster extraction of the severely injured
from the City Room to a location where they could receive clinical care.

Early stages of a multi-agency response or Major Incident

11.54 The Joint Doctrine devoted a section to the early stages of a multi-agency response to a Major Incident:

“Applying simple principles for joint working are [sic] particularly important in the early stages of an incident, when clear, robust decisions and actions need to be taken with minimum delay, in an often rapidly changing environment.

…

In the early stages of an incident, employees of one service may arrive before employees of another and, as a result they may carry out tasks that are not normally their responsibility. If this happens, command and control arrangements for the relevant service should start as soon as the right personnel are in place in sufficient numbers.”

11.55 The Joint Doctrine continued:

“Recognising that an incident will involve working with other emergency services and/or
other responder agencies is very important. The earlier other responder agencies are notified of the incident, the sooner joint working arrangements can be agreed and put into place.

…

In order to help all agencies gather initial information about an incident in a consistent manner, a common approach is recommended. The ‘METHANE’ model brings structure and clarity to the initial stages of managing any multi-agency or major incident.

A major incident is defined as:

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

11.56 The Major Incident declaration is no mere formality. An early declaration ensures that structures that may take time to set up are initiated as soon as possible.
METHANE

11.57 Before JESIP was introduced, the emergency services operated a mnemonic which was used to capture key information from the scene. METHANE replaced that mnemonic. The Joint Doctrine provided as follows:

“The METHANE model is an established reporting framework which provides a common structure for responders and their control rooms to share major incident information. It is recommended that M/ETHANE be used for all incidents.

…

Each responder agency should send a M/ETHANE message to their control room as soon as possible. The first resources to arrive on scene should send the M/ETHANE message so that situational awareness can be established quickly. The information received through multiple M/ETHANE messages will gradually build to support shared situational awareness in those responding to the incident and between control rooms.”

48 INQ004542/9
### Figure 23: METHANE mnemonic from the Joint Doctrine⁴⁹

11.58 The Joint Doctrine went on:

“It is important that all individuals who could be first on scene for their respective responder agency are able to declare a major incident, and that they understand the implications of declaring one. They must also be able [to] convey incident information using

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⁴⁹ INQ004542/9
the M/ETHANE model. Declaring a major incident begins the process of activating relevant plans.”

11.59 BTP and NWAS personnel provided METHANE messages to their respective control rooms. In BTP’s case it took longer than it should have, despite Force Incident Manager Inspector Benjamin Dawson’s best efforts. I will set out Inspector Dawson’s role in Part 13. Neither BTP nor NWAS shared their METHANE messages with other responder agencies. At no point did anyone from GMP ask for or provide a METHANE message, whether from its own responders or any other agency.

11.60 During the critical period of the response, GMFRS was not at a location from which a useful METHANE message could have been passed. At no point did NWFC ask any other agency if they had a METHANE message to pass on.

11.61 BTP declared a Major Incident. This declaration was shared with NWAS. Separately, NWAS declared a Major Incident. Neither BTP nor NWAS informed GMP, NWFC or GMFRS that they had declared a Major Incident. GMP, NWFC and GMFRS did not declare a Major Incident during the critical period of the response. They
did not enquire of any other responder agency if that agency had declared a Major Incident.

Control rooms

11.62 The Joint Doctrine stated:

“Control rooms play a vital role in managing the early stages of a multi-agency incident. There cannot be a co-ordinated multi-agency response or effective communication if control rooms do not deliver a swift and joint approach to handling them.

…

Control rooms generally operate from separate fixed locations and therefore cannot feasibly co-locate. They can, however, help in co-locating responders and commanders by jointly agreeing the initial multi-agency rendezvous points.

…

A multi-agency discussion between control room supervisors in the affected control rooms at the earliest opportunity starts the process of sharing information about the incident.”

52 INQ004542/10
11.63 It went on:

“Discussions between control rooms should be frequent and cover the following key points:

• Is it clear who the lead agency is …? If so, who?

• What information and intelligence does each agency hold …?

• What hazards and risks are known by each agency …?

• What assets have been – or are being – deployed …?

…

• At what point will multi-agency interoperable voice communications be required, and how will it be achieved?”

11.64 On 22nd May 2017, the question of what assets had been or were being deployed was an important one for NWFC to ask of the other emergency services. At no point was there a concerted and organised effort by NWFC staff to find this out. Once Station Manager Andrew Berry decided not to mobilise GMFRS resources to the scene, it was a question that needed to be robustly pursued. Had it been, GMFRS would
have realised much earlier than it did that all other responders regarded the scene as being sufficiently safe to deploy to. I will set out Station Manager Berry’s role on the night of the Attack in Part 15.

11.65 The Joint Doctrine continued:

“Control room supervisors should be ready to set up multi-agency interoperable voice communications for commanders if and when required …

… when each service has allocated a commander to the incident, the value of making interoperable voice communications available should be considered.”

11.66 There was a failure to establish effective multi-agency voice communications on the night of the Attack. This is a topic to which I will return in Part 12.

Commanders

11.67 The Joint Doctrine stated:

“Operational commanders will be working with colleagues from other responder agencies. This will most likely be at, or close to, the scene of the incident.”
Communication and co-ordination between commanders is critical. Tactical commanders should be located at a mutually agreed location where they can maintain effective joint command of the operation ... The fire and rescue service tactical commander will be located where they can maintain effective tactical command of the operation, invariably they will be in attendance at the scene ...

The tactical commander is likely to be in place before the strategic commander and is also likely to be the first senior officer taking command of the incident. In the early stages of an incident, the tactical commander is likely to set priorities before the strategic commander has set a strategy.

The strategic commander from each agency has overall authority on behalf of their agency. They are responsible for the resources of their own agency and for formulating their single agency strategy for the incident.”

55 INQ004542/27-28
11.68 On the night of the Attack, GMFRS did not have a commander of any kind at the scene for over two hours. The NWAS Operational Commander did not work with the GMP Operational/Bronze Commander. Although they were both in the City Room for much of the critical period of the response, the GMP Operational Firearms Commander and the GMP Operational/Bronze Commander did not speak to each other. BTP’s nominated Bronze Commander did not arrive until after 01:00 on 23rd May 2017.

11.69 The Joint Doctrine stated: “The joint decision model is designed to help commanders make effective decisions together.”56 I will deal with the Joint Decision Model next.

Joint Decision Model

11.70 The Joint Doctrine stated:

“One of the difficulties facing commanders from different responder agencies is how to bring together the available information, reconcile potentially differing priorities and then make effective decisions together.

The Joint Decision Model (JDM) … was developed to resolve this issue.”57
11.71 Figure 24 shows the Joint Decision Model process:

Figure 24: Joint Decision Model

11.72 The most important consideration, throughout the decision-making process, is "to save lives and reduce harm". Every stage of the decision-making process should have this as its focus.

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58 INQ004542/15
59 INQ004542/16
11.73 The Joint Doctrine states:

“When using the joint decision model, the first priority is to gather and assess information and intelligence. Responders should work together to build shared situational awareness, recognising that this requires continuous effort as the situation, and responders’ understanding, will change over time. Understanding the risks is vital in establishing shared situational awareness.”

11.74 When making his initial command decisions, the NWAS Operational Commander should have worked with GMP to gather and assess information and intelligence. This would have developed his situational awareness and improved his decision-making.

11.75 The Joint Decision Model was explained to me by the Fire and Rescue Expert, Matthew Hall. He assured me that, once a person has been trained in using it, it was an effective way of making decisions. I can readily accept that in theory it is a very good way of ensuring that all relevant considerations are taken into account. However, in practice, when under enormous pressure in an emergency, the Joint Decision

60 INQ004542/15-16
61 110/110/15-111/10
62 See Appendix 11 in Volume 2-II
Model will be much harder to follow. It needs to be part of the ‘muscle memory’ through training and exercises, so that it becomes instinctive.

11.76 It is clear to me that use of the Joint Decision Model is of greatest value when commanders come together and jointly make decisions, as it provides a framework for a short and focused discussion.

Joint organisational learning

11.77 The Joint Doctrine stated:

“The lessons identified from de-briefing activities are now at the forefront of many key changes in emergency services policy and practices.

Issues have frequently been identified but not successfully acted upon to improve effective joint working. It is essential that joint organisational learning is accepted as the standard for multi-agency learning and is adopted by all response agencies to ensure interoperability is continually improved.

…”

It is important to capture lessons while events are fresh in the minds of those involved.

…”
To continually improve emergency response interoperability, all responder agencies must capture lessons identified from incidents, exercises and training …

…

Following any incident, exercise or training, those involved should ensure appropriate de-briefs are scheduled and that all those involved in the response are represented.”

11.78 In Part 12, I will consider the key multi-agency exercises that took place in the period prior to the Attack. There were significant failures to make necessary changes identified by those exercises. In relation to one in particular, Exercise Winchester Accord, there remains a stark disagreement between GMP and other participants as to what areas for improvement ought to have been identified.
Key findings

- In January 2016, the third edition of Responding to a Marauding Terrorist Firearms Attack and Terrorist Siege: Joint Operating Principles for the Emergency Services (JOPs 3) was published.

- JOPs 3 provided a series of principles guiding the way in which the emergency services should respond to such a situation.

- The Foreword to JOPs 3 made it clear that it was guidance.

- JOPs 3 applied in the event a police service declared Operation Plato.

- JOPs 3 defined three Operation Plato zones: hot, warm and cold. The definitions needed to have been clearer than they were.

- JOPs 3 expected that the boundaries of these zones would be reviewed frequently.

- JOPs 3 envisaged that there may be circumstances in which non-specialist resources would be deployed into an Operation Plato warm zone. The way in which this was expressed in JOPs 3 could have been clearer.
Introduction

11.79 In January 2016, the third edition of *Responding to a Marauding Terrorist Firearms Attack and Terrorist Siege: Joint Operating Principles for the Emergency Services* (JOPs 3) was published.\(^{64}\) It is a JESIP-badged publication.

11.80 It is important to remember that JOPs 3 becomes applicable on the declaration of Operation Plato. Only the police are able to formally identify that a Marauding Terrorist Firearms Attack is under way and declare Operation Plato. As a result, any failure to follow JOPs 3 is the responsibility of those GMP officers who knew that the Operation Plato declaration was in place, and of GMP for failing to share such a declaration.

11.81 There were occasions during the Inquiry oral evidence hearings when people who were unaware of the declaration of Operation Plato sought to justify their decisions by reference to JOPs 3. It is unlikely that consideration of JOPs 3 played any part in their decision-making on 22nd May 2017. As a result, analysing decision-making by reference to something that was not under consideration at the time was not of assistance to me.

11.82 On 22nd May 2017, GMP declared Operation Plato at 22:47. GMP was the lead agency. To the
extent JOPs 3 prescribed a different approach to that under the Joint Doctrine, it was GMP’s responsibility to follow JOPs 3 and lead others, unless there was a clear and good reason not to.

Foreword

11.83 The Foreword stated:

“Welcome to the third edition of Responding to a Marauding Terrorist Firearms Attack and Terrorist Siege: Joint Operating Principles for the Emergency Services. This guidance has been revised to reflect recent live exercising and operational learning that has taken place and influenced the response. It has also been revised to incorporate the national standard for multi-agency interoperability as described in the Joint Doctrine: The Interoperability Framework.

… This guidance should be used to inform existing major incident procedures and must be used in conjunction with local and national Standard Operating Procedures. …

… It is essential that specialist responders and commanders are competent in the implementation of these Joint Operating Principles, are familiar with their use and are trained appropriately. Organisations are responsible for ensuring systems are in place for training, monitoring and assessment of staff.”

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65 INQ008372/2
11.84 The reference to the Joint Doctrine is to the first edition, although the impending publication of the second edition is acknowledged.

Glossary

11.85 The Glossary contained the following definitions:

<table>
<thead>
<tr>
<th>Zone</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cold Zone</td>
<td>Area where it has been assessed that there is no immediate threat to life.</td>
</tr>
<tr>
<td>Warm Zone</td>
<td>Where the attackers are believed to have passed through but could enter/re-enter imminently. These areas cannot be guaranteed as safe.</td>
</tr>
<tr>
<td>Hot Zone</td>
<td>Where the attackers are present and/or there is an immediate threat to life.</td>
</tr>
<tr>
<td>On-scene commander</td>
<td>An appropriate police, FRS [fire and rescue service] or ambulance commander at the scene who is responsible for undertaking an ongoing joint assessment of risk and for decision-making on the deployment of their organisation’s assets at that location. On-scene commanders will therefore ensure the emergency services’ response is effectively co-ordinated at scene.</td>
</tr>
<tr>
<td>Tactical Firearms Commander (TFC)</td>
<td>Develops, commands and coordinates the overall tactical response in accordance with strategic objectives.</td>
</tr>
<tr>
<td>Strategic Firearms Commander (SFC)</td>
<td>Determines the strategic objectives and sets any tactical parameters. Retains strategic oversight and overall command responsibility.</td>
</tr>
</tbody>
</table>

Table 1: Selected definitions from Glossary in JOPs 3\(^66\)
11.86 The footnote to the on-scene commander entry stated:

“For FRS [fire and rescue service] and ambulance this is the equivalent of the operational commander role as defined in the Joint Doctrine … However given the specific nature of police command and control for firearms incidents the term on-scene commander has been retained for an MTFA [Marauding Terrorist Firearms Attack].”

11.87 In Part 13, I will consider the approach taken on the night of the Attack to the issues of the police on-scene commander and zoning, by reference to these definitions. For reasons I will set out in Part 13, I find that the JOPs 3 zones were concerned exclusively with the threat from a terrorist with a firearm. It is sufficient to say at this stage that, given the disputes that emerged during this Inquiry, the definitions provided by JOPs 3 needed to be clearer.

**Introduction**

11.88 The introduction to JOPs 3 stated:

“A terrorist attack involving the use of firearms in a way designed to inflict large numbers of casualties and fatalities would present significant challenges for the emergency
services. A marauding terrorist firearms attack (MTFA) may involve:

- Shooting
- The use of explosives [redacted text]
- [Redacted text]
- Other injuries
- [Redacted text][68]

11.89 The recognition that a Marauding Terrorist Firearms Attack may involve the use of explosives meant that the explosion caused by SA was capable of being interpreted as forming part of such an attack. This was the basis of the FDO Inspector Dale Sexton’s declaration of Operation Plato on the night of the Attack.

### Joint Operating Principles

11.90 The aim of JOPs 3 was explained as follows:

“These Joint Operating Principles (JOPs) provide further guidance on the key aspects of any rapid joint response that are critical to saving life and ensuring the protection of emergency service personnel. Use of the JOPs is intended to support the aim of working together, saving lives and reducing harm.”
The principles detailed in this document are not prescriptive but are intended to provide an overarching framework for a standardised approach across the UK.”69

11.91 It is important to note that principles within JOPs 3 were described as “guidance” and “not prescriptive”.70 This meant that operational discretion should play a part as well.71 What this means in practical terms is that those who know they are operating under JOPs 3 should apply the principles, departing from them where there is a clear and good justification for doing so. This was not the approach that all of those responding on the night of the Attack believed they had been taught.72

Identification, mobilisation and scene assessment

Paragraph 4.1

11.92 Paragraph 4.1 of JOPs 3 stated:

“This Personnel from any emergency service should not hesitate to report that an MTFA is underway. Information on a suspected MTFA should be shared amongst emergency service control rooms
immediately. The police are responsible for formally declaring that an MTFA is occurring and that the response, Operation Plato, will be used.

Operation PLATO is the multi-agency response to the incident, whilst MTFA describes the type of incident. Early identification of an MTFA and rapid implementation of an appropriate joint response will be crucial to protecting the lives of both members of the public and responders. If a declaration is made in error then it can be rescinded.”

11.93 On 22nd May 2017, Operation Plato was mentioned by firearms officers at 22:38 and 22:43. Operation Plato was formally declared by the FDO, Inspector Sexton, at 22:47. I consider this declaration to be justified based on the guidance and training at the time.

Paragraph 4.2

11.94 Paragraph 4.2 of JOPs 3 stated:

“The police will inform emergency service partners immediately once an MTFA has been declared to enable FRS and

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73 INQ008372/9
74 INQ018367T/2
75 INQ024445T/1
76 97/162/22-164/3
Ambulance services to put their contingency plans into effect.

As soon as the police have declared an MTFA, the ambulance and FRS control rooms should be notified immediately. It is imperative that this action is undertaken straight away so that MTFA contingency plans for those services can be initiated to enable a co-ordinated, multi-agency response. …

Any delay in notifying emergency service partners of the declaration could place lives at risk and hinder the implementation of an effective joint services response. Advice to police forces in developing contingency plans for responding to an attack of this type clearly identified early notification to other emergency services partners as a priority.”

11.95 Contrary to the requirement of paragraphs 4.1 and 4.2 in JOPs 3, none of the control rooms for the other emergency services were informed by GMP immediately.

Paragraph 4.3

11.96 Paragraph 4.3 of JOPs 3 stated:

“An attack of this kind will probably involve the use of firearms and potentially explosives or other types of weapons used by terrorists.”
A robust response will be required by the police in deploying armed officers to identify, locate and confront the threat. This deployment is likely to be initially authorised and commanded by the Initial Tactical Firearms Commander located in the relevant police force control room. Over time, this Initial Tactical Firearms Commander may be replaced by a dedicated Cadre Tactical Firearms Commander located as part of the Tactical Coordinating Group (TCG) in a control/operations room. A Strategic Firearms Commander will also be notified as soon as practicable.”78

11.97 In accordance with the above principle, Inspector Sexton undertook the role of Initial Tactical Firearms Commander. He was not relieved of this role for over an hour and a half. The on-call Cadre Tactical Firearms Commander did not relieve him. Another officer, who had not been on call or on duty, assumed the Tactical Firearms Commander role after midnight on 23rd May 2017.79

11.98 Assistant Chief Constable Deborah Ford was the on-call Strategic Firearms Commander and she
took up that role in response to the Attack 20 minutes after it had occurred. 80

Paragraph 4.4

11.99 Paragraph 4.4 of JOPs 3 stated:

“The Police will instigate a three-way telecommunication link between the emergency services’ control rooms.

... The provision of unbroken communication links between the emergency services’ control rooms should enable the timely passing of information and intelligence that will inform deployment decisions. It will also facilitate the effective management of a co-ordinated response in deploying key decision-making personnel (i.e. on-scene commanders at the scene of attacks).

... It should also be noted that in the initial response to an MTFA, the initial police on-scene commander may not be a TFC [Tactical Firearms Commander]. Where this is the case, they will work under the command of the TFC located at the control/operations room until a TFC arrives and assumes the role of

80 97/54/4-15
police on-scene commander. When a TFC does assume the role of the police on-scene commander, a review of the command protocol with the control/operations room based TFC should be undertaken.”

11.100 No three-way telecommunication link between control rooms was instigated on the night of the Attack by GMP or any other responder agency during the critical period of the response.

11.101 A Tactical Firearms Commander did not arrive at the Victoria Exchange Complex until shortly before the end of the golden hour, that is, the first hour of the emergency response. Prior to this point, the command structure for GMP was not clear. The Operational/Bronze Commander and Operational Firearms Commander acted independently of each other at the scene. The Operational Firesarms Commander was directly answerable to the Initial Tactical Firearms Commander, Inspector Sexton. From 22:50, the Operational/Bronze Commander was directly answerable to Temporary Superintendent Arif Nawaz, who relieved Inspector Sexton of the Tactical/Silver Commander role at that point. The Operational/Bronze Commander did not know of the Operation Plato declaration. He did not

81 INQ008372/10-11
82 53/108/17-24
83 102/28/21-29/1, 102/35/20-38/7
know he was supposed to be operating under JOPs 3.

**Paragraph 4.5**

11.102 Paragraph 4.5 of JOPs 3 stated:

“The police control room will, as a matter of priority, liaise with ambulance and FRS control room managers to jointly agree a rendezvous point (RVP) for the initial response.”

11.103 This requirement of paragraph 4.5 was not fulfilled on the night of the Attack. There was no jointly agreed Rendezvous Point (RVP). By the time Operation Plato was declared, each emergency service had decided for itself a rendezvous or muster point. Four minutes after the declaration of Operation Plato, GMP Control informed NWAS Control that they should send ambulances to Hunts Bank. This was not adopted immediately by NWAS for all of its personnel. I shall return to this in Part 14.

**Paragraph 4.8**

11.104 Paragraph 4.8 of JOPs 3 stated:

“The police on-scene commander, in consultation with FRS and ambulance...
counterparts is responsible for identifying a suitable FCP for specialist emergency service personnel.

For a MTFA response, FCPs are points where the multi-agency on-scene command team function and operate. Specialist emergency personnel will deploy into hot and warm zones from the FCP.”

11.105 No Forward Command Post (FCP) was established by the police or any other agency during the critical period of the response.

Paragraph 4.9

11.106 Paragraph 4.9 of JOPs 3 stated:

“Owing to the dynamic nature of the incident there may be insufficient time to establish an FCP.”

11.107 An FCP could and should have been established by GMP approximately 30 minutes after the explosion.

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87 INQ008372/13
88 147/6/7-14
89 INQ008372/13
90 147/7/3-13
Paragraph 4.10

11.108 Paragraph 4.10 of JOPs 3 stated:

“The police on-scene commander will lead a joint assessment of risk at the FCP (or RVP) with ambulance and FRS counterparts to determine when and where to deploy emergency service responders, taking into consideration all available information. Whilst this process will be led by police, each emergency service will be responsible for deploying its respective resources.

A joint assessment of risk will take place at the FCP (or RVP in the event that FCPs cannot be established).

A joint assessment of risk is necessary primarily to ensure that all attending emergency responders are aware of the nature of the threat and the risks that they may face on entering warm zones.”91

11.109 No joint assessment of risk took place at the scene during the critical period of the response. The only personnel on scene who knew of the potential existence of any Operation Plato zones

91 INQ008372/14
were the GMP firearms officers. In fact, as I will set in Part 13, inadequate thought was given to the Operation Plato zones on the night of the Attack.

Paragraph 4.11

11.110 Paragraph 4.11 of JOPs 3 stated:

“In conducting a joint assessment of risk the police, FRS and ambulance on-scene commanders will use the Joint Decision Model detailed in JESIP Joint Doctrine. This process will be led by the police but on-scene commanders from all three services will be informed by their own service’s agreed risk management processes.

The use of a single methodology for assessing the risk to emergency service personnel is considered the most efficient means for determining when, and under what circumstances, deployments into warm zones take place. The joint assessment of risk is intended to enable the on-scene commanders to work towards a common understanding of the threats, hazards and risks that may be present in warm zones.

…”
Whilst it will remain the responsibility of the respective on-scene commanders to determine when to deploy their organisation’s personnel, it is preferable that appropriate resources from across the three services are deployed in unison. This will maximise levels of operational effectiveness in warm zones to achieve collaborative aims.”

During the golden hour, none of the NWAS personnel or unarmed police officers at the scene knew that Operation Plato had been declared. However, the approach to risk assessment expected by JOPs 3 was the same as that expected by the Joint Doctrine. As I set out in paragraph 11.109 and will discuss further in Parts 13 and 14, no joint assessment of risk took place during the golden hour between the commanders at the scene.

Paragraph 4.12

Paragraph 4.12 of JOPs 3 stated:

“The boundaries of the hot, warm and cold zones must be frequently reviewed.

On-scene commanders from each service need to ensure that there is clear understanding in relation to the agreed boundaries of hot, warm and cold zones and
agreed LoE [Limits of Exploitation], and that these are effectively communicated to operational personnel being deployed forward from the FCP.

Continuous assessment and review of the zones and LoE should be a priority. The use of the JDM [Joint Decision Model] will influence the establishment of the zones where practicable and as soon as safe to do so, consideration should be made to re-zoning the warm zone into a cold zone in order to allow non-specialist responders to deploy, continue casualty management and save life.”

11.113 During the golden hour, there was a substantial failure by GMP to impose Operation Plato zones and review them. Having declared Operation Plato, GMP was under an obligation to identify which, if any, areas of the Victoria Exchange Complex were ‘hot’, which were ‘warm’ and which were ‘cold’. It was the imposition of these zones and the approach to the deployment of the emergency services within them that gave Operation Plato its unique character.

11.114 Despite this, zones were not identified by those GMP personnel who were aware of the Operation Plato declaration during the golden hour. No
an attempt was made to inform the unarmed GMP officers or emergency service partners of the zoning that had been applied. There was no review of the zones during the critical period of the response. It is notable that there was disagreement between the witnesses who gave evidence as to what the appropriate zoning was for the City Room during the course of the emergency response.95

Paragraph 4.16

11.115 Paragraph 4.16 of JOPs 3 stated:

“Emergency personnel who are not in possession of full ballistic protection (ballistic body armour and helmets) for the threat will not normally be deployed into warm zones.

A police commander however may consider that the prevailing circumstances require that unarmed officers with standard personal protective equipment (PPE) be deployed to support warm zone activity. Such deployments will be subject to a joint assessment of risk and in doing so commanders should take into consideration existing advice for responding to firearms incidents, such as the Stay Safe principles. Then only when, in the particular

95 106/30/21-31/4, 106/175/24-176/14, 107/10/4-13, 107/55/2-56/7, 110/42/6-23, 110/220/2-221/15
circumstances, it is assessed that it is reasonable to deploy officers with standard personal protective equipment should deployment take place.”

11.116 This is an important principle. It is important because the text in bold makes clear that there is no absolute prohibition under JOPs 3 on the deployment of emergency personnel without full ballistic protection into the warm zone. This conflicts with the evidence given by some witnesses who believed that such deployment was completely forbidden. This should not have happened.

11.117 There is a potential for confusion caused by the non-bold text within paragraph 4.16. The use of the word “however” in the first sentence is capable of being read as meaning that there was only one exception to who would “normally be deployed into warm zones” and that exception was the police. This was the way in which the GMP’s Ground Assigned Tactical Firearms Commander, the NWAS Operational Commander and the National Interagency Liaison Officer from GMFRS understood JOPs 3. It was not the intended meaning.
11.118 The intended meaning was that operational discretion existed for the deployment of personnel from any of the emergency services, as implied by the passage in bold. The non-bold passage was intended to provide some additional specific guidance to police commanders.\textsuperscript{100}

### The Purple Guide

**Key findings**

- The Purple Guide provided guidance to those providing healthcare services at events.

- The outline guidance for an event of the size of that which took place on 22nd May 2017 was: 1–2 doctors; 2–4 nurses; 2–4 paramedics; 11 first aiders; 1 ambulance crew.

- It advised that a comprehensive risk assessment was required to identify the number and skills of those providing healthcare services at events.

- It advised that a first aid at work certificate was insufficient qualification on its own for those acting as first aiders at events.

- It advised that during an event there should be clear lines of communication between those running the event and the local ambulance service.

\textsuperscript{100} 141/33/13-34/20
• It advised that, once a Major Incident is declared, it is important that the arriving ambulance staff know with whom to liaise from the event healthcare service.

Introduction

11.119 In 1993, the Health and Safety Executive (HSE) published *The Purple Guide to Health, Safety and Welfare at Music and Other Events*.\(^{101}\) It was substantially updated by the HSE in 1999.\(^{102}\) The HSE began work on a third edition, but this was never published.\(^{103}\) In 2013, the HSE stopped regulating first aid and ceased to be responsible for publishing the Purple Guide.\(^{104}\) Responsibility for it was handed over to the Events Industry Forum.

11.120 The edition in force in the period running up to and including the Attack was published in November 2015 by the Events Industry Forum.\(^{105}\) I shall refer to this edition as ‘the Purple Guide’.

11.121 I will rehearse without commentary the relevant parts of the Purple Guide. In Part 16, I shall consider SMG’s and Emergency Training UK’s
preparedness for and response to the Attack by reference to its content.

Status of the Purple Guide

11.122 The introduction to the Purple Guide stated:

“This guide aims to help those who organise music or similar events, so that the events can run safely. As an employer, the event organiser … has a general duty to ensure, so far as reasonably practicable, the health, safety and welfare of their employees. They also have a duty to ensure, so far as is reasonably practicable, that others – including volunteers and spectators – are not exposed to risks to their health and safety arising from the operation of the event.”

106 INQ042758/1

11.123 It went on:

“This guide goes beyond the compliance with the Health and Safety at Work Act and covers not only legislation and good practice for Health and Safety, but other legislation and good practice across the industry including the Licensing Act 2003, the Civil Contingencies Act 2004 the Regulatory Reform (Fire Safety) Order 2005 … The contents are not designed to be prescriptive but simply seek to highlight
legal criteria and non-legislative good practise.”

Chapter 4: Contingency & emergency planning

11.124 Chapter 4 began by identifying a number of “key points”. Among these were that being prepared for the initial response to an emergency may be the responsibility of the event safety management team. The importance of risk management and having plans in place was also identified, along with testing the plans “in the most practicable way”.

11.125 A list of hazards or threats that might result in an emergency were listed. This included “bomb threat”.

Chapter 5: Medical

11.126 Chapter 5 was titled “Medical”. As the introductory remarks made clear, the chapter was not confined to care provided by doctors, but also that provided by paramedics and first aiders. To avoid confusion, I shall use the term ‘healthcare services’. I intend this to include all care directed at a person’s health and wellbeing by
an appropriately qualified person or people. This will range from care which can only be competently provided by doctors through to the initial assessment and treatment of minor physical and mental health issues.

11.127 The chapter began:

“The aim of this chapter is to set out the responsibilities of an event organiser to ensure appropriate medical, ambulance and first aid provision is available to all those involved in music and similar events, whatever their type and size.”

Event pre-planning

11.128 The Purple Guide stated that it was important to undertake a healthcare services resource assessment in order to determine “the skill mix and how many personnel will be appropriate”. As part of that review, the organiser should have considered a number of factors, including the number of attendees, what might cause injuries and the likelihood of such risks eventuating.

11.129 It went on to state: “It is important to ensure that the spectrum of care is available, commensurate with the size of event. This may encompass the competencies of doctors, nurses, paramedics,
ambulance and first aid staff who bring different skill levels to the event.”

The Ambulance Service Experts, Christian Cooper and Michael Herriot, stated that the guidance expected a comprehensive risk assessment. They explained that this should identify the “right skills” required to anticipate the type of conditions that may be encountered.

11.130 Once the risk assessment was completed, the Purple Guide expected that a “medical plan” would be produced. This was to set out the details of the event and, among other things, the numbers and skill mix of the staff and the intended receiving hospital(s) for casualties. The expectation was that the receiving hospital(s) would have been pre-notified of the event.

11.131 The medical plan was to be communicated to the regional ambulance service, even if it was not involved. It should also be made available to the licensing authority.

11.132 There was an expectation that all details of cover being provided should be made in writing.
11.133 RVPs should be shared with staff within an event to “assist a smooth flow to any incident, whether major or not”. The Purple Guide advised that ambulance control rooms and Area Managers surrounding the event “should be aware of these areas prior to the event, as should the other emergency services, where appropriate”.

### During an event

11.134 The Purple Guide advised that the medical control should have clear lines of communication to the event organiser and the NHS ambulance service. A communications plan detailing the medical communications links should be produced and held at both the medical control point and incident control room, and shared with the NHS ambulance service for the area.

11.135 In the event of the NHS ambulance service being requested or the declaration of a Major Incident, the person with overall responsibility for healthcare provision would be the liaison point between the site medical provider and the NHS ambulance service.
Competence of personnel

11.136 The Purple Guide identified a number of categories of person who might provide healthcare: first aiders, doctors, nurses, paramedics, emergency care practitioners and ambulance personnel.

11.137 In relation to those termed first aiders, it stated: “A first aider is a person who holds a current certificate in first aid competency, issued by an organisation that meets the HSE guidelines on first aid training.” However, it went on: “The holding of a Health and Safety at Work, or three-day First Aid at Work certificate does not in itself qualify a person as competent to administer first aid to the public at events.” The Ambulance Service Experts confirmed that this level of qualification had not been designed for first aid given to others at public events. The Purple Guide did not specify what the minimum standard was.

Number of personnel

11.138 A table setting out “outline guidance” as to the number and skill mix of healthcare services required was provided by the Purple Guide. The table was introduced with a repetition that the level of provision needed to make an event

124 INQ041126/10 at paragraph 5.47
125 INQ041126/11 at paragraph 5.48
126 145/48/1-7
safe can only be determined after a comprehensive risk assessment.  

11.139 The entry from the table for a “medium”-sized event is shown in Table 2.

<table>
<thead>
<tr>
<th>Medium Event</th>
<th>10,000–50,000 attenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor-led cover</td>
<td>Consider:</td>
</tr>
<tr>
<td>1–2 doctors</td>
<td>Specialist doctors,</td>
</tr>
<tr>
<td>2–4 nurses or ENPs [Extended Nurse Practitioners]</td>
<td>pit crews, substance</td>
</tr>
<tr>
<td>2–4 paramedics or ECPs [Emergency Care Practitioners]</td>
<td>abuse team etc</td>
</tr>
<tr>
<td>10 first aiders or first responders for first 10,000 attenders + 1/5,000 above 10,000</td>
<td>where indicated</td>
</tr>
<tr>
<td>Ambulance(s) and crew for on-site service and transfers to hospital (minimum 1 ambulance)</td>
<td></td>
</tr>
<tr>
<td>1 Rapid Response Vehicle</td>
<td></td>
</tr>
</tbody>
</table>

Table 2: Outline guidance table for healthcare provision at medium-sized events

127 INQ042764/1
128 INQ042764/2
Major Incident

11.140 The Purple Guide explained that once a Major Incident is declared, it is important that the arriving NHS staff are aware of key personnel on site with whom to liaise and whether the event medical provider has commenced effective triage and initial casualty management. Clear communications between the on-site provider and the NHS ambulance service is key to ensuring effective handover and co-ordination of the incident.\(^{129}\)
Part 12

Emergency services preparedness

Introduction

12.1 Part 12 will examine the emergency preparedness of British Transport Police (BTP), Greater Manchester Police (GMP), North West Ambulance Service (NWAS), North West Fire Control (NWFC) and Greater Manchester Fire and Rescue Service (GMFRS) to respond to a Major Incident requiring a multi-agency response, in particular a Marauding Terrorist Firearms Attack.

12.2 Part 12 will review the plans and policies used by each emergency service with a focus on those that were relevant to the emergency response to the Attack. It will also review the training that was given to emergency services personnel, the available equipment, and the opportunities to test equipment and training in exercises.

12.3 Part 12 will begin with a review of the work of the Greater Manchester Resilience Forum (GMRF), the role of which was to help to prepare for a multi-agency response in Greater Manchester. It will conclude with a review of multi-agency
communications and multi-agency exercising, with a focus on Exercise Winchester Accord, which occurred a year before the Attack.
Key findings

- Local resilience forums should have the ability to ensure members attend and participate in multi-agency planning.

- Local resilience forums need a sufficient budget and access to adequate resources to function properly.

- The Greater Manchester Resilience Forum (GMRF) was fit for purpose, but some critical failings were identified prior to the Attack.

- North West Fire Control should have been invited to participate in GMRF as a separate attendee, not through Greater Manchester Fire and Rescue Service.

- In the two years before the Attack, British Transport Police (BTP) failed regularly to attend GMRF top-tier meetings.

- BTP failed to send a representative of sufficient seniority to GMRF top-tier meetings.

- Greater Manchester Police failed to send a representative of sufficient seniority to most GMRF top-tier meetings in the two years before the Attack.
• GMRF did not have an adequate system in place to ensure that lessons were learned from training and exercises.

Framework for local resilience forums

12.4 The Civil Contingencies Act 2004 (the 2004 Act) imposed a collective responsibility on responders to plan, prepare and communicate in a multi-agency environment.¹ Local resilience forums were a key mechanism for this multi-agency collaboration.² The 2004 Act, the Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005 (the 2005 Regulations) and Cabinet Office guidance provided the nationwide framework for local resilience forums.³

12.5 The Cabinet Office guidance explained:

“The LRF [local resilience forum] itself is a strategic group and should attract a sufficiently senior level of representation. The local authority representative, for example, should be the chief executive or deputy chief executive and the police representative should be the area chief constable or deputy chief constable.”⁴

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¹ 58/19/20-24/1
² 58/14/2-12, 58/25/7-26/12
³ 58/19/11-20/11, INQ019376/1
⁴ INQ018894/12
12.6 The need for the most senior representatives of each local resilience forum member organisation to attend its meetings is obvious. They are the ones tasked with ensuring that the systems necessary for joint working are in place within their individual organisation. If more junior representatives attend, they may not have the overview of their senior colleagues and, in any event, they are unlikely to have the authority to drive forward any change that is necessary.

12.7 I regard that as common sense, but it is also the experience of the Policing Experts, Ian Dickinson, Iain Sirrell and Scott Wilson, that a strong local resilience forum is vital in order to provide the direction necessary for the emergency services to deliver what is needed.5 This is a point which, as the evidence will show, was particularly important in Greater Manchester before the Attack.

12.8 There were 38 local resilience forums in England.6 The area each local resilience forum covered matched the jurisdiction of the local police service.7 Each local resilience forum acted as “a local forum for local issues”8

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5 146/57/13-59/11; see Appendix 11 in Volume 2-II
6 68/123/4-18
7 58/19/8-10
8 58/30/19-24
12.9  As I set out in Part 11, the 2004 Act imposed civil protection duties on certain emergency services designated as Category 1 responders.⁹ Through the network of local resilience forums, Category 1 responders were required to assess the risk of emergencies within their area and make appropriate plans. They must make emergency plans, facilitate co-ordination and efficiency between local emergency responders, and make information available to the public about civil protection matters.¹⁰

12.10  The definition of “emergency” given in Section 1 of the 2004 Act included an “event or situation which threatens serious damage to human welfare”, such as loss of life, or act of terrorism that “threatens serious damage to the security of the United Kingdom”. There can be no doubt that the Attack fell within the 2004 Act definition of an emergency.¹¹

12.11  Local resilience forums had no operational role to respond to an emergency.¹² A core purpose was to bring together regularly the people who would form part of a Strategic Co-ordinating Group in an emergency.¹³ This was to ensure that responders

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⁹ 58/20/12-21/6
¹⁰ 58/22/12-24/1, INQ019376/10
¹¹ 58/24/5-19
¹² 58/38/11-21
¹³ 58/34/12-35/18
build up over time an understanding of the challenges and pressures faced by their partners and gain experience of working together. The first time that people from different organisations work jointly should not be when an emergency is taking place.\textsuperscript{14}

12.12 The Chair of GMRF in the period before, and at the time of the Attack, was GMFRS Deputy Chief Fire Officer Paul Argyle.\textsuperscript{15} Deputy Chief Fire Officer Argyle explained that a strategic purpose of a local resilience forum was to support each responder to deliver their responsibilities under the 2004 Act through collaboration and co-operation. He agreed that an incident like the Attack was a good example of why that was important.\textsuperscript{16} The preparation of plans and the exercising of those plans were of critical importance.\textsuperscript{17}

12.13 Local resilience forums were required to produce a Community Risk Register.\textsuperscript{18} This set out the key emergency risks that could occur in the local area to help individuals, businesses and the local community be better prepared.\textsuperscript{19} The Community Risk Register reflected a strategic approach to
preparing for emergencies.\textsuperscript{20} There was a public and private version. The private version was only for use by the local resilience forum to help it plan and prepare. It contained operationally sensitive information.\textsuperscript{21} The publicly available copy of the Community Risk Register in place at the time listed “\textit{Terrorist attacks on crowded places}” as a recognised risk.\textsuperscript{22}

\textbf{Resilience and Emergencies Division}

12.14 In 2017, the Resilience and Emergencies Division was responsible for liaison and coordination of the national network of local resilience forums. It was part of the Department for Communities and Local Government.\textsuperscript{23} It had offices in Leeds, Birmingham, Bristol and London.\textsuperscript{24} The titles of these organisations have changed since 2017 but are used for the purpose of this Report as they were in use at the time.\textsuperscript{25}

12.15 In 2017, Margaret Gillespie was the Department for Communities and Local Government’s Head of Resilience for the North of England.\textsuperscript{26} She explained that the role of the Resilience and
Emergencies Division was to link in with local responders and act as the conduit for information to and from central government.\(^{27}\)

12.16 The Resilience and Emergencies Division had resilience advisers who supported local resilience forums, shared best practice and government guidelines, and helped resilience forums to develop plans.\(^ {28}\) It acted as a “critical friend”\(^ {29}\) to local resilience forums, but it did not have an assurance role to approve or correct particular plans drawn up by a resilience forum.\(^ {30}\)

12.17 The resilience adviser attended executive meetings of the local resilience forum and its sub-groups.\(^{31}\) The resilience adviser then reported on those meetings to a head of resilience at the Resilience and Emergencies Division.\(^ {32}\)

12.18 From the available evidence, the resilience adviser did not play a critical role in the preparedness of GMRF to respond to a terrorist attack. Nonetheless, it was a role that provided an important link between the local resilience forum network and central government.
12.19 The Resilience and Emergencies Division did not have legal powers to compel local resilience forums to take specific types of action or require its members to do so. Margaret Gillespie said that the Resilience and Emergencies Division sought to work in collaboration with local resilience forums, not through enforcement. She believed that its work at “persuasion” and “influencing” was very effective. I am unconvinced that this approach is the right one.

12.20 The 2005 Regulations required local resilience forums to meet every six months and for Category 1 responders to attend. A local resilience forum, however, did not have powers to penalise members who did not attend. It worked through agreement and collaboration with its members. Deputy Chief Fire Officer Argyle considered that there were “sufficient mechanisms” in place to resolve disputes within a local resilience forum and through the supporting mechanisms provided by central government, including the Resilience and Emergencies Division.
12.21 In my view, the lack of power available to local resilience forums to compel members to attend is a weakness. There is a material possibility that it will limit the effectiveness of a local resilience forum to ensure all its members prepare properly.\textsuperscript{38} Consideration should be given to giving local resilience forums powers to compel members to attend and participate in multi-agency planning. In Part 20 in Volume 2-II, I will return to this.

12.22 The Resilience and Emergencies Division captured lessons learned from the local response to an incident and fed that into central government.\textsuperscript{39} Margaret Gillespie said that the work of embedding lessons identified by local responders was taken forward by each local resilience forum. It was the responsibility of local partners to do this.\textsuperscript{40}

12.23 When an emergency occurred, the resilience advisers would attend a Strategic Co-ordinating Group in the role of a government liaison officer.\textsuperscript{41} This was the main channel of communication to link the local emergency response back to central government. Tim Godson was GMRF’s resilience adviser at the
time of an important multi-agency exercise held in Greater Manchester called Exercise Winchester Accord.\textsuperscript{42} He participated in the exercise as a government liaison officer to assist with the set-up of the Strategic Co-ordinating Group and to test IT and other systems.\textsuperscript{43} A representative from the Resilience and Emergencies Division fulfilled this role in the Strategic Co-ordinating Group in response to the Attack.\textsuperscript{44}

12.24 Margaret Gillespie said that, for every local resilience forum that takes part in an exercise, there would be a tracker for the lessons from that exercise. This was to help make sure the lessons were actioned. She said she would not expect that to be discussed at every executive meeting of a local resilience forum, but it should be discussed by one of its working groups. That would then flag to the executive meeting if there were an issue that needed to be addressed.\textsuperscript{45}

GMRF

12.25 GMRF was set up in 2005.\textsuperscript{46} Its terms of reference set out its core objectives.\textsuperscript{47}

\begin{itemize}
\item \textsuperscript{42} 68/141/18-21
\item \textsuperscript{43} 68/149/10-150/10
\item \textsuperscript{44} 68/123/19-124/20
\item \textsuperscript{45} 68/151/12-152/16
\item \textsuperscript{46} 58/45/7-10, Greater Manchester Resilience Strategy 2020-2030 at page 26
\item \textsuperscript{47} 58/45/11-46/13, INQ012418/1
\end{itemize}
These focused on ensuring that responders coordinate and collaborate. The objectives aimed to ensure that, in the event of an emergency, responders work together and achieve a better outcome.\(^{48}\)

12.26 GMRF’s terms of reference explained:

“[GMRF] sits at the apex of Greater Manchester’s civil protection arrangements. Its overall purpose is to ensure that there is an appropriate level of preparedness to enable an effective multi-agency response to emergency incidents which may have a significant impact on the communities of Manchester.”\(^{49}\)

12.27 In combination, the failings revealed by the evidence meant that GMRF was unable to discharge adequately this vital role in the protection of the public.

12.28 It was GMRF’s responsibility to analyse risks, prepare the plans and identify the capabilities to address those risks.\(^{50}\) Deputy Chief Fire Officer Argyle said that, if an organisation identified a new issue or risk that could not be resolved by it individually and could affect a

\(^{48}\) 58/14/10-15, 58/45/11-46/10

\(^{49}\) INQ012418/1

\(^{50}\) 58/120/3-121/8
co-ordinated response to an emergency, it should be escalated to GMRF.\textsuperscript{51}

12.29 Deputy Chief Fire Officer Argyle explained that GMRF did not audit or monitor all the activities of its members.\textsuperscript{52} The role of GMRF was to bring people together, to identify where better co-operation and co-ordination could deliver an improved emergency response.\textsuperscript{53}

Membership, structure and funding of GMRF

12.30 The membership of GMRF comprised Category 1 responders including GMP, NWAS, GMFRS and BTP.\textsuperscript{54} The Association of Greater Manchester Civil Contingencies and Resilience Unit represented the ten local authorities in Greater Manchester on GMRF.\textsuperscript{55} Category 2 responders such as Network Rail and Transport for Greater Manchester, as well as other organisations, were also GMRF members.\textsuperscript{56} Some bodies, such as local coroners and universities, were not listed as either Category 1 or Category 2 responders but were members of GMRF.\textsuperscript{57}

\textsuperscript{51} 58/120/3-121/8
\textsuperscript{52} 58/118/19-119/8
\textsuperscript{53} 58/117/14-25
\textsuperscript{54} 58/60/21-61/5
\textsuperscript{55} 58/66/25-68/8
\textsuperscript{56} 58/66/2-8
\textsuperscript{57} 58/66/2-24
12.31 GMRF had a wide membership of organisations across Greater Manchester. NWFC was not a member in its own right. Deputy Chief Fire Officer Argyle said that no one from NWFC attended GMRF while he was the Chair. NWFC’s interests were represented, he said, through GMFRS.

12.32 Deputy Chief Fire Officer Argyle explained that, although NWFC was its own legal entity, it was, save for a few exceptions, “wholly staffed” by members of the four fire and rescue services it served. He acknowledged, however, that the direct line management role of the fire control room had changed with the establishment of NWFC.

12.33 Deputy Chief Fire Officer Argyle’s characterisation of the staffing at NWFC was incorrect. While many of NWFC’s employees had previously worked for one of the four fire and rescue services it served, some members of staff had not. It is important that NWFC’s status as a separate entity is recognised. There is a risk that assumptions are made about the knowledge of its staff if this is not kept firmly in mind.

58 58/62/9-16
59 58/61/2-62/21
60 58/64/19-65/21
61 58/64/19-65/21
62 INQ035431/1 at paragraph 2, INQ041685/1 at paragraph 2
12.34 There was no adequate explanation for the failure to include NWFC at the executive and training level of GMRF. It was a significant oversight. It weakened a central purpose of GMRF to ensure collaboration between emergency responders. It was a missed opportunity to ensure NWFC, a relatively new organisation in 2017, was part of the planning for a multi-agency emergency response.

12.35 Deputy Chief Fire Officer Argyle was in post as Chair from the summer of 2015 and attended meetings. 63 GMRF was usually chaired either by a representative from GMP or GMFRS. 64 GMRF had a top tier, which held executive meetings, to which each Category 1 responder was expected to send a senior representative. Beneath the top tier of GMRF were various sub-groups and working groups. 65

12.36 Deputy Chief Fire Officer Argyle described the Resilience Development Group as the “workhorse of the resilience forum”. 66 It was the primary sub-group that GMRF would direct work to. It was the main way that work was progressed. 67

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63 58/16/23-17/1
64 58/18/16-19/1
65 58/14/16-15/1
66 58/14/23-15/1
67 58/46/4-21
12.37 Usually, debriefs from training exercises would be passed through the Resilience Development Group.\textsuperscript{68} It checked if it agreed with the learning points. If so, it would design a solution to deliver any resulting recommendations.\textsuperscript{69} Deputy Chief Fire Officer Argyle explained that if GMRF was not part of an exercise it would only be aware of learning points arising if someone or a sub-group such as the Resilience Development Group escalated it to them.\textsuperscript{70} Deputy Chief Fire Officer Argyle did not accept that “it was a bit pot luck”\textsuperscript{71} whether issues that had come up during training exercises were referred to GMRF.\textsuperscript{72} Although Deputy Chief Fire Officer Argyle did not agree, this was a fair analysis of the situation from the evidence before the Inquiry. The system to capture learning by GMRF was haphazard. It requires improvement.

12.38 Other sub-groups of GMRF included the Training and Exercising Co-ordination Group, the Mass Casualties Group, and the Warning and Informing Group.\textsuperscript{73} Representatives from each responder or agency sat on the sub-groups.\textsuperscript{74} The sub-

\textsuperscript{68} 58/121/12-122/12, 58/124/20-125/13
\textsuperscript{69} 58/121/12-123/8
\textsuperscript{70} 58/121/12-123/8, 58/124/20-125/13
\textsuperscript{71} 58/123/17-124/19
\textsuperscript{72} 58/123/17-124/19
\textsuperscript{73} INQ035309/34
\textsuperscript{74} 58/14/16-15/12
groups reported upwards to GMRF top tier and received work downwards.\textsuperscript{75}

12.39 Local partners funded GMRF. There was no consistent or guaranteed budget from central government.\textsuperscript{76} Deputy Chief Fire Officer Argyle rightly acknowledged that this was a potential problem but it was not one he had faced in Manchester. He was aware that it was a challenge nationally and that some local resilience forums did not have the resources to progress tasks.\textsuperscript{77} It is important that local resilience forums are funded consistently and sufficiently to do their important work.

12.40 During his tenure as Chair, Deputy Chief Fire Officer Argyle said GMRF had one full-time employee. He accepted that one person was not sufficient to do all the work that was required.\textsuperscript{78} That was inadequate to provide assistance with the work of a body as important as GMRF. While GMRF did seek support from its members, it would have been far better for it to have had its own dedicated staff.\textsuperscript{79} As with access to funding, it is important to ensure that local resilience forums have access to adequate staff and

\textsuperscript{75} 58/15/2-18
\textsuperscript{76} 58/46/25-47/7
\textsuperscript{77} 58/46/22-48/20
\textsuperscript{78} 146/66/11-67/5
\textsuperscript{79} 58/48/21-49/11
administration to support their work. That is what was required for GMRF to discharge its responsibilities. I am pleased to have been told that steps are being taken to resolve this.

12.41 GMRF was responsible for assessing approximately 70 different risks in its area. For each, it used past experience and scientific modelling to determine the likelihood and impact of such risks occurring in Greater Manchester. Contingency plans for those risks were reviewed and the results of each risk assessment recorded in the private Community Risk Register. Due to its sensitive nature, GMRF handled the risk of terrorism separately from other civil emergencies.

12.42 GMRF contingency plans focused on the arrangements for a multi-agency response to an emergency. Each organisation had its own plans. GMRF multi-agency plans focused on arrangements for activation, command and control, and information-sharing between organisations. Examples of GMRF multi-agency plans included a strategic recovery guidance plan, an emergency communications
and media plan, and a resilience telecommunications plan. 85 Deputy Chief Fire Officer Argyle explained that GMRF multi-agency plans helped “to enhance the coordination”. 86

12.43 Deputy Chief Fire Officer Argyle did not consider that it was realistic for GMRF to have multi-agency site-specific plans. 87 The Policing Experts considered that a local resilience forum was the right organisation to create such plans. In my view, such plans should be created within the structure of local resilience forums. 88 Better use should have been made by GMRF of multi-agency plans. In particular, site-specific multi-agency plans for locations such as the Arena are essential for successful multi-agency working.

Attendance at GMRF meetings

12.44 Deputy Chief Fire Officer Argyle said that the top tier of GMRF met quarterly during the period from 2015 to 2017. He considered that this was sufficient. 89 There was a minimum requirement under Regulation 4 of the 2005 Regulations for two meetings a year. 90 GMRF continued to meet quarterly until Deputy Chief Fire Officer Argyle

85 58/53/17-55/11
86 58/52/19-53/10
87 58/155/21-157/10
88 146/81/15-86/23
89 58/49/12-16, 58/49/17-19
90 58/133/14-134/12
retired as Chair in August 2019. The top-tier meetings typically lasted half a day.

12.45 The frequency of sub-group meetings was not fixed. The Resilience Development Group had a regular schedule of meetings, but other sub-groups may have convened only when the work required it. Most sub-groups met more often. Most work was done outside the meetings. This was normal practice.

12.46 The Cabinet Office reference document required that participants in local resilience forums be of a sufficiently senior level of responsibility. This meant that they must be at Chief Officer level. Deputy Chief Fire Officer Argyle believed that “usually” GMRF achieved this. As the evidence showed, this was not usually the case for either BTP or GMP.

12.47 Participants in a local resilience forum must also be from the cadre of officers who can form a Strategic Co-ordinating Group. The Policing Experts explained that these officers should know each other, be familiar with multi-agency plans...
and have participated in exercises together for their strategic emergency role.\textsuperscript{99} Deputy Chief Fire Officer Argyle agreed with this analysis.\textsuperscript{100}

12.48 There were nine meetings of the GMRF top tier between 13\textsuperscript{rd} March 2015 and 27\textsuperscript{th} March 2017, the latter being the final meeting before the Attack.\textsuperscript{101}

12.49 While GMP was represented at each meeting, a Chief Officer from GMP only attended three out of the nine top-tier meetings of GMRF. On no occasion did the Chief Constable or Deputy Chief Constable of GMP attend. On only three occasions did an Assistant Chief Constable attend. On two occasions, attendance was by an Inspector only.\textsuperscript{102}

12.50 BTP was only present at three of those meetings in any capacity.\textsuperscript{103} A Chief Inspector attended one meeting and two different Inspectors the other two meetings, one with a civilian member of staff.\textsuperscript{104}

12.51 Judged against the sensible standard expected by the Cabinet Office document, the participation

\textsuperscript{99} INQ035309/55-56
\textsuperscript{100} 139/8/24-9/10
\textsuperscript{101} INQ035309/55-56
\textsuperscript{102} INQ035309/55-56
\textsuperscript{103} INQ035309/55-56
\textsuperscript{104} INQ035309/55-56
by GMP and BTP in GMRF meetings in the two years prior to the Attack was seriously deficient.

12.52 Deputy Chief Fire Officer Argyle could not recall the failure of BTP to attend. He said that he would have been “disappointed and wanted attendance from BTP”.\textsuperscript{105} He stated he would expect a senior representative of BTP in the context of Greater Manchester to attend but said he did not personally contact BTP to enquire about their attendance.\textsuperscript{106} Disappointment without action was an insufficient reaction from Deputy Chief Fire Officer Argyle. He should have taken steps to make clear to senior officers within BTP the importance of BTP’s proper participation in GMRF meetings.

12.53 On behalf of BTP, Assistant Chief Constable (ACC) Sean O’Callaghan accepted that the level of its engagement in GMRF meetings in the two years prior to the Attack was “not very good” and “not satisfactory”.\textsuperscript{107} Inevitably, that meant it did not fulfil its role to take part in joint planning.\textsuperscript{108} ACC O’Callaghan said that his assessment was that “a lot of the people that had been asked to attend simply didn’t understand the importance
of an LRF [local resilience forum] or the benefit of working with partners ahead of an event”. 109

12.54 This was an appropriately candid concession. It reveals an unsatisfactory and unacceptable approach by BTP. The 2004 Act and its accompanying 2005 Regulations had been law for well over a decade at the time of the Attack. 110 The failures to understand the importance of local resilience forums and the benefit of joint working with partners in 2017 were serious shortcomings in BTP’s approach.

12.55 ACC O’Callaghan said that, prior to him joining BTP in June 2018, responsibility for attending the local resilience forum was at a local subdivisional level across the country. This is now overseen by a resilience manager and a central structure across BTP. 111 Wherever possible, a Superintendent now attends each local resilience forum and attendees are never lower than Chief Inspector rank. 112

12.56 Deputy Chief Constable (DCC) Ian Pilling, on behalf of GMP, acknowledged that “there should have been more consistent attendance by chief officers” at GMRF meetings. 113 He accepted that

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109 139/13/7-16
110 58/77/15-22
111 139/1/18-21, 139/10/23-11/13
112 139/10/13-11/13
113 130/181/3-13
failing to do so risked a perception that GMP did not place enough emphasis on joint working. He stated that perception would be incorrect and that GMP “were very much engaged with the process”. He agreed GMP should have had better representation at Assistant Chief Constable level.

12.57 GMP Inspector June Roby was Chair of the GMRF Training and Exercising Co-ordination Group. She was a regular member of the Resilience Development Group. She acted as an adviser to the GMP senior officer attending GMRF meetings. The evidence shows that she attended three of the nine meetings which preceded the Attack, once as the most senior officer from GMP. Inspector Roby stated that it was not the case that GMP lacked interest. She explained GMP’s attendance record on the basis of budget cuts and a number of movements at senior officer level. She agreed that GMP’s attendance record was unsatisfactory.

12.58 The Ambulance Service Experts noted that NWAS covered the same area as 5 separate fire
and rescue services, 5 police services and 46 local authorities. Each local resilience forum had several sub-groups which required input from NWAS. Taking the resources available to NWAS into consideration, the Ambulance Service Experts considered NWAS’s participation to have been reasonable. 121

12.59 I do not disagree with the Ambulance Service Experts’ assessment that NWAS’s participation was reasonable by reference to the standards prior to the Attack. However, active participation at a senior level in all local resilience forums is an important part of every Category 1 responder’s responsibility. Resources must be made available to achieve this.

12.60 The Fire and Rescue Expert considered that GMFRS engaged adequately with GMRF in the three years prior to the Attack. There is clear evidence to support this. GMFRS played an active role in GMRF. Deputy Chief Fire Officer Argyle was the Chair of GMRF at the time of the Attack. 122

12.61 GMRF must bear some responsibility for not doing more to encourage organisations to attend regularly and participate through personnel of sufficient seniority. Although I recognise that local

121 INQ041856/5
122 58/1/20-25
resilience forums did not have powers to compel attendance, care must be taken in future to monitor attendance and to flag promptly any concerns.

**Strategic Co-ordinating Group**

12.62 A Strategic Co-ordinating Group does not respond operationally to an incident, but it has an important function to facilitate liaison between relevant local responders at the time of an emergency. A Strategic Co-ordinating Group is a multi-agency meeting attended by a senior person from each emergency responder, often by those commanding the response. A Strategic Co-ordinating Group co-ordinates the strategic response to an incident and the initial stages of the recovery. Local resilience forums plan how the formation of a Strategic Co-ordinating Group takes place. This is to ensure it happens smoothly and without misunderstandings.

12.63 Deputy Chief Fire Officer Argyle said that, if there were a Major Incident, a Strategic Co-ordinating Group would always be needed. It is, he agreed, a reason why everybody should know that a Major Incident has been declared. This

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123 [58/34/7-23]
124 [58/34/18-23]
125 [58/44/1-8]
126 [58/44/9-17]
127 [58/38/23-40/12]
knowledge will ensure there is better co-operation and co-ordination through a Strategic Co-ordinating Group. Usually, the police will lead the first Strategic Co-ordinating Group, but it is dependent on the type of incident.\textsuperscript{128} In a terror-related incident, the police chair the Strategic Co-ordinating Group.\textsuperscript{129} The time and location of the Strategic Co-ordinating Group will be announced and each organisation will decide who needs to go. When a Strategic Co-ordinating Group is called, it is normal for the Strategic/Gold Commander from each Category 1 responder to attend.\textsuperscript{130}

12.64 The Greater Manchester Multi-Agency Generic Response Plan (the GMRF Generic Response Plan) set out the process for activating a Strategic Co-ordinating Group and the role it fulfils in co-ordinating an emergency response. It stated that a Strategic Co-ordinating Group is activated when an incident threatens to overwhelm the capacity of an organisation or an "integrated strategic effort" will help the emergency response.\textsuperscript{131} The GMRF Generic Response Plan also stated that a Strategic Co-ordinating Group is activated where a

\begin{itemize}
  \item \textsuperscript{128} 58/64/19-65/21
  \item \textsuperscript{129} 58/39/2-41/7
  \item \textsuperscript{130} 58/42/9-16
  \item \textsuperscript{131} 58/55/22-56/7, INQ012487/1-3
\end{itemize}
catastrophic event has occurred or is imminent, or the Tactical Co-ordinating Group requests it.\textsuperscript{132}

12.65 The Force Duty Officer (FDO) in the local police service was usually the person who activated a Strategic Co-ordinating Group in order to co-ordinate the response to a Major Incident. Any organisation can request, usually through the FDO, that a Strategic Co-ordinating Group is activated.\textsuperscript{133} Deputy Chief Fire Officer Argyle explained that a Strategic Co-ordinating Group should be convened as early as possible in an incident.\textsuperscript{134} People needed to be warned to attend and be prepared to contribute to it effectively.\textsuperscript{135}

12.66 The first Strategic Co-ordinating Group after the Attack was not convened until 04:15 on 23\textsuperscript{rd} May 2017.\textsuperscript{136} This was an unacceptable delay. The delay was due to factors that arose that night. If, however, there had been a better culture of attending GMRF meetings by senior officers from all organisations involved in the emergency response on 22\textsuperscript{nd} May 2017, it may be that the importance of convening a Strategic Co-ordinating Group earlier in the emergency response would have been apparent.

\begin{itemize}
\item \textsuperscript{132} 58/56/8-15
\item \textsuperscript{133} 58/56/8-20
\item \textsuperscript{134} 58/58/17-59/8
\item \textsuperscript{135} 58/58/17-59/8
\item \textsuperscript{136} 105/206/4-14
\end{itemize}
Planning and exercising

12.67 GMRF was aware through the Community Risk Register what capabilities were in place in Greater Manchester, as well as the threats and risks the community faced. It used the Community Risk Register to plan exercises and training. Sometimes members of GMRF identified a new issue that required joint training. Usually GMRF became involved in training to ensure that there was multi-agency collaboration and to draw together lessons learned from such training and exercises.

12.68 Deputy Chief Fire Officer Argyle set out in a witness statement a number of exercises that GMRF was involved in between 2012 and 2017. These exercises were designed to test joint working between the emergency services. Many focused on aspects of the multi-agency response to a terrorist incident.

12.69 Examples of these exercises include the following. In 2012, Exercise Joint Enterprise tested the joint response by GMP, NWAS and GMFRS to an Operation Plato incident.

137 58/31/13-32/18, 58/74/24-75/13, INQ018888/3
138 58/74/16-76/16
139 58/68/13-70/4
140 INQ023876/14-17, 58/77/24-84/5, 58/91/22-93/17
141 58/77/9-80/18, 58/81/6-83/10
142 58/93/18-20
143 58/78/10-79/4
In 2013, tabletop Exercise Mars raised awareness of Tactical/Silver Commanders to respond to a Major Incident.\textsuperscript{144} In 2014, there were exercises to test evacuation plans at Manchester Victoria Railway Station and to test the response to a Marauding Terrorist Firearms Attack.\textsuperscript{145}

12.70 Deputy Chief Fire Officer Argyle explained that in 2015 there were a number of multi-agency exercises. These included Exercise Lionheart to test GMP firearms support with multi-agency partners, Operation Thunder Wave to test preparedness for a Bataclan-style attack and Exercise Lawman to test the multi-agency response to a Marauding Terrorist Firearms Attack.\textsuperscript{146}

12.71 There were at least nine further multi-agency exercises in 2016 and 2017 in which GMRF was involved.\textsuperscript{147} These tested different aspects of a multi-agency emergency response, including evacuation plans, disaster victim identification and mass casualty trauma training.\textsuperscript{148} Exercise Hawk River in March 2017 was notable as it was focused on the response to a Marauding Terrorist

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\textsuperscript{144} 58/79/5-19  \\
\textsuperscript{145} 58/79/20-80/5  \\
\textsuperscript{146} 58/81/6-19  \\
\textsuperscript{147} INQ023876/14-17  \\
\textsuperscript{148} 58/82/24-83/2, 58/91/25-93/20
\end{flushleft}
Firearms Attack. It was an opportunity to apply the key principles from the latest edition of *Responding to a Marauding Terrorist Firearms Attack and Terrorist Siege: Joint Operating Principles for the Emergency Services* (JOPs 3).\(^{149}\)

12.72 The evidence showed that there was a good level of multi-agency training and exercising to ensure collaboration between most, but not all, of the key emergency responders with responsibility for Greater Manchester. A notable absentee was NWFC.\(^{150}\)

12.73 I will address multi-agency exercising at the conclusion of this Part, at paragraphs 12.733 to 12.899. Included within this will be a review of Exercise Winchester Accord.

12.74 Deputy Chief Fire Officer Argyle made the point that it would be "unmanageable and untenable" for a local resilience forum to be passed all learning points from all exercises.\(^{151}\) However, he said that the local resilience forum should be told about the lessons from exercises that identified a potential breakdown in multi-agency working, unless the organisations were clear that they could resolve the issue internally.\(^{152}\)
12.75 Deputy Chief Fire Officer Argyle went on to explain that the Category 1 and Category 2 responders had a responsibility to share information.\textsuperscript{153} If they identified a problem, they had a “duty” to share that information and make sure it was resolved to comply with the 2004 Act.\textsuperscript{154} He said that “at any point an officer of any level could identify a significant issue”\textsuperscript{155} and there had to be a structure in place to allow that information to be shared upwards internally and, if necessary, with the local resilience forum.\textsuperscript{156}

12.76 Deputy Chief Fire Officer Argyle explained that usually the lessons from an exercise would be captured through the debrief process. That debrief would be allocated owners who would then take it to the local resilience forum to resolve it in a multi-agency way. The local resilience forum would in turn say: “[L]et’s test what you have put in place works.”\textsuperscript{157}

12.77 Deputy Chief Fire Officer Argyle said that a “far stronger”\textsuperscript{158} learning process was put in place following the Attack. There was a recognition that, while you could debrief effectively, the proposed solution might ensure greater scrutiny.
It was, he explained, important to test and check the problem was solved.\textsuperscript{159}

**Conclusions**

12.78 The local resilience forum network is an important way for emergency responders to plan and prepare for how they will respond together to a Major Incident.

12.79 Although it was well organised, GMRF was under-staffed. It also had problems with membership and attendance. NWFC was not invited to attend GMRF meetings in its own right. BTP and GMP did not regularly send officers of sufficient rank to attend meetings. The evidence also suggested that there was not a rigorous approach to debriefs and learning from multi-agency exercises.

12.80 These are issues that must be addressed and kept under review. A robust local resilience forum is vital to ensure that there is a successful, co-ordinated multi-agency response to any Major Incident.

12.81 I am concerned, furthermore, that the position in Manchester may be replicated in different parts of the country. The Policing Experts told me that was likely to be so.\textsuperscript{160} Around the UK, some local

\textsuperscript{159} 117/18/1-20

\textsuperscript{160} 146/70/17-22
resilience forums are strong while some are weak. That needs to change. Each local resilience forum should be strong. This is an issue the Home Office should address.

British Transport Police preparedness

Key findings

• British Transport Police’s (BTP’s) Major Incident Manual was deficient in a number of respects which were relevant to BTP’s response to the Attack.

• The Major Incident Manual had not been updated to reflect the introduction of the Joint Emergency Services Interoperability Programme in 2012. It should have been.

• BTP did not have a site-specific plan for the Victoria Exchange Complex. It should have done.

• Although BTP officers had received some training in the Joint Emergency Services Interoperability Programme, the principles were not sufficiently embedded.

• BTP officers were not adequately trained in first aid. This was a national issue and not the fault of BTP.
• BTP’s approach to participating in multi-agency exercises should have been more rigorous than it was.

Introduction

12.82 BTP provides policing to the railway network across England, Scotland and Wales. It is expert in the policing of the railway network, which contains complex hazards and restrictions.

12.83 BTP is governed by the British Transport Police Authority. This is a statutory body appointed by the Secretary of State for Transport. The British Transport Police Authority is the governing body which checks that BTP is delivering against its agreed plans. It sets out the strategic direction of BTP and arranges the budget.

12.84 BTP’s jurisdiction was determined by Section 31 of the Railways and Transport Safety Act 2003. This provided BTP officers with the powers of a Constable in a number of areas associated with the railway, including the track, stations, other land used for the purpose of or in relation to the railway, and any land for which the freehold is held by Network Rail.
12.85 BTP used the terms Bronze, Silver and Gold for its Operational, Tactical and Strategic Commanders.\textsuperscript{164}

C Division

12.86 BTP divided the areas it was responsible for into divisions. Manchester fell into C Division, which was the largest of the divisions and included the other major transport hubs of Birmingham and Leeds.\textsuperscript{165} In May 2017, the C Division Commander was Chief Superintendent Allan Gregory.\textsuperscript{166}

12.87 There were three BTP police stations in the Manchester area, including one at the Peninsula Building which is less than five minutes’ walk from the Victoria Exchange Complex. The C Division headquarters was based at a different police station in Manchester.\textsuperscript{167}

12.88 There was one explosives detection dog based in Manchester.\textsuperscript{168} In 2017, BTP did not have a firearms capability outside London.\textsuperscript{169}

\begin{flushleft}
\textsuperscript{164} INQ025614/5 at paragraph 28 \\
\textsuperscript{165} 36/10/21-25 \\
\textsuperscript{166} 36/11/12-16 \\
\textsuperscript{167} 36/12/16-13/1 \\
\textsuperscript{168} 36/13/15-25 \\
\textsuperscript{169} 36/16/18-20
\end{flushleft}
BTP Control

12.89 The control room for BTP (BTP Control) was located across two sites: Force Control Room London and Force Control Room Birmingham. The Force Incident Manager and Senior Duty Officer operated from London. On the night of the Attack, the Force Incident Manager was Inspector Benjamin Dawson and the Senior Duty Officer was Chief Inspector (CI) Antony Lodge. The Deputy Force Incident Manager operated from Birmingham.

12.90 The Force Incident Manager’s role in a Major Incident was to take initial command. The Force Incident Manager undertook the duties of the Silver Commander until one could be appointed by the Gold Commander.

12.91 The Senior Duty Officer role was created by BTP in 2015. It was not the subject of any specific training. CI Lodge understood his role in a Major Incident to be ensuring the appropriate response and resources were provided for an incident. He described his role as having “oversight” of the incident, “informing a number
of key internal/external stakeholders” and spotting “any gaps”. ¹⁷⁶

12.92 Force Control Room Birmingham generally managed the C Division calls and radio traffic. ¹⁷⁷ The calls and radio traffic related to the Attack were handled by Force Control Room Birmingham. This was despite the fact that, until after the golden hour, a term I define in Part 10, had passed, BTP’s response was commanded by Inspector Dawson in London. ¹⁷⁸

Major Incident Manual

12.93 The Major Incident Manual in force at the time of the Attack was produced in 2011. ¹⁷⁹ It had not been updated to reflect the Joint Emergency Services Interoperability Programme, although an updated draft was under way which had not been finalised. ¹⁸⁰ It ran to 127 pages. It encouraged joint working, listing that the “first priority” was to “work with the other emergency services”, ¹⁸¹ and it provided a structure within which BTP could respond to a Major Incident. The document was too long to be useful to anyone while they were

¹⁷⁶ 93/6/3-7/7
¹⁷⁷ INQ025614/8 at paragraph 48
¹⁷⁸ 92/124/2-9
¹⁷⁹ INQ025614/4 at paragraph 22
¹⁸⁰ 139/66/3-13
¹⁸¹ INQ025700/13 at paragraph 2.1
responding to the early stages of a Major Incident.\textsuperscript{182}

**JESIP**

12.94 ACC O’Callaghan accepted on behalf of BTP that the Major Incident Manual in 2017 did not embrace the Joint Emergency Services Interoperability Principles (JESIP) in important ways.\textsuperscript{183} I agree.

12.95 Had the Major Incident Manual been reviewed and properly rewritten in light of JESIP and the *Joint Doctrine: The Interoperability Framework* (the Joint Doctrine), as it should have been, it would have been more focused on the substance of a multi-agency response. One example of where the Major Incident Manual failed to keep up with the changes in the Joint Doctrine is that it referred to the predecessor to the METHANE mnemonic.\textsuperscript{184} I set out the METHANE mnemonic in Figure 23 in Part 11.

**First officer on scene**

12.96 The role of first officer on scene was defined in Appendix C of the Major Incident Manual. That person’s role was: “*To access the incident and provide immediate information to FCR(L) [Force Control Room London] or FCR(B) [Force Control Room Birmingham]*.”

\begin{itemize}
  \item \textsuperscript{182} 73/37/9-17, 92/23/7-14
  \item \textsuperscript{183} 139/66/10-13
  \item \textsuperscript{184} 139/65/24-66/9, INQ025700/24-25 at paragraph 4.2
\end{itemize}
Room Birmingham]. To declare a major incident (when appropriate).” The predecessor to the METHANE mnemonic was again listed. That mnemonic also included consideration of a Major Incident declaration.

12.97 The first officer on scene was expected to assume interim command until relieved, establish a Forward Command Post (FCP) and complete a dynamic risk assessment. There was emphasis on maintaining communication with BTP Control.

Command

12.98 Also set out in Appendix C were command roles. These were described by reference to the responsibilities of each position. This could have been improved by listing the actions expected of each. NWAS, by contrast, operated a system of action cards which complemented its Major Incident Response Plan. The use of action cards is an effective way to give a commander responding to a Major Incident a ready checklist of what they need to remember to do.

12.99 Another matter that was not satisfactorily addressed by the Major Incident Manual was
scene command. It correctly recognised that the BTP Silver Commander, unlike some other emergency service responders, may not be at the scene. 189 This is because, as a national police service, it will not always be practicable for the Silver Commander to reach the scene in sufficient time to discharge the responsibilities of that role. As the events of 22nd May 2017 demonstrated, a better decision may be for the Silver Commander to travel to BTP Control and operate from there.

12.100 However, this makes ensuring the timely arrival of a person undertaking the Bronze Commander role all the more important. The Major Incident Manual required the Bronze Commander to be appointed by the Silver Commander. 190 This is in contrast to the approach of GMP on the night of the Attack, whose Operational/Bronze Commander was on duty and self-appointed. 191 Between the two, I think GMP’s approach is the better one.

12.101 GMFRS’s approach to on-scene command was that the most senior officer on scene took command. 192 That person was then relieved,
following a handover, by a more senior officer when they arrived.\textsuperscript{193}

12.102 BTP’s approach as set out in the Major Incident Manual had the potential to build in delay. Inspector Dawson, as Force Incident Manager, was the initial Silver Commander. He did not appoint a Bronze Commander. The Bronze Commander was appointed by Chief Superintendent Gregory, who was to assume the role of Silver Commander. The appointment of a Bronze Commander did not occur until over 40 minutes after the explosion.\textsuperscript{194}

12.103 BTP should review its processes for appointing a Bronze Commander in the event of a Major Incident. The time it took to appoint a Bronze Commander and the time it took for that person, Superintendent Kyle Gordon, to reach the scene and take up that role meant that BTP did not have a functioning Bronze Commander for the entirety of the critical period of the response. By the critical period of the response, I mean the period from the explosion at 22:31 to the removal of the final living casualty from the City Room at 23:39.

12.104 As I said in Part 10, GMP’s Operational/Bronze Commander, Inspector Michael Smith, performed

\textsuperscript{193} INQ026714/31 at paragraph 140
\textsuperscript{194} 92/124/1-9
his role to a high standard. Given how geographically spread BTP is, BTP should ensure that all its Inspectors are able to undertake a Bronze Commander role in the event of a Major Incident and that they are empowered to self-appoint into this role, subject to ratification once the Silver Commander is able to do so.

12.105 It is essential that the system ensures that a competent Bronze Commander, of whichever rank, is on scene as soon as possible. They can always be relieved by a more senior officer if the incident continues to develop.

12.106 Sergeants should also receive training in what is required of a Bronze Commander, so they are able to ensure that important initial steps are taken before an Inspector arrives on scene.

Primacy

12.107 The Major Incident Manual addressed the question of which police service, whether a Home Office police service or BTP, should take the lead in the emergency response. It stated: “Agreement on responsibilities between BTP and the local police force will be subject to negotiation with all relevant local police forces at the outset of any major incident.” Inspector Dawson stated

195 139/18/20-24
196 INQ025700/14 at paragraph 2.5
in evidence that this should occur “as early as possible”. 197

12.108 On the night of the Attack, agreement was not reached until after 01:00 on 23rd May 2017. 198 Many of those who responded proceeded on the basis that GMP was leading the response. However, discussions still took place within BTP about this issue during the critical period of the response. 199 This was time that would have been better spent focusing on more urgent things which needed to be done.

12.109 It is important that this issue is not overstated. It did not absorb large quantities of time during the response. There is no basis to conclude that any casualty did not receive attention from a BTP officer when they could have, because of it. At most, it was a distraction for some. 200 It should not have been.

12.110 Agreement as to the circumstances in which either of the two police services, GMP and BTP, would lead a response should have been reached in advance. During a Major Incident, this issue should require no more than a confirmation from one control room to another as part of the early communication in which situational

197 92/15/7-12
198 94/137/10-138/2
199 93/27/21-25
200 186/113/7-23
awareness is shared. In no circumstances during the early stages of a Major Incident should it require “negotiation”\textsuperscript{201} as suggested by the Major Incident Manual.

12.111 Once agreement has been reached as to the factors that determine which police service has primacy in a Major Incident, it should be stress-tested in exercises. All police officers and staff should then be trained in it.

**Senior Duty Officer**

12.112 Finally, the Major Incident Manual made no provision for the Senior Duty Officer role or what part that person should play during a Major Incident.\textsuperscript{202} The Senior Duty Officer was capable of playing an important role in a Major Incident. The Senior Duty Officer role within a Major Incident should have been specified in BTP’s plan. It should have had a corresponding action card.

12.113 Although there was a Senior Duty Officer manual which did give some guidance as to what a Senior Duty Officer should do in a Major Incident,\textsuperscript{203} this should have been integrated into the Major Incident Manual so there was a single, unified plan.

\textsuperscript{201} INQ025700/14 at paragraph 2.5
\textsuperscript{202} 92/140/23-25
\textsuperscript{203} INQ041112/8 at paragraph 3.2, INQ041112/9 at paragraph 3.6.2
Site-specific plan

12.114 The Victoria Exchange Complex comprised a number of significant elements from a policing point of view. It functioned as a substantial transport hub, with six national railway platforms, four Metrolink tram platforms, a large indoor car park and an outdoor car park. It also functioned as an entertainment centre, with the Arena one of the largest and busiest venues in Europe, with a capacity of 21,000,\textsuperscript{204} and a go-karting track. In addition, there was office space, which increased the footfall further.\textsuperscript{205}

12.115 The freehold interest in the Arena was owned by Network Rail. This meant it was within BTP’s jurisdiction.\textsuperscript{206} The only part of the Victoria Exchange Complex not policed by BTP was the Metrolink tram platforms. These were policed by GMP.\textsuperscript{207}

12.116 While BTP has considerably larger transport hubs within its remit, the Victoria Exchange Complex was unique as it included the only major leisure venue it had responsibility to police.\textsuperscript{208} This fact alone should have been sufficient justification for BTP to operate under a site-specific plan for the
Victoria Exchange Complex. The fact that the same site hosted a busy transport hub and other facilities made the need for such a plan a necessity.\(^\text{209}\)

12.117 ACC Robin Smith was the BTP Gold Commander on the night of the Attack. He was based in the south of England. He did not know the geography of the Victoria Exchange Complex. In evidence, he stated that he would have benefited from a site-specific plan when commanding BTP’s response to the Attack.\(^\text{210}\) His evidence provided a good example of why such a plan is necessary.

12.118 This site-specific plan should have been drawn up and approved at a multi-agency level. GMRF was the natural place for this work to have been done. I note the Policing Experts stated that site-specific plans were not ordinarily prepared by local resilience forums.\(^\text{211}\) BTP was the obvious organisation to take the lead in preparing this plan. GMRF was the obvious place for it to be considered and approved by all Category 1 responders.

12.119 GMP had a site-specific contingency plan for the Arena.\(^\text{212}\) I will return to this plan when I address

\(^{209}\) 139/77/25-78/4

\(^{210}\) 94/100/6-7

\(^{211}\) INQ041870/1 at paragraph 5

\(^{212}\) INQ007219
GMP preparedness later in this Part at paragraphs 12.135 to 12.368.

Training and equipment

Training

12.120 The Policing Experts were “satisfied that all front line [BTP] officers had access to JESIP training”. This was in the form of College of Policing approved online learning, which provided for three levels of training: Police Constables and Police Community Support Officers (PCSOs); Sergeants and Inspectors; and Chief Inspectors and Superintendents. The latter two categories also received classroom-based JESIP training.

12.121 Major Incident awareness training was delivered as part of the initial training package.

12.122 The College of Policing provided training courses for Bronze, Silver and Gold Commanders. These accredited officers to command events and respond to incidents. BTP required officers to pass the public order command course in order to be authorised to command incidents. Inspectors could be trained up to Bronze level, Chief Inspectors to Silver level and Superintendents to Gold level.

213 INQ041870/38 at paragraph 172
214 INQ025614/11 at paragraphs 74-75
215 INQ025614/11 at paragraph 76
216 INQ025614/11 at paragraph 72
12.123 There is no doubt that BTP officers at the scene worked well with their counterparts at GMP to provide what treatment they could and assist casualties from the City Room. A Rendezvous Point (RVP) was also identified by a Police Constable within 15 minutes of the explosion.\(^{217}\)

12.124 However, none of the officers at the scene sought to provide a METHANE message of their own volition. Inspector Dawson repeatedly asked for a METHANE message before receiving one. All BTP officers should have been prepared by their training to recognise that at a very early stage of a Major Incident it was important for at least one of them to step back and provide a METHANE message.

12.125 The desire to help, which all of those from BTP who bravely entered the City Room were operating under, is natural and powerful. It is the function of training to override this desire when to do so is in the interests of a more effective response. The training provided by BTP failed to achieve this in any of the officers who responded.

12.126 I accept the evidence of the officers who said they had an understanding of what JESIP was.\(^{218}\) But there was a failure to embed JESIP into the muscle memory of BTP officers at the scene.

\(^{217}\) 53/22/22-23/7
\(^{218}\) 73/36/1-5, 74/7/25-8/4
This was well explained by Cl Lodge, when he candidly said of his own experience of the JESIP training: “At the time I felt trained in it, but looking back, I think with just one input I think some of those principles should have been further inset in my mind and maybe they weren’t.” As a Chief Inspector, he had access to the highest level of JESIP training provided by BTP, including a classroom-based component which Police Constables and PCSOs did not. As Senior Duty Officer, he was expected to “spot any gaps” and oversee the response. It is of substantial concern that the training had not equipped him to do this adequately.

12.127 First aid training was provided to new recruits over four days. There was a requirement for it to be refreshed annually with four hours of further training. The initial course included the provision of CPR and managing blood loss. The course was intended to enable officers to provide first aid until paramedics arrive. The evidence I received from a number of BTP officers was that they did not believe their first aid training was sufficient for the scale of the challenge with which they were confronted. This is inevitable to a
degree. This does not mean that improvements cannot be made.

12.128 For unarmed officers, the first aid training given to BTP officers did not include the applications of tourniquets. The College of Policing course did not include this on its curriculum. I will return to the issue of tourniquets when addressing the Care Gap in Part 20 in Volume 2-II.

Equipment

12.129 The equipment generally available to BTP officers in May 2017 included leg restraints and an optional first aid pouch. The optional first aid pouch contained one “revive aide”, which is used to provide mouth-to-mouth resuscitation, a pair of gloves and antiseptic wipes.

12.130 BTP officers were not issued with tourniquets as part of their personal kit. Tourniquets were not included in the green first aid kit in the cab of BTP patrol cars or in the orange grab bags which were also stored in those vehicles. I have included mention of leg restraints here because, without access to tourniquets, some officers on
the night of 22\textsuperscript{nd} May 2017 improvised using their standard issue leg restraints.\textsuperscript{228}

\textbf{Exercising}

12.131 Exercise Kestrel was a tabletop classroom training package for Major Incidents. Although it was in existence at the time of the Attack and BTP officers in the South East had received training in it, it was not delivered in C Division until after the Attack.

12.132 By the time of the Attack, many BTP officers had participated in “the Ickenham terrorism immersive exercise”.\textsuperscript{229} This was not a live exercise, in the sense that it involved role play, but it was interactive and required the discussion of a terrorist scenario.\textsuperscript{230}

12.133 As I set out in Part 7 in Volume 1, two BTP police officers attended Exercise Sherman in July 2016. This was a multi-agency exercise hosted by GMRF which involved a terrorist scenario in the City Room. It resulted in no learning for BTP,\textsuperscript{231} despite being an opportunity to consider how primacy in the response might quickly be established between BTP and GMP.

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{228} 74/21/7-21, 91/54/12-14, 133/136/17-23
\item \textsuperscript{229} 36/46/24-47/1
\item \textsuperscript{230} 36/47/4-22
\item \textsuperscript{231} 36/52/8-13
\end{enumerate}
\end{footnotesize}
12.134 BTP’s approach to exercising for scenarios like the Attack should have been more rigorous than it was. Thoughtful participation in well-designed exercises, with an effective debrief process, would have eliminated many of the problems with BTP’s response on the night of 22\textsuperscript{nd} May 2017. The JESIP teaching should have been robustly put to the test. This did not occur.

Greater Manchester Police preparedness

**Key findings**

- The effect of austerity cuts was greater on Greater Manchester Police (GMP) than some other police services. This principally affected GMP’s Planning Department and Firearms and Policy Compliance units.

- GMP had a Major Incident Plan. This plan should have been rewritten in light of the Joint Emergency Services Interoperability Principles (JESIP). It was written in the expectation of the GMP Tactical/Silver Commander attending the scene. It had not been updated to reflect GMP’s practice in 2017 of the Tactical/Silver Commander attending GMP Headquarters.
• GMP had a site-specific plan for the Victoria Exchange Complex. It had not been updated to take account of the extensive refurbishment and rearrangement which took place in 2014.

• GMP had a Silver Commanders Guide. It had not been updated to reflect JESIP. It had not been updated to reflect the Joint Operating Principles and Operation Plato. It had not been read by the Tactical/Silver Commander on duty at the time of the Attack.

• By 22\textsuperscript{nd} May 2017, there were three potentially applicable Operation Plato plans. The process by which those plans were created and managed was unsatisfactory.

• By 2017, GMP was well-aware that, in the event of an incident such as occurred on 22\textsuperscript{nd} May 2017, the Force Duty Officer could become overwhelmed or overburdened. GMP failed to take adequate steps to address this problem.

• With the exception of the Tactical/Silver Commander between 22:50 on 22\textsuperscript{nd} May 2017 and 00:00 on 23\textsuperscript{rd} May 2017, all GMP commanders who had a role in the response were competent for the role they performed.
• The Tactical/Silver Commander between 22:50 on 22\textsuperscript{nd} May 2017 and 00:00 on 23\textsuperscript{rd} May 2017 was not competent to perform the role he was required to perform in response to the Attack.

• GMP failed to embed JESIP adequately in its officers and staff prior to the Attack.

• GMP failed to train its unarmed officers in what Operation Plato was. Neither the Operational/Bronze Commander nor the Tactical/Silver Commander for the period 22:50 on 22\textsuperscript{nd} May 2017 to 00:00 on 23\textsuperscript{rd} May 2017 knew what Operation Plato was.

• GMP frontline officers were not adequately trained in first aid. This was a national issue and not the fault of GMP.

• Firearms officers should have received more training in when they should use their enhanced first aid skills.

• Firearms offices were not adequately trained in Operation Plato zoning.

• GMP dedicated an appropriate level of resources, time and commitment to exercising.
Introduction

12.135 In common with other sections in this Part, I shall consider GMP’s arrangements for the infrastructure, its planning, the training of its officers and exercising.

12.136 Unlike other sections in this Part, it has been necessary to set out the detail of the analysis, most notably in relation to GMP’s approach to Operation Plato plans. The reason for this is simple. As the evidence emerged, it was clear that GMP had caused a situation to develop in which there were multiple plans in operation by 22\textsuperscript{nd} May 2017. How that came to be is instructive for how such a situation can be avoided in future.

Infrastructure

GMP Control

12.137 The Operational Communications Branch within GMP was responsible for the collation of information received by GMP. It had two Operational Control Rooms from which radio traffic was managed. Neither of the Operational Control Rooms was based at GMP HQ. There was also a Contact Management Call Handling Centre which managed telephone calls.\textsuperscript{232} I shall refer to these collectively as GMP Control.
12.138 The FDO was based in the larger of the two Operational Control Rooms. This building was approximately 15 to 20 minutes’ driving time from GMP HQ. On the night of the Attack, the FDO was Inspector Dale Sexton. The FDO’s role included responsibility for initially acting as the Tactical/Silver Commander in response to an incident. In the event firearms were deployed, the FDO would also take up the role of Initial Tactical Firearms Commander. There was a dedicated telephone line for the FDO.

12.139 The FDO was supported by the Force Duty Supervisor. The Force Duty Supervisor sat next to the FDO in the Operational Control Room. On the night of the Attack, the Force Duty Supervisor was Ian Randall. There was a dedicated telephone line for the Force Duty Supervisor.

Force Command Module

12.140 GMP’s Force Command Module was a large room with three separate areas at GMP HQ. GMP HQ was based in the Central Park business park in the Newton Heath area of Manchester. The Force Command Module could be activated as part of GMP’s response to a Major Incident. The space could be sub-divided into three rooms

233 99/170/4-14
234 99/169/2-170/25
using intersecting doors. One area was for the Strategic/Gold Commander. It was referred to as the Gold Control Room. The other two areas were for the Tactical/Silver Commander(s). These were referred to as the Silver Control Room(s).  

12.141 The Gold Control Room and Silver Control Room had allocated spaces within them for representatives of other emergency services and responders. Personnel only occupied these rooms once they were activated. For these rooms to become operational, it was necessary to power up the facilities in them, such as the computers and radio terminals.

12.142 On the night of 22nd May 2017, the Strategic/Gold Commander, ACC Deborah Ford, took the decision not to sub-divide the Force Command Module. This meant the multi-agency strategic/gold command and tactical/silver command operated in a single space. Despite this, some of those responding on the night referred to this space as the ‘Silver Room’ or the ‘Silver Control Room’.

**Approach to planning generally**

12.143 The financial crisis of 2008 led to a period of economic recession in the UK. In 2010, that led
to the introduction of an austerity programme by the Conservative and Liberal Democrat coalition government. The period that followed is often called the ‘age of austerity’. Indeed, that is the way in which David Cameron, then Prime Minister, publicly characterised it. This period was marked by a drive to reduce public expenditure by billions of pounds each year.

12.144 Whether the age of austerity was a necessary policy and whether it was successful are issues beyond the scope of my terms of reference. Nothing I say in this Report should be interpreted as expressing a view about those issues. Nonetheless, austerity has been referred to by a number of GMP witnesses as having had an impact upon that police service’s ability to do everything that it must have recognised it was important to do. It is therefore essential that I address this issue.

12.145 A number of GMP officers gave evidence about the impact of austerity upon their work. At a corporate level, both former Chief Constable Ian Hopkins and DCC Pilling gave evidence about the level of savings that it was necessary for GMP to make. Between 2010/11 and 2017/18,
GMP’s income fell substantially from £632,987,763 to £545,394,197. The number of officers fell by 25 per cent from 8,219 to 6,159. Staff posts and PCSOs were also lost. The decrease in income and personnel is striking.

12.146 In further detail, the figures for the reduction in GMP’s total income, and for the reduction in number of officers, between 2010/11 and the financial year the Attack took place are shown in Figures 25 and 26.

Figure 25: Reduction in GMP’s total income from 2010/11 to 2017/18

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241 INQ041506/3
242 INQ041506/3-4
243 INQ041506/3
Figure 26: Year-on-year decrease in establishment figures (the number of officers for whom funding is available) from 2010 to 2018\textsuperscript{244}

12.147 GMP experienced a significantly greater cut in income than was the average across all police services in the same period. The difference arose because GMP, in common with other metropolitan police services, receives a lower portion of its income from council tax revenues than non-metropolitan police services. Consequently, a larger portion of its income comes from central government than is the case for non-metropolitan police services.\textsuperscript{245}

12.148 As a result, the reductions in central government funding hit GMP and the other metropolitan police services disproportionately hard.\textsuperscript{246} I do not know

\textsuperscript{244} INQ041506/3-4
\textsuperscript{245} 131/102/17-103/3
\textsuperscript{246} 131/102/17-103/3
to what extent this was taken into account by the Home Office in the decisions it made. I recommend that the Home Office consider the different arrangements for funding police services if a similar programme of budgetary cuts and austerity occurs in the future.

12.149 This diminution in funding was bound to have an impact upon policing within Greater Manchester, and it did. I accept that GMP had to make hard decisions about where such substantial cuts should be made.

12.150 Just as it is not for me to make a judgement about whether austerity was an appropriate policy, so it is not for me to make a judgement about whether the decisions made by GMP in this regard were appropriate. That would be outside the Inquiry’s terms of reference, and, in any event, the evidence does not enable me to make such assessments. However, what I can and will do is make observations about what the impact of this was, as a matter of fact, on the issues that are within the terms of reference.

12.151 In my view, the cuts did have a significant impact on the ability of GMP to provide an adequate public service in certain respects.

12.152 DCC Pilling said in evidence that GMP did not seek to use austerity and the cuts it necessitated as a reason or excuse “for many of the areas
where we should have done better”. 247 I am certain he is right to make that concession, but that does not mean that the cuts were irrelevant.

12.153 DCC Pilling explained that GMP decided it needed to maintain frontline staff but that this made it necessary to make reductions in other areas. That included cuts to the Planning Department, and the Firearms Training and Policy Compliance units. 248 Those cuts had a significant impact upon the matters relating to the emergency response that I considered in evidence.

12.154 Police Constable (PC) Katrina Hughes worked in the Specialist Operations Planning Unit of GMP from 2007. 249 For many years prior to the Attack, she was responsible for the maintenance of the operational planning database of GMP. Her focus was on the planning for GMP’s response to an emergency. 250 From 2012, cuts to her department meant that she was struggling to keep plans up to date. 251

12.155 In the end, it became impossible for her to achieve the aims of her department. PC Hughes raised this with a senior colleague in 2015.
Nothing changed. In 2016, she escalated this to a Chief Inspector within the Specialist Operations Planning Unit. Nothing changed, save that her workload increased. 252 I will deal with the specific impact that this had on the Arena contingency plan (the site-specific plan) and the Major Incident Plan within paragraphs 12.167 to 12.210. For now, it will suffice to observe that the evidence of PC Hughes serves to illustrate the impact that the cuts had on planning within GMP.

12.156 Further evidence of this was provided by Inspector Simon Lear. 253 He was a long-serving operational firearms officer. In 2014, he moved from an operational firearms team to assume responsibility for the Policy Compliance Unit. 254 The Policy Compliance Unit was set up as part of the Firearms Training Unit, as a result of action taken following the unlawful killing of a police officer in 2008. 255 It was separate from and independent of the operational firearms teams. That division was deliberate and was designed to enable the unit to act independently. 256

12.157 The responsibilities of the Policy Compliance Unit included the maintenance of firearms policy and

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252 37/105/25-107/6
253 66/11/25-12/7
254 66/7/20-25
255 66/6/12-18
256 66/7/4-8/9
conducting compliance checks on those policies. It was an important role. The policies were ones that concerned police operations involving the potential for lethal force to be used. The policies ought to have been kept up to date. They ought to have been comprehensive and comprehensible. They ought to have been understood by all officers likely to be involved in their implementation. For that to be achieved, the Policy Compliance Unit needed to be adequately staffed and resourced.

12.158 Inspector Lear explained that, when the Policy Compliance Unit came into existence, a Chief Inspector was in charge, supported by an Inspector, a Sergeant and three or four other members of staff. When he inherited the unit in 2014, cuts meant that he was supported only by a Sergeant and then, after about a year, he lost that officer, too. This was a very significant reduction in personnel.

12.159 To compound the strain he was under, Inspector Lear then inherited the Firearms Training Unit as well. To that point, the unit had had its own Inspector. This created a workload for Inspector Lear that was unmanageable and placed him under an intolerable degree of pressure. By the
end of 2017, it had made him unwell and it became necessary for him to move away from a firearms role altogether.\textsuperscript{260}

12.160 I was grateful to Inspector Lear for his considerable candour on this issue and other issues. His evidence served to illustrate in very stark terms the impact of austerity and the cuts it generated upon planning within GMP in the years leading up to the Attack. In simple terms, as Inspector Lear said, the Policy Compliance Unit was not adequately resourced to perform its important function properly while he was there between 2014 and 2017.\textsuperscript{261}

12.161 Superintendent Leor Giladi was part of the Specialist Operations Branch with responsibility for the Firearms Training Unit and Policy Compliance Unit during the period I considered.\textsuperscript{262} He explained that he was aware of the pressure that Inspector Lear was under. He agreed that the impact of the cuts was significant.\textsuperscript{263} When asked what he had done to address the pressure upon Inspector Lear, he said:

\textit{“Unfortunately, we were operating in a wider review of constant reviews and constant cuts.}
I don’t remember a specific occasion where I would have flagged up my concerns, but no doubt I would have, not in a formal meeting, but maybe with my line manager or others, but it was beyond my capability to, unfortunately, provide him with that extra support that was needed and the reviews were just constant throughout the branch. Throughout my time at the branch there was review after review after review, reshuffle after reshuffle, so it was [a] very, very difficult environment in which to operate."²⁶⁴

12.162 I have quoted this evidence directly because it encapsulates what was happening within this part of GMP in the lead-up to the Attack. Superintendent Giladi was an experienced and competent senior police officer. It was plain to me from his evidence that he cared about his staff. Ultimately, the financial pressures were such that there was nothing he could do to help Inspector Lear or to alleviate the difficulties that were developing in the Policy Compliance Unit.

12.163 Other witnesses who worked within the area of GMP planning expressed similar concerns about the cuts, including CI Michael Booth²⁶⁵ and Sergeant David Whittle.²⁶⁶
12.164 I have no doubt that the cuts that resulted from austerity had a damaging impact upon GMP’s planning for all emergencies. Whether that is an area in which cuts should not have been made is not a matter for me. However, cuts appear to have landed very heavily in this area, to the detriment of policing within Greater Manchester.

12.165 The result is that a vital function of policing in GMP was not operating as well as it should. As I will explain in this Part and in Part 13, this had real consequences. There was confusion about which version of the Operation Plato plan was in place. Even more significantly, no action cards had been introduced into GMP Control by the date of the Attack.²⁶⁷ I am confident the removal of resources from the planning function of GMP played a part in this, although that does not provide a complete explanation.

12.166 I do not consider that it is appropriate or possible for me to make a recommendation in this area. The most I can say is that, while frontline policing is, of course, of vital importance, the evidence has demonstrated to me that the value of those involved in planning for policing should not be underestimated. This is an issue upon which I invite His Majesty’s Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS), the
College of Policing and the Home Office to reflect. The events in Manchester demonstrate the critical role of planning in effective policing, and the consequences or potential consequences if that does not occur.

**Major Incident Plan**

12.167 GMP maintained a Major Incident Plan. It was originally compiled in 2011. It was subsequently revised a number of times. The most recent update prior to the Attack was in March 2017. This update added the Major Incident definition, references to JESIP and updates in relation to the Tactical and Strategic Co-ordinating Groups.\(^{268}\) It was 225 pages long. The Major Incident Plan was too long to be useful to anyone when responding to the early stages of a Major Incident.\(^{269}\)

12.168 The Major Incident Plan described itself as a “generic” plan for use in responding to any Major Incident.\(^{270}\)

12.169 The Major Incident Plan made clear that it was not to be read prescriptively but as a guide.\(^{271}\) It went on to state: “*The response to a Major Incident should be flexible and tailored to reflect*
the specific circumstances of the incident. Crucial to the effective management of a major incident by GMP is a robust command and control system that is quickly put into place.”272 This is an appropriate approach for GMP to take. The emphasis is rightly on gripping the incident swiftly.

Role cards

12.170 The appendices to the Major Incident Plan provided a description of the duties of the “Core Roles”.273 It referred to these as “Role Cards”. These are not the same as action cards. Action cards were created for Operation Plato and were less detailed.274 I will consider the Operation Plato action cards in paragraphs 12.219 to 12.310 when looking at the GMP Operation Plato plans.

12.171 Laminated hard copies of the role cards were stored by GMP in the Major Incident boxes within the Major Incident trailers.275 Consequently, unless the Major Incident trailer was deployed, these hard-copy role cards would not be available to anyone responding to a Major Incident. Even if the Major Incident trailer were deployed, it is unlikely it would have been on scene and accessible early in a no-notice
incident. To be useful, role cards needed to be immediately accessible from the outset to those responding whose role justified access.

12.172 It was suggested by DCC Pilling, who gave evidence on behalf of GMP, that the role cards could be read out over the radio. While this provides a potential safety net, on the night of the Attack, no one thought to ask for these cards to be read out or offered to read them out. I found this unsurprising. There was no evidence that considering the role cards in the early stages of a response formed part of the way in which GMP commanders were trained to respond. There is a risk that important steps are overlooked if available prompts, such as role or action cards, are not used.

12.173 GMP should give consideration to developing and utilising simple and focused action cards similar to those produced by the National Ambulance Resilience Unit (NARU). This would provide commanders with a reminder of the key actions. The cards should be immediately available to commanders, whether in hard copy or electronically. I will deal with the NARU action cards later in this Part at paragraph 12.450, when I turn to address NWAS’s preparedness.

276 INQ029288/58 at paragraph 301
Treatment of JESIP

12.174 A section specific to JESIP was included in the Major Incident Plan. It stated: “For larger or major incidents the responders should co-locate at the Forward Command Point where they can communicate and coordinate the response … a METHANE message (which will be an appraisal of the situation) should be used to inform Gold Control and the partner organisations.”

A number of JESIP concepts were set out on the following page. There were hyperlinks embedded in the text for those reading online.

12.175 I recognise that JESIP informed a number of parts of the Major Incident Plan, beyond the one and a half pages which are exclusively dedicated to it. However, the introduction of JESIP, which had been well established by March 2017, demanded a comprehensive rewrite. JESIP was not a bolt-on. It was fundamental to all aspects of a Major Incident response.

Major Incident declaration

12.176 The Major Incident Plan included a section which dealt with what a Major Incident is. Nowhere in this section is a statement of the need for a Major
Incident to be declared early. The Joint Doctrine stated: “It takes time for operational structures, resources and protocols to be put in place. Declaring that a major incident is in progress as soon as possible means these arrangements can be put in place as quickly as possible.”

12.177 The METHANE message was dealt with in a number of places across the Major Incident Plan. One of those places was under the initial actions of the first officer on the scene. As its first component, the person delivering the METHANE message is required to ask whether a Major Incident has been declared. The question of whether a Major Incident has been or needs to be declared was also listed as one of the initial actions of the Tactical/Silver Commander.

12.178 As no one from GMP delivered a METHANE message on the night of the Attack, the opportunities to think about whether a Major Incident had been declared as part of the composition and receipt were missed.

12.179 A clear statement of the importance of an early declaration of a Major Incident was absent from the section of the Major Incident Plan dealing

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281 INQ004542/8
282 INQ007279/72
283 INQ007279/73
with what a Major Incident is. It should not have been.

12.180 On the night of the Attack, GMP failed to recognise the importance of declaring a Major Incident early. It was not declared by any of the first officers on the scene. It was not declared by Temporary Superintendent Arif Nawaz who took up the role of Silver Commander from the FDO. GMP did not declare a Major Incident until 00:57 on 23rd May.284

Forward Command Post

12.181 The Major Incident Plan provided a description of what an FCP was and how it should be selected. It described the FCP as “the management post for the incident officer (officer in charge at that time) and the central point of contact for all emergency and support services engaged at the scene”.285 While this did not contradict the JESIP approach to an FCP, as set out in the Joint Doctrine, it failed to capture the fundamental importance of this location and the need to establish it as quickly as possible. This section of the Major Incident Plan was silent on this point.

12.182 The Joint Doctrine stated:
“When commanders are co-located, they can perform the functions of command, control and co-ordination face-to-face. They should meet as early as possible, at a jointly agreed location at the scene that is known as the Forward Command Post (FCP).”

12.183 The Major Incident Plan failed to capture the importance and urgency of establishing an FCP as expected by JESIP. This is an example of the need for a comprehensive rewrite of the Major Incident Plan incorporating the Joint Doctrine.

12.184 On the night of 22\textsuperscript{nd} May 2017, there was a failure by all emergency responders, including GMP, to recognise the importance of an FCP and the need for it to be established early. The way in which the Major Incident Plan was drafted in relation to FCPs put insufficient emphasis on the FCP’s importance to a successful response.

Tactical/Silver Commander

12.185 The Major Incident Plan used the terms ‘Silver Commander’ and ‘Tactical Commander’ interchangeably. For this reason, I will use the term ‘Tactical/Silver Commander’ when referring to a GMP commander in that role. I will adopt this approach to the ‘Strategic/Gold’ and ‘Operational/Bronze’ Commander roles, for the same reason.
Reference solely to ‘Strategic’, ‘Tactical’ or ‘Operational’ will be to the firearms commanders with those roles.

12.186 The Major Incident Plan anticipated that the FDO would initially assume the role of Tactical/Silver Commander. It envisaged that the FDO would identify an appropriate officer to take the role of Tactical/Silver Commander. At night this was expected to be the person undertaking the Night Silver role. The Strategic/Gold and Tactical/Silver Commanders were then expected to identify the other core roles that are necessary.\textsuperscript{287}

12.187 The Major Incident Plan stated:

“The overarching aim of the tactical commander is to ensure rapid and effective actions are implemented that save lives, minimise harm and mitigate the incident.”\textsuperscript{288}

12.188 This aim is achieved by, among other things, establishing “a common view of the situation between the responder agencies”\textsuperscript{289} and identifying and agreeing “a common multi-agency forward control point for all operational commanders and remain[ing] suitably located in order to maintain effective tactical command of the incident or operation and maintain shared

\textsuperscript{287} INQ007279/10
\textsuperscript{288} INQ007279/17 at paragraph 3.1.2
\textsuperscript{289} INQ007279/17 at paragraph 3.1.2
situational awareness”. I understand the term “forward control point” to mean the same as ‘Forward Command Post’.

12.189 Temporary Superintendent Nawaz was notified of the Attack at 22:39 on 22nd May 2017. He spoke to the FDO at 22:50. He was relieved of the role of Tactical/Silver Commander at 00:00 on 23rd May 2017. During that time, he failed to establish a common view of the situation between responder agencies. He did not contact the Tactical/Silver Commanders from BTP or GMFRS. His conversation with the NWAS Tactical Commander at around 23:15 failed to identify the differing approach to entry to the City Room by the two organisations. He failed to identify and agree a common multi-agency FCP.

12.190 The issue of where the Tactical/Silver Commander should locate themselves is important for the events of 22nd May 2017. Under the heading “Operational (Bronze) Commander”, the Major Incident Plan stated: “It is important that both operational and tactical commanders are easily identifiable on the ground by means of identification tabards.”

290 INQ007279/18
291 99/193/10-22, INQ018839T/5-6
292 104/33/3-14, INQ018855T/2-4
293 104/60/21-61/1
294 104/56/14-57/20
295 INQ007279/21-22
12.191 As shown in Figure 27, “Command and Control” was displayed pictorially in the Major Incident Plan. One of the entries was “Scene Tactical Commander and Silver Control”.\(^{296}\)

**Figure 27: Annotated Command and Control diagram from the Major Incident Plan\(^ {297}\)**

12.192 Appendix B to the Major Incident Plan was an entry specific to the role of Tactical/Silver Commander. The heading is as shown in Figure 28.
TACTICAL (SILVER) COMMANDER

(aka INCIDENT OFFICER) ON SCENE

IDENTIFY YOURSELF BY WEARING THE APPROPRIATE TABARD AVAILABLE FROM THE FORWARD COMMAND POD

DO NOT BECOME INVOLVED IN RESCUE OPERATIONS

IT IS VITAL TO ENSURE YOUR OWN SAFETY AND THE SAFETY OF OTHERS
DO NOT ADD YOURSELF TO THE CASUALTY LIST
APPROACHING THE SCENE WITHOUT SEEKING ADVICE COULD PROVE FATAL

Figure 28: Appendix B within the GMP Major Incident Plan

12.193 The entry continued by stating: “Wear your Incident Commander Tabard (JESIP) so that you can clearly be identified.” Further on, it stated:

“Together with the Fire Incident Officer, and Traffic Management Officer identify a common approach route for emergency services attending the Marshalling Area … The sighting [sic] of the FCP must be decided following liaison between yourself and the Fire Incident Officer in attendance.”

12.194 Taking the Major Incident Plan as a whole, the expectation communicated by the various entries above was that the Tactical/Silver Commander
would go to the scene.\textsuperscript{301} I recognise that the Major Incident Plan made clear that it was to be treated as a guide and operated flexibly. However, in taking the approach it did, the Major Incident Plan failed to recognise that a very important early decision was likely to be whether or not the Tactical/Silver Commander went to the scene or to GMP HQ.

12.195 The Major Incident Plan did not set out the factors which might be relevant to that decision. Nor did it recognise and allow for circumstances in which any provision was made to cover the actions expected of the Tactical/Silver Commander at the scene.

12.196 By May 2017, the culture which had developed within GMP was that the Tactical/Silver Commander would go to GMP HQ because of the facility there.\textsuperscript{302} This approach was not reflected anywhere in the Major Incident Plan. It should have been. Had the Major Incident Plan contemplated this decision, it is likely that careful consideration would have been given to the risk of a command vacuum at the scene in the event the Tactical/Silver Commander deployed to GMP HQ.

\begin{flushleft}
\textsuperscript{301} 37/129/9-23 \\
\textsuperscript{302} 37/126/13-128/8
\end{flushleft}
12.197 The culture of going to GMP HQ rather than the scene was not something of which Temporary Superintendent Nawaz was aware. It is a matter of significant concern that the Night Silver on 22\textsuperscript{nd} May 2017 did not know where GMP expected him to go in the event of a Major Incident. Had he travelled to the scene, which is where he believed he should go, immediately upon notification, he would have unwittingly acted contrary to the expectations of others within GMP.

**Operational/Bronze Commander**

12.198 Section 3.1.3 of the Major Incident Plan set out the “*Operational (Bronze) Commander*” role. A list of initial actions was included. The role of Operational/Bronze Commander was not identified in the list of “*core roles*” in the appendices. It should have been, as it was intended that laminated hard copies would be available for use during incidents. The roles of Inner Cordons Manager and Outer Cordons Manager were included. On the night of the Attack, Inspector Smith assumed the Operational/Bronze Commander role for GMP. In evidence, he confirmed that he was not undertaking either...
the Inner or Outer Cordons Manager role on the night.\textsuperscript{307}

12.199 The absence of an Operational/Bronze Commander role card in the appendices did not make any difference on the night of the Attack. This was because Inspector Smith did not seek to consult the role card relevant for his position. However, had Inspector Smith sought to do so, as DCC Pilling envisaged might happen, there would not have been one available. Given its importance, the Operational/Bronze Commander should have been included in the “core roles” section of the appendices.

**Treatment of GMFRS**

12.200 The Major Incident Plan had a section devoted to GMFRS. It spoke of GMFRS’s role in “firefighting, rescue and salvage operations.”\textsuperscript{308} It identified seven responsibilities. While it did identify “[l]ife-saving through search and rescue”\textsuperscript{309} as the first responsibility, the Major Incident Plan should have been much clearer about GMFRS’s capability of working with NWAS to treat and move casualties within an incident scene to an area in which they can receive care.

\textsuperscript{307} 102/165/22-166/10
\textsuperscript{308} INQ007279/26 at paragraph 3.2.2
\textsuperscript{309} INQ007279/26
12.201 None of the GMP officers at the scene recognised that GMFRS was not present during the critical period of the response.\textsuperscript{310} This was despite the challenges those in the City Room were experiencing in the emergency treatment and movement of casualties. The GMP Operational/Bronze Commander, Inspector Smith, stated in evidence: “I don’t think I realised that many, if not all, of the Fire Service personnel were trauma trained.”\textsuperscript{311} He stated that he did not know that NWAS’s Hazardous Area Response Team (HART) and GMFRS’s Specialist Response Team trained together.\textsuperscript{312}

12.202 The way the Major Incident Plan was drafted was consistent with the general lack of understanding of the importance of GMFRS’s potential contribution among GMP frontline officers. This is an important area for improvement across all areas of GMP planning and training.

Site-specific plan

12.203 GMP held a plan entitled “Contingency Plan – Phones 4U Arena” (the GMP Arena contingency plan). It was dated June 2013.\textsuperscript{313} It was updated to reflect the name change at the Arena in

\textsuperscript{310} 75/36/11-16, 75/154/17-155/3
\textsuperscript{311} 102/149/12-151/20
\textsuperscript{312} 102/149/12-151/20
\textsuperscript{313} INQ007219/2
December 2013. 314 It was marked for review in June 2016. 315 It had not been reviewed by the time of the Attack, 11 months later. 316 The need for review had been identified by GMP’s Contingency Planning Unit. The intention was that a joint plan for the entire Victoria Exchange Complex would be created. 317 Steps had been taken to progress this, but there was work still to be done by 22nd May 2017. 318

12.204 In 2014, the Victoria Exchange Complex underwent a substantial refurbishment. 319 As a result, the internal layout changed. The plan of the configuration of the Victoria Exchange Complex contained in the GMP Arena contingency plan showed the arrangement before the refurbishment and in very little detail. 320

12.205 The preface to the GMP Arena contingency plan stated:

“*This is a site specific plan designed as an aide to assist officers responding to an incident. It must be used in conjunction with the GMP Major Incident Plan.*” 321
12.206 It went on to say that “GMP is the lead agency in the preparation of this plan and all Category 1 responders have been consulted in its preparation.”

12.207 On the fourth and fifth pages, a Major Incident checklist was provided.

12.208 The GMP Arena contingency plan provided useful background information in relation to the Arena. It provided maps, contact numbers and evacuation procedures. It provided suggested RVPs.

12.209 Overall, the GMP Arena contingency plan was a potentially useful document to anyone responding to an incident, despite being in need of review. On the night of the Attack, only one person accessed it: Temporary Superintendent Nawaz. He did not find it easy to locate. He was unable to recall how much of it he read. He did not use the Major Incident checklist. He did not refer to the suggested RVPs or the maps.

12.210 A large venue such as the Arena should have had a multi-agency site-specific plan. GMP commanders should have been informed of its existence and trained in a system that allowed them immediately to access it.

322 INQ007219/4
323 INQ007219/5-6
324 104/29/15-30/8
325 104/32/7-15
326 104/33/22-34/11
Silver Commanders Guide

12.211 All Superintendents in GMP were expected to be on the Night Silver rota.\textsuperscript{327} Being a qualified public order Silver Commander was not a mandatory requirement for being a Superintendent.\textsuperscript{328} There was no specific training for the role of Night Silver. Officers who were required to undertake it were expected to ensure that they addressed training gaps themselves. They also shadowed more experienced officers.\textsuperscript{329}

12.212 GMP produced a document entitled ‘Silver Commanders Guide’. The copyright date on this document was given as 2010.\textsuperscript{330} It did not contain any reference to JESIP, from which I infer that it was not updated after JESIP was introduced. It should have been. The document was aimed at providing support to Superintendents when undertaking the role of Night Silver.\textsuperscript{331}

12.213 Before 22\textsuperscript{nd} May 2017, Temporary Superintendent Nawaz had not read the Silver Commanders Guide.\textsuperscript{332} He should have done, although it would not have given him assistance with some matters which were important on 22\textsuperscript{nd} May. Temporary
Superintendent Nawaz was not sure whether he even knew of this document’s existence before 22nd May 2017.333

12.214 The introduction to the Silver Commanders Guide began:

“The night silver superintendent provides an active role within the force and attends any serious, major or unusual events; ensuring incidents are effectively managed and properly resourced.”334

12.215 The use of the word “attends” mirrored what can be found in the Major Incident Plan: GMP’s plans were based upon an approach in which the Tactical/Silver Commander went to the scene. The assumption that the Tactical/Silver Commander would travel to the scene was reinforced in a number of places throughout the document.

12.216 Nothing in the Silver Commanders Guide provided any direct assistance to a Tactical/Silver Commander in relation to the factors relevant to the important decision of whether they should or should not go to the scene. This is a significant omission in light of GMP’s practice by 2017 of Tactical/Silver Commanders not going to the

333 104/6/3-25
334 INQ034751/10
scene. As with the Major Incident Plan, this should have been updated.

12.217 The Silver Commanders Guide had a section entitled “Terrorism”. That section said nothing about Operation Plato or what the Night Silver should do in the event Operation Plato was declared. Given the complexity of a Marauding Terrorist Firearms Attack, this was an area which should have been covered by the Silver Commanders Guide.

12.218 Aside from the Silver Commanders Guide and in any event, every officer who undertook the role of Night Silver should have been trained in Operation Plato. As I shall address shortly, this was not the case.

Operation Plato plans

12.219 Over four days between 26th and 29th November 2008, ten members of a violent Islamist extremist group called Lashkar-e-Taiba launched a series of terror attacks on civilian sites in Mumbai, India. They did so in a co-ordinated way, using automatic weapons and hand grenades. At least 174 people were murdered. This was a shocking development in global terrorism.
12.220 At this time, a body named the Association of Chief Police Officers (Terrorism and Allied Matters) (ACPO (TAM)) was responsible for delivering and co-ordinating national counter-terrorism policing and strategy in the UK. In due course, ACPO (TAM) became Counter Terrorism Policing Headquarters (CTPHQ).  

12.221 In the aftermath of what happened in Mumbai, ACPO (TAM) conducted a major review of UK planning, preparedness and response to a Mumbai-style attack.

12.222 In 2012, as a result of that review, ACPO (TAM) issued guidance. The purpose of that guidance was to assist individual police services to create a plan for responding to what was termed a Marauding Terrorist Firearms Attack. In order to ensure that common terminology was used across all police services and, indeed, across the emergency services more generally, it was agreed nationally that the operational name for such a response would be Operation Plato.

12.223 Following this national guidance, the Specialist Operations Branch of GMP devised its own Operation Plato plan. The Specialist Operations Branch had responsibility for a wide range of
specialist policing activity, including firearms policing and therefore Operation Plato. As I have explained, Superintendent Giladi was part of the Specialist Operations Branch with responsibility for the Firearms Training Unit and Policy Compliance Unit during the period I considered.

12.224 GMP’s Operation Plato plan was initially called Standard Operating Procedure 47 (SOP 47).

**Standard Operating Procedure 47 v.1 to v.3**

12.225 The first version of that plan, SOP 47 v.1, was created by Inspector Andrew Fitton on 18th July 2012 and approved on 25th July 2012. It was given a review date of 25th July 2013.

12.226 The review took place earlier than that date. The second version of the plan, SOP 47 v.2, was created by Inspector Fitton in late December 2012. The changes between v.1 and v.2 were minimal. Indeed, the only substantive change was to include a short section at page 5 that is sensitive but also irrelevant to the issues for my consideration. SOP 47 v.2 was given a review date of 25th December 2013.
12.227 Again, the review took place rather sooner than was scheduled. Inspector Roby, whose position I will address in paragraph 12.231, reviewed and updated SOP 47 in April 2013. GMP was unable to locate a copy of SOP 47 v.3 for the Inquiry. However, I heard evidence from Inspector Roby about it. Before dealing with her evidence on this issue, I will introduce the role of the FDO in greater detail as that role plays an important part in SOP 47.

**Force Duty Officer**

12.228 In the event of the declaration of Operation Plato, the FDO has a vital and pivotal role to play, certainly in the early stages of the response. I will deal with this in further detail in Part 13. Obviously, therefore, each version of the GMP Operation Plato plan ought to have dealt clearly and comprehensively with the discharge by the FDO of their responsibilities.

12.229 All police services operate a control room. The control room provides the hub of the police response to incidents 24 hours a day and 365 days a year. Police control rooms typically have a hierarchical management structure, with the FDO in charge. In some police services, such as BTP, the FDO is known as the Force Incident Manager. Where any Major Incident occurs, the FDO will

343 67/14/18-15/7
provide the initial tactical/silver command function. That includes acting as the Initial Tactical Firearms Commander.\(^{344}\) It is obvious that, in the event of a Major Incident, the FDO role will be demanding.

12.230 The Operational Communications Branch was responsible for the functioning of the control rooms, which were known as Operational Control Rooms. As I have said, I refer to this collectively as GMP Control.\(^{345}\)

12.231 Inspector Roby joined GMP in 1987. Between 1998 and 2000, as a Sergeant, she worked within GMP Control.\(^{346}\) During this period, it became necessary for Inspector Roby to understand the role of the FDO so that, in the event of a Major Incident, she could ensure the person in that role was supported. As a result, she became aware of the “massive responsibilities placed on the shoulders”\(^{347}\) of the FDO in such a situation. She believes that GMP as an organisation was aware of that burden.\(^{348}\) I accept her evidence. It follows that GMP had been aware at an organisational level of the burden that would fall upon the FDO in the event of a Major Incident occurring since

\(^{344}\) INQ024271/125
\(^{345}\) INQ029175/1 at paragraph 1
\(^{346}\) 67/4/1-19
\(^{347}\) 67/6/1-6
\(^{348}\) 67/6/19-24
the late 1990s, nearly 20 years prior to the Attack.

12.232 Another very experienced officer, Sergeant Whittle, described the role of the FDO as “an impossible task … it would be almost like being hit by a tidal wave”. 349 He was describing knowledge that both he and his colleagues had had for many years.

12.233 Inspector Roby could not recall having updated SOP 47 v.2, so as to create SOP 47 v.3. She explained by reference to her general approach that she would not have had the authority to put v.3 into circulation. 350 Instead, she would have made any amendments to v.2 that seemed to her to be necessary before sending it on for approval. She stated that prior to doing this work, she had received no training in Operation Plato and had no experience or training as a firearms officer. Moreover, she thought it unlikely she would have considered the role of the FDO in the work of review that she did. 351

12.234 Inspector Roby, for all her experience and obvious qualities, was plainly not the right person to review the Operation Plato plan. She was unable to recall to whom, if anyone, v.3 was
sent.\textsuperscript{352} Her expectation was that someone with firearms experience would have considered v.3 before it was approved by Superintendent Giladi for release. I have seen no evidence that this occurred or that there was any procedure in place that would have required it to happen. This is a criticism of GMP as an organisation, not of Inspector Roby.

12.235 All policies should be reviewed regularly. They should be reviewed by those with the skills and experience to assess them properly so as to make meaningful improvements. Where changes are made to a policy, they should be clearly visible and the fact that there has been a change should be apparent. I recommend that the College of Policing, the Home Office and HMICFRS consider issuing guidance to this effect. The problem with the development of v.3 was replicated throughout the course of GMP’s approach to its Operation Plato policy.

Standard Operating Procedure 47 v.4

12.236 SOP 47 v.3 appears to have remained in operation for a period of 18 months. It was then reviewed by Sergeant Simon Wright in October 2014. He produced SOP 47 v.4.\textsuperscript{353} He made only limited changes to v.3, although v.4

\textsuperscript{352} 67/16/3-21
\textsuperscript{353} INQ040146/1-2
did give the FDO the additional responsibility of notifying particular assets of the incident.\textsuperscript{354}

12.237 SOP 47 v.4 was given a review date of October 2015.\textsuperscript{355} That review did not occur. Superintendent Giladi said that was down to a lack of staff in the Policy Compliance Unit.\textsuperscript{356} I accept that evidence. This provides a clear example of how cuts were having a real effect within GMP.

**Standard Operating Procedure 47 v.5**

12.238 The next significant event in the relevant chronology involved a counter-terrorism inspection by HMICFRS. Andrew Buchan was an Associate Inspector and led HMICFRS’s specialist inspections programme over the period that I considered.\textsuperscript{357} He was responsible for a nationwide inspection known as Counter-Terrorism Policing Part 2 or CT2.\textsuperscript{358}

12.239 This inspection was focused on police services’ preparedness for a terrorist attack, particularly a Marauding Terrorist Firearms Attack. A number of police services were visited between October 2016 and March 2017, including GMP. The visit to GMP was scheduled for between

\textsuperscript{354} INQ040146/7
\textsuperscript{355} INQ040146/2
\textsuperscript{356} 91/109/2-110/9
\textsuperscript{357} 61/5/2-25
\textsuperscript{358} 61/6/1-4
31st October and 4th November 2016, and the evidence indicated that it did take place between those dates.  

12.240 In 2016, Catherine Hankinson was a Chief Superintendent within GMP. On 1st October 2016, she commenced a period of temporary ACC duties. She assumed responsibility for the Specialist Operations portfolio. Shortly after her appointment, Temporary ACC Hankinson became aware of the impending visit of HMICFRS. She received an email from the Inspectorate on 14th October 2016 which made clear that the inspection would look at how well set up police services were to respond to a Marauding Terrorist Firearms Attack. Other emails made clear to her that a focus would be on how the FDO coped with the first four hours of such an attack. These were matters within her area of responsibility. 

12.241 Understandably, Temporary ACC Hankinson set about preparing for the visit of HMICFRS. At 14:35 on Sunday 30th October 2016, as part of that work, Temporary ACC Hankinson emailed Superintendent Giladi and another senior officer, stating:

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359  61/13/10-24
360  127/75/14-79/1
“Not sure who’s in order Monday, but need one of you to action this. All forces received a letter from ACC Chris Shead NPOCC [National Police Coordination Centre] in August dated 10th Aug relating to National Armed policing spontaneous mobilisation update. It reiterated the instruction that if we were dealing with an MTFA [Marauding Terrorist Firearms Attack] type incident, that neighbouring forces would send [X] ARVs [Armed Response Vehicles] to the affected force. It specifically requires us to review our Op Plato plans to take account of this and ensure our commander’s and FDOs are aware. Our Plato plan seems to need review and this needs to be done urgently given HMIC [Her Majesty’s Inspectorate of Constabulary] are here Tuesday. Can you ensure its [sic] updated and then circulate to relevant people …”

12.242 The email refers to a need to review SOP 47 v.4 for a particular purpose, namely to address the issue of cross-border co-operation. However, by this stage, a review of the plan was a year overdue, and in that period the third edition of JOPs had been issued. JOPs 3 was of obvious relevance to GMP’s Operation Plato plan. In these circumstances, a comprehensive review
of SOP 47 v.4 was called for. That is what should have happened. It did not.

12.243 Ultimately, Superintendent Giladi assumed responsibility for the review of SOP 47 v.4. He endorsed v.5 to indicate that it was the product of a review and update in October 2016. It appears, therefore, that he conducted his work over the course of Sunday 30th October 2016 and/or Monday 31st October 2016 so as to ensure SOP 47 v.5 was ready, as instructed, by Tuesday 1st November 2016. He produced SOP 47 v.5 by making only limited changes to SOP 47 v.4.

12.244 There are a number of troubling aspects to the circumstances in which SOP 47 v.5 was created. First, Superintendent Giladi had never worked as an FDO or received any training in that role. He did not recall anyone ever pointing out to him that, in the event of the declaration of Operation Plato, the FDO might be the single point of failure. He accepted that in October 2016 he did not fully grasp the pressures the FDO would be under in such a situation, even with support.

12.245 Given the central role the FDO had in the response to a declaration of Operation Plato, the person reviewing the plan needed to have a
detailed knowledge of what that role involved or the support of someone else who did. Superintendent Giladi had neither. He was not an appropriate person to carry out this work. I do not regard either Superintendent Giladi or Temporary ACC Hankinson as being at personal fault in this regard. Each had been put in a position they should not have been in. The fault is GMP’s at a corporate level.

12.246 Second, Superintendent Giladi was required to produce SOP 47 v.5 under a pressure of time that was unrealistic and unreasonable. As Superintendent Giladi accepted, the pressure of time meant that the policy was not reviewed in the detail that was required. He recognised that there ought to have been a thorough review of the whole document. The timescales made that impossible. Once more, the fault in this rests with GMP corporately. Neither Temporary ACC Hankinson nor Superintendent Giladi should have been placed in this position.

12.247 Third, someone who lacked the experience to review the Operation Plato plan was required to conduct that review in a timescale that would have been inadequate even for an expert. In considering that unacceptable state of affairs, it is
relevant to note that the plan in question was not one of limited importance.

12.248 It was a plan designed to eliminate a terrorist threat and protect innocent life in the event of an attack by marauding terrorists with firearms. It could hardly have been more important. That gives rise to the question of why something so significant was being dealt with in such an unsatisfactory way. The answer is clear. SOP 47 v.5 did not represent a meaningful attempt by GMP to reassess the Operation Plato plan. It was designed to ensure that HMICFRS did not identify a failure by GMP to have an up-to-date plan. It was window dressing.

Findings of HM Inspectorate of Constabulary and Fire and Rescue Services Inspectors

12.249 As GMP intended, the hastily prepared SOP 47 v.5 was the plan that HMICFRS was provided with and which it considered during its inspection. One of those who carried out the HMICFRS inspection was John Bunn. He prepared a review of the plan, which contained the following relevant findings.

12.250 In relation to the FDO, John Bunn found:

“The evidence indicates that the FDO is expected to control the early stages of a Plato
and to call out and inform various roles, ranks and units. This evidence is set out in bullet points, with no narrative. The number of tasks the FDO is expected to perform, in all likelihood are so many that it may be that some will not be completed or at least not in the order expected which is acknowledged in the force plan. One point the force plan makes is the pressure the FDO is going to be under including transfer of command to a Cadre Tactical Firearms Commander. This is raised in a paragraph as ‘will bring its own challenges’ but there is no resolution to this question and it is left unresolved.”367

12.251 He assessed the impact of this as follows:

“Such apparent vagueness may cause confusion or doubt in a live scenario. There is a need to provide the FDO with more immediate support or resources to assist with all the functions expected of that role.”368

12.252 John Bunn also found that the plan lacked:

“… details and relevant information and is very tactical dealing in large part with the armed roles of ARVs [Armed Response Vehicles], OFCs [Operational Firearms Commanders], TFC [Tactical Firearms
Commander] cadre, SFCs [Strategic Firearms Commanders] and the FDO. Initial response to a possible Plato by first responders, unarmed is a gap that requires to be covered. There is no question that the FDO is being overloaded with tasks in the initial stages of a potential Plato and will require urgent help. No Referencing to imaging transfer. No specific reference to the initial information/intelligence gathering within the FCR [Force Control Room].”

12.253 Those findings were unsurprising and correct. Andrew Buchan described the following in evidence. First, SOP 47 v.5 was very tactical and focused on the roles, responsibilities and tactics of firearms officers and firearms commanders. There was no mention in the plan of working with other agencies responding to the incident, although there were isolated, bullet point references to JESIP. The plan included the stay safe guidance but did not identify how this would be communicated to those responding to a terrorist attack.

12.254 Second, HMICFRS was well aware of the extreme burden that the FDO would come under in the event of the declaration of Operation Plato. HMICFRS considered that SOP 47 v.5 placed an

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369 INQ008345/5
370 61/73/1-74/18
over-reliance on the FDO to complete a significant number of functions in the early stages of a terrorist attack. It was the view of HMICFRS that GMP needed to provide more support to the FDO, allowing that person to focus on commanding the initial response.\textsuperscript{371}

12.255 SOP 47 v.5 also contained obvious errors. It contained a list of reference documents.\textsuperscript{372} It was, in any event, undesirable to cross-reference a series of other documents in a plan that should have been internally comprehensible by someone likely to be operating under considerable pressure. What is more, the list was inaccurate. It referred to the second edition of JOPs, when the third edition was by then in force. This seems to me likely to represent a gap in Superintendent Giladi’s knowledge for which he is not to blame, as opposed to being a typographical error. Furthermore, the plan referred to a regional policy that had never been in force.\textsuperscript{373}

12.256 HMICFRS’s report at the conclusion of Counter-Terrorism Policing Part 2 was not available to GMP until after the Attack. However, at the conclusion of the inspection within GMP, Andrew Buchan conducted a “hot debrief” with

\begin{flushright}
371 61/74/19-76/19
372 INQ039970/2
373 66/38/18-39/25
\end{flushright}
Temporary ACC Hankinson. This took place on 3\textsuperscript{rd} November 2016. Andrew Buchan explained in evidence that at this debrief he had described to Temporary ACC Hankinson the evidence that had been gathered during the inspection.\textsuperscript{374} He was clear that this included informing her about the risk that the FDO would become overburdened in an Operation Plato situation and the need for something to be done about this urgently within GMP.\textsuperscript{375}

12.257 Temporary ACC Hankinson was unable to recall this meeting with Andrew Buchan.\textsuperscript{376} She accepted, having regard to a handwritten note she had made\textsuperscript{377} and to an email she sent to her Chief Officer colleagues on 3\textsuperscript{rd} November 2016,\textsuperscript{378} that the hot debrief had taken place that day. She accepted, too, that the role of the FDO had been raised with her. Indeed, in her handwritten note, she had written: “[I]s there enough resilience around FDO[?]”

12.258 Before giving evidence to me, Temporary ACC Hankinson had attempted to work out or reconstruct what her note and email meant she had been told by Andrew Buchan. The view she
initially came to was that what was being communicated to her was not a risk that the FDO would become overburdened or overwhelmed, but instead the importance of support for the person in that role.\textsuperscript{379} It was further her initial view that, in any event, she was not being told of something that required urgent attention.\textsuperscript{380}

12.259 While I do not doubt that Temporary ACC Hankinson was doing her best to help me, I have come to the conclusion that Andrew Buchan is correct in his evidence that he briefed her about the risk of the FDO becoming overburdened and of the need to address this urgently.

12.260 First, HMICFRS went in to its inspection of GMP with a concern that, in an Operation Plato situation, the FDO would become overburdened and came out of the inspection of GMP with that concern reinforced. The issue of the FDO was raised in the hot debrief, and I can identify no credible reason why Andrew Buchan would have done anything other than set out the full intensity of the concerns of HMICFRS in that meeting. In evidence, Temporary ACC Hankinson realistically accepted this logic.\textsuperscript{381}
12.261 Second, when questioned in the oral evidence hearings, Temporary ACC Hankinson ultimately accepted that it was likely that what was being communicated to her by Andrew Buchan was indeed the issue of whether the FDO would be able to cope in the event of an Operation Plato declaration and that what was being described was something that in fact required urgent attention, even if she did not accept that Andrew Buchan had emphasised the need for urgency. This was a fair and realistic concession by Temporary ACC Hankinson.

12.262 To her credit, Temporary ACC Hankinson did take action in response to what she was told in the hot debrief. At 19:36 on 3\textsuperscript{rd} November 2016, the day of the meeting itself, she sent an email to the GMP Chief Officers.

12.263 Her email makes clear that a number of issues had been raised by Andrew Buchan, including the absence of training of unarmed staff in Operation Plato, an issue to which I will turn in due course. The FDO issue was also raised. The first “area for development” identified by Temporary ACC Hankinson was in the following terms:

“\textit{Is there enough resilience around the FDOs in the event we have an MTFA [Marauding Terrorist Firearms Attack] style incident? This}”

\footnote{127/93/2-94/4, 127/168/23-170/3}
wasn’t really about numbers of people, but about people having specific roles in specific seats. Our FDOs were able to evidence that they had picked this up from exercising during summer and they were on with producing guidance and crib cards for colleagues. HMIC [Her Majesty’s Inspectorate of Constabulary] did accept that our current IT hampered us but are aware this is being upgraded.”

12.264 What this email does not do is make clear the extent of HMICFRS’s concerns about the risk of the FDO being overwhelmed. Nor does it state the need for urgent action that I am satisfied Andrew Buchan explained to Temporary ACC Hankinson. Temporary ACC Hankinson could not recall sending the email and was therefore unable to explain from memory why her email had not achieved these two important aims. The explanation, in my view, is complex.

12.265 At the time of her appointment, Temporary ACC Hankinson had no recent experience of the Specialist Operations Branch and was unaware of GMP’s corporate knowledge of the risk that the FDO would become overburdened in an Operation Plato situation. That was not her fault. Again, this was the position she had been
placed in by GMP. Had she had such knowledge, I am satisfied that Andrew Buchan’s indication of urgency would have struck home in a way that it did not.

12.266 Temporary ACC Hankinson plainly also thought that what was being described to her was a national problem; indeed, she said as much in her email. As a result, she thought that the solution would be a national one and not something for GMP to address individually.386

12.267 In any event, her understanding was that work was already under way within GMP to ensure that, in the event of an Operation Plato situation, the FDO would be properly supported by staff around them who would understand, through the use of action cards, the tasks that had been delegated to them.387 It is understandable that Temporary ACC Hankinson should have thought that, although she acknowledged that something had ultimately gone wrong, namely that action cards had not been embedded,388 an issue to which I shall turn towards the end of Part 12.

12.268 Temporary ACC Hankinson was right to email her senior colleagues, but she should have made clear in her message the extent of the risk and

386 127/170/25-171/5
387 127/69/4-72/17
388 127/98/23-99/6
the need for urgent action. Moreover, given her responsibility for the Specialist Operations Branch, she should have done more to follow up what was being done to address the issue within GMP. These failures are mitigated by the matters I have set out, but only in part.

12.269 GMP, as an organisation, bears the main responsibility for the lack of action. It had longstanding corporate knowledge of the risk that the FDO would become overburdened in the event that Operation Plato was declared. Here, in the hot debrief, was confirmation by HMICFRS of that risk. There was a need for urgent action. The necessary action included, but went beyond, the introduction and embedding of action cards. The necessary action did not occur.

12.270 One of the things that should have happened was that information about the inadequacies identified by HMICFRS in SOP 47 v.5 should have been communicated beyond the Chief Officer Group. In particular, the Policy Compliance Unit should have been informed, given their central role in the review of plans. That did not happen.

12.271 Inspector Lear, who as I have explained headed the Policy Compliance Unit at this time, stated that if the views of HMICFRS had been communicated to the Policy Compliance Unit
promptly after the 3rd November 2016 hot debrief, then work on reviewing SOP 47 v.5 would have started immediately.\footnote{389} Given the pressure on the Policy Compliance Unit, I doubt work would in fact have started straight away, but I do accept that this issue would have moved up the list of priorities. I accept that the work of review would have started long before it in fact did on 2\textsuperscript{nd} May 2017.

**Counter Terrorism Policing Headquarters**

**Operation Plato guidance**

12.272 At the same time as HMICFRS was undertaking its fieldwork as part of Counter-Terrorism Policing Part 2, CTPHQ (as it had become) was reviewing the original ACPO (TAM) Operation Plato guidance. Both Andrew Buchan and CI Richard Thomas, CTPHQ’s Head of Specialist and Counter-Terrorism Armed Policing, explained that during this period, their two organisations co-ordinated.\footnote{390} HMICFRS wanted to ensure that CTPHQ had knowledge of its findings prior to publication of the Counter-Terrorism Policing Part 2 report, which did not happen until August 2017.\footnote{391} That was good practice.
12.273 In March 2017, CTPHQ published its refreshed Operation Plato guidance.\textsuperscript{392} This took into account the findings of Andrew Buchan’s HMICFRS team, even though the Counter-Terrorism Policing Part 2 report had not by that stage been published.

12.274 On 23\textsuperscript{rd} March 2017, the refreshed guidance was circulated to all UK police services.\textsuperscript{393} This was accompanied by a letter dated on the same day from Chief Constable Francis Habgood, the National Police Chiefs’ Council Lead for this policy area.\textsuperscript{394} The National Police Chiefs’ Council had by this stage succeeded to the role and responsibilities of ACPO. The day before the letter, the Westminster Bridge terror attack had taken place: an attacker had driven a car into pedestrians, killing four and injuring many others; he then left the vehicle and fatally stabbed a police officer, before being shot dead by a firearms officer.

12.275 The opening paragraph of Chief Constable Habgood’s letter read:

\textit{“My purpose in writing to you, is to share with you the new national PLATO guidance for UK policing. In light of the terrorist attack in}
London yesterday, I would encourage you to commission an urgent review of your local PLATO response plans against this new national guidance (attached). You will see that the refreshed guidance includes sections relating to operational staff and supervisors, control room staff and firearms commanders (including control room based initial commanders).”395

The Whittle Plan

12.276 An email chain shows that the following then happened within GMP.396 At 14:58 on 28th March 2017, Chief Constable Hopkins emailed DCC Pilling and ACC Robert Potts to suggest that they task officers to ensure GMP’s Operation Plato plan contained what CTPHQ considered it should contain. His email made plain that he expected a formal report then to be made to the Chief Officer Group. Chief Constable Hopkins was acting promptly, which is to his credit, but he did not follow up on this important issue. He should have done.397

12.277 At 16:17 the same day, ACC Potts delegated this task to Superintendent Giladi who, for reasons I have explained, was ill-equipped to perform it personally. Superintendent Giladi confirmed in

395 INQ016686/1
396 INQ040408/3
397 137/13/16-15/25
evidence that he understood he was being instructed to ensure that the Operation Plato plan was in proper order and report back to the Chief Officer Group.\footnote{398}

12.278 Chief Constable Hopkins explained that the next meeting of the Chief Officer Group took place on 27\textsuperscript{th} April 2017.\footnote{399} He agreed that there was no mention in the minutes of that meeting of the Operation Plato plan. It had been overlooked. That, he acknowledged, was not good enough.\footnote{400} I agree. This was an issue of the utmost importance, which should have been high up on the agenda. The fact that it fell off the agenda is likely, in my view, to have contributed to the delay that occurred.

12.279 In any event, even if the issue of the Operation Plato plan had been scheduled for discussion at that meeting, there would have been nothing for the Chief Officers to look at. That is because nothing effective appears to have been done in response to the Chief Constable’s instruction for over a month.

12.280 Although not revealed by the email chain, Inspector Lear confirmed that, on 6\textsuperscript{th} April 2017, he had received an email from Superintendent

\footnote{398}{84/182/17-184/7} \footnote{399}{137/13/7-14/19} \footnote{400}{137/14/14-16/15}
Giladi directing him to ask Sergeant Whittle to update the Operation Plato plan.\textsuperscript{401} The evidence did not reveal what was done in the three weeks that followed, although Inspector Lear said he had spoken to Sergeant Whittle.\textsuperscript{402}

12.281 At 12:05 on 29\textsuperscript{th} April 2017, ACC Potts chased Superintendent Giladi by email indicating that the plan was needed for the May meeting of the Chief Officer Group. In evidence, Superintendent Giladi made clear that he would not have ignored an instruction from a Chief Officer but could not recall why nothing appeared to have been done to progress work on the plan before then. He agreed that it looked like a month had been lost.\textsuperscript{403}

12.282 At 10:27 on 2\textsuperscript{nd} May 2017, three days later, Superintendent Giladi raised with Inspector Lear the preparation of the plan.\textsuperscript{404} Inspector Lear replied six minutes later. Subsequent exchanges between the two of them on the same day indicate that Inspector Lear felt under time pressure to produce the new plan.\textsuperscript{405} That is hardly surprising.

\textsuperscript{401}66/46/1-47/19
\textsuperscript{402}66/47/20-25
\textsuperscript{403}84/184/8-24
\textsuperscript{404}INQ040408/2
\textsuperscript{405}84/185/4-187/7
12.283 The subject line of the email had originally read “Questions for MTFA [Marauding Terrorist Firearms Attack]”. On forwarding the chain to Inspector Lear, Superintendent Giladi added to this so that it read “Questions for MTFA PLATO REVIEW URGENT!!!!!!”. Inspector Lear explained in evidence that he understood the plan was required by 5th May 2017, three days later.

12.284 Substantial time was lost between the email of Chief Constable Hopkins on 28th March 2017 and the events of 2nd May 2017. The chronology did not explain what happened during this period, and so I am not in a position to criticise any officer. However, it is a fact that the three days from 2nd May 2017 plainly did not provide a sufficient period to prepare an adequate updated Operation Plato plan.

12.285 In early May 2017, Inspector Lear still had the benefit of Sergeant Whittle’s support in the Policy Compliance Unit. Inspector Lear delegated the task of complying with the Chief Constable’s instruction to Sergeant Whittle, although precisely when he did so is not entirely clear. By 4th May 2017, two days after Superintendent Giladi’s email, Sergeant Whittle had produced what the Inquiry termed “the Whittle Plan” during
the course of the evidence. For reasons that I will explain, it was badged “North West Armed Policing Collaboration” and was entitled “Operation Plato – Initial Response to a Marauding Terrorist Firearms Attack (MTFA) by North West Region”.

12.286 Just as there are a number of troubling aspects with the circumstances in which SOP 47 v.5 was created, so there are a number of troubling aspects with the circumstances in which the Whittle Plan was created.

12.287 First, not for the first time, a piece of work that was of a high degree of importance was being prepared in a rush. In his evidence, Inspector Lear explained that he could not understand why there was this rush. He was satisfied that, had he been tasked to arrange an updated Operation Plato plan shortly after the hot debrief on 3rd November 2016 or indeed at any point that allowed time for proper research and reflection, the product would have been better.

12.288 For example, Inspector Lear recognised that the Whittle Plan placed obligations not only on the firearms officers and unarmed officers who might deploy to the scene but also on the staff in GMP Control. Inspector Lear explained that more time
would have enabled liaison to have taken place with colleagues in GMP Control in relation to the support they needed, for example the important issue of action cards. In the end, Sergeant Whittle was given just a few days to finalise the plan. What was required was impossible to achieve in that timescale.

12.289 Second, as I have explained, HMICFRS identified what I regard as significant inadequacies with the approach to Operation Plato reflected in SOP 47 v.5, namely whether the FDO would be able to cope in the event of an Operation Plato event and the absence of training of unarmed staff in Operation Plato. These two issues were communicated to GMP in the hot debrief of 3rd November 2016. Inspector Lear and Sergeant Whittle plainly needed to be informed that HMICFRS had identified these issues if they were to produce an adequate Operation Plato plan.

12.290 Inspector Lear confirmed that no one told him about the issues identified by HMICFRS. He was therefore unable to tell Sergeant Whittle. Sergeant Whittle understandably observed in evidence that it would have been better if he had known these facts. GMP should have ensured

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410 66/18/4-28/12
411 66/18/4-11
412 65/96/17-24
that these officers knew what had been identified by HMICFRS.

12.291 Third, a degree of confusion seems to me to have crept into what was expected of Inspector Lear and then Sergeant Whittle. At this time, there existed a hierarchy of provisions beneath the CTPHQ guidance. An organisation called the North West Armed Policing Collaboration was brought into existence in 2012. It represented a number of police services in the North West, including GMP.

12.292 The North West Armed Policing Collaboration created a series of plans. The top layer of those plans involved a plan that addressed cross-border armed support. Beneath that was a regional policy that dealt with how the North West as a region would respond to a Marauding Terrorist Firearms Attack. This was known as Appendix C, and Version 10 was in force at the time I am considering.

12.293 Inspector Lear understood that he had been instructed to create a plan that would replace Appendix C and SOP 47 v.5 and that would therefore be a plan for the whole of the North West. Sergeant Whittle understood that he had

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413 65/65/23-68/20
414 INQ017233/1, 65/67/22-68/13
415 66/49/1-50/8
been instructed to create a plan that would replace Appendix C but that SOP 47 v.5 would continue to run beneath it as a plan for GMP only, at least initially. 416

12.294 Either way, the reason why Sergeant Whittle marked his plan v.2 was because it was a development on Appendix C v.10. What he appears to have been asked for was simply a replacement for the GMP plan, namely SOP 47 v.5, but that was not made clear to him. 417

12.295 Ultimately, the North West Armed Policing Collaboration declined to accept the Whittle Plan as the regional policy. 418

12.296 The confusion about what Inspector Lear and Sergeant Whittle were actually required to produce serves to underline that GMP was approaching an important task in a way that was inadequate. It lacked structure. Those actually doing the job lacked information, and the work was required to be completed in too short a timescale.

12.297 Unsurprisingly, given the circumstances in which it was created, the Whittle Plan was flawed.
12.298 SOP 47 v.5 contained a section dealing with FDO actions. It provided: “[T]he FDO will need strong support from the OCB [Operational Communications Branch] team. Some of the actions are likely to be delegated to OCB supervision.”\(^{419}\) So, this plan at least acknowledged that the FDO would be incapable of personally discharging all of the responsibilities listed, although it said nothing about when or how support would be provided.

12.299 The Whittle Plan then removed any reference to delegation, creating the impression that all listed tasks were ones for the FDO.\(^{420}\) It added substantially to the responsibilities on the FDO in the event of an Operation Plato declaration.\(^{421}\) The Whittle Plan made worse the risk of the FDO being overburdened in such a situation. I do not blame Sergeant Whittle or Inspector Lear for that. They were acting without the information they required and under an unacceptable pressure of time. The fault was that of GMP itself.

12.300 In the period prior to the Attack, GMP’s approach to its Operation Plato policy was inadequate.

12.301 On 12\(^{th}\) May 2017, Inspector Lear circulated the Whittle Plan and other documents to a variety of
recipients, including all FDOs and some Chief Officers. The email related to command training for the year 2017/18. This email was sent at a time of significant pressure for the Policy Compliance Unit and Inspector Lear in particular.

12.302 Nonetheless, as Inspector Lear acknowledged, there were problems with this communication. The email made no reference to the relationship between Appendix C v.10, SOP 47 v.5 and the Whittle Plan. The version of the Whittle Plan that was attached was marked with the word “Draft”. Inspector Lear said this may have been a clerical error. The email did not indicate to the recipients which plan they ought to follow in the event of the declaration of Operation Plato, and the training that was proposed was months in the future. This was a highly undesirable and confusing situation which had been allowed to develop.

Three plans

12.303 By 22\textsuperscript{nd} May 2017, there were three Operation Plato plans which were capable of applying to GMP: the regional plan Appendix C v.10, and the GMP plans SOP 47 v.5 and the Whittle Plan. They were not consistent. The problem this
created was real, not imagined. The evidence revealed that different officers, including those who performed vital roles, had different views about which plan was the one that ought to be followed on the night of the Attack. 426

12.304 Furthermore, GMP appears to have allowed an ad hoc system to develop in which officers would digest the available policies and create their own “crib sheet”, as Sergeant Whittle described it. 427

12.305 This was an unacceptable state of affairs. Something so important should have been organised by GMP and gone through a proper approval process.

12.306 I cannot be sure what effect this chaotic state of affairs had on the events of 22\textsuperscript{nd} May 2017. I am sure that, had the planning for an Operation Plato declaration been approached competently by GMP, action cards would have been available within GMP Control on the night. That would have reduced the burden on the FDO. Whether that would have made a material difference to the outcome, I do not know, but it may have done.

12.307 The situation that GMP allowed to develop was dangerous. Even if it led to no loss of life on 22\textsuperscript{nd} May 2017, it was capable of doing so.
GMP’s approach to its Operation Plato plan deserves significant criticism.

12.308 This situation should never have happened and should never happen again, not just in Manchester but anywhere in the country.

12.309 All police services must recognise the importance of planning. Even if pressure on resources exists, no police services should allow a situation to develop in which planning for a Major Incident assumes the low level of priority that it assumed in GMP between at least 2013 and 2017.

12.310 I recommend that HMICFRS, the College of Policing, CTPHQ and the Home Office work together to put in place robust systems, policies and guidance to ensure all police services have sufficient resources dedicated to the operational plans, particularly for responding to Major Incidents, including terrorist attacks.

Training

Force Duty Officer training

12.311 Inspector Sexton was the FDO for GMP on the night of the Attack. In evidence, he explained what that role involved. Along with managing day-to-day business across the service, he had responsibility for the initial command and control.
of major critical incidents. That included acting as Initial Tactical Firearms Commander in the event that a firearms response was required. It also included having authority to activate GMP’s emergency plans, such as the Operation Plato plan.

12.312 As is obvious, Major Incidents can occur spontaneously. In the early stages of such an event, the command structure needed to address the incident is unlikely to be in place. The FDO is intended to fill what would otherwise be a void. During that period, the FDO will be making decisions at a strategic level, a tactical level and an operational level. It is a role that is both important and demanding.

12.313 By 2017, Inspector Sexton was an experienced police officer. He joined GMP in 1991 and by 2001 had reached the rank of Inspector. He had principally worked as a uniformed officer. Prior to 2014, he had no experience of firearms operations, save that while working as a uniformed response inspector he had on occasion performed the role of unarmed Operational/Bronze Commander for firearms operations.
Incidents. In 2014, he applied to join the FDO cohort. He was successful in that application and was appointed as an FDO in June 2014. By that stage, he had 23 years’ experience as a police officer.

Inspector Sexton carried out a period of FDO training prior to undertaking the role. This involved being mentored for a number of months. It also involved training as an Initial Tactical Firearms Commander. Inspector Sexton agreed that, by the night of the Attack, he was familiar with JESIP and with the importance of the emergency services co-locating in the event of a Major Incident.

One topic on which Inspector Sexton did not receive dedicated training prior to the Attack was Operation Plato. He explained that he did receive annual training in order to maintain his accreditation as a firearms commander. Inspector Sexton set out that this training included a component on Operation Plato. Subsequent to the Attack, Inspector Sexton attended a course that was dedicated exclusively to Operation Plato. While he did not consider attendance on that course revealed any gaps in his May 2017 knowledge, I consider that there was more that
he needed to know prior to the night of the Attack. In particular, he had not received any specific training in zoning. That is a critical aspect of the declaration of Operation Plato. I recommend that in future all FDOs and Force Incident Managers attend a comprehensive course that is dedicated to Operation Plato before taking up their role.

12.316 That training should ensure that all FDOs understand the exceptional demands that will be placed upon them in the event of an Operation Plato declaration, even if proper support is available to them. It should also ensure that: they understand the need to carry out regular reviews of the declaration of Operation Plato; they understand the need to identify with clarity the zones into which different emergency responders may enter; they communicate those zones to all emergency services promptly; and they keep their zoning decisions and the declaration of Operation Plato more generally under review. The training should ensure that each emergency service understands the need to work jointly with partners and that there is a mutual appreciation of how commanders of other emergency services apply Operation Plato. The need to work jointly with emergency service partners must be ingrained. None of this was achieved on the night
of the Attack. This recommendation is directed to all emergency services and their supervisory bodies.

12.317 Having been trained, Inspector Sexton regularly undertook the role of GMP FDO prior to May 2017. That included being Initial Tactical Firearms Commander for a large number of firearms incidents.\textsuperscript{437} He also performed the role of Initial Tactical Firearms Commander during training exercises in early 2016 and through that had gained some experience of zoning.\textsuperscript{438} That was no substitute for thorough training on that important issue. By the date of the Attack, Inspector Sexton regarded himself as highly experienced in the role of FDO. He was confident in his training and experience.\textsuperscript{439} Of course, he did not know what he did not know. Nor, in my view, was he prepared by his training and experience for what confronted him on the night of the Attack.

12.318 I accept that in general terms Inspector Sexton was a professional and committed police officer. He was undoubtedly competent to deal with the overwhelming majority of incidents that confronted the GMP FDO. However, as I will come on to explain in Part 13, on the night of the
Attack he failed in a number of important respects. Those failures, in turn, played a major part in the total failure of joint working that night.

12.319 I consider Inspector Sexton’s failures to be the consequence of two connected things.

12.320 First, notwithstanding his training and experience, the importance of joint working, namely JESIP, had not become sufficiently ingrained in Inspector Sexton. Nor had he developed the skills to deal with the situation with which he was confronted. This is why I have made a recommendation in relation to FDO training.

12.321 Second, the sheer scale of the task that confronted Inspector Sexton that night was capable of overwhelming any FDO. As I have explained, GMP well knew that in an Operation Plato situation there was a real risk that the FDO would be overburdened. In Part 13, I will explain that I consider that is exactly what happened on the night of 22nd May 2017. I will also explain why that was not only predictable but also avoidable.

Unarmed commander training

12.322 In order to attain Sergeant and Inspector ranks, police officers have to pass examinations. For ranks above Inspector, there is training specific to role and rank. To be promoted to Chief Officer rank, there is a rigorous selection process,
followed by a three-month command course which must be passed. There is an expectation within GMP that officers can carry out command roles commensurate with their rank and experience.

12.323 The College of Policing accredited public order commander training courses. Once passed, officers were then subject to a period of workplace shadowing and mentoring. Once signed off, officers must complete annual refresher training to retain their accreditation. The two key specialisms were firearms and public order. There was substantial overlap between the training provided on a public order commander training course and the Major Incident command roles. The public order course is focused on the Tactical/Silver Commander role for pre-planned, as opposed to spontaneous, events.

12.324 Inspector Smith qualified as a public order Bronze Commander in 2012. He carried out the necessary refresher training to maintain this. He had undertaken Authorised Firearms Officer

440 INQ035309/173 at paragraph 10.1.5
441 INQ029288/44 at paragraph 229
442 INQ029288/45 at paragraph 232
443 INQ029288/45 at paragraph 231
444 104/5/3-6/2
445 104/5/17-21
446 102/142/23-143/9
training. He had never operated in this role. He had not undertaken any firearms commander training. He undertook the role of Operational/Bronze Commander on the night of the Attack. He had sufficient training and was competent to operate as an Operational/Bronze Commander. He was an experienced Operational/Bronze Commander.

12.325 Temporary Superintendent Nawaz qualified as a public order Silver Commander in 2016. He had not undertaken any firearms commander training. It was not a requirement of his role as GMP Night Silver or his rank of Temporary Superintendent for him to have done so. He undertook the role of Tactical/Silver Commander on the night of the Attack. He had not had sufficient training and, as a result, was not competent to operate as a Tactical/Silver Commander during an Operation Plato incident.

12.326 Temporary Superintendent Christopher Hill qualified as a public order Silver Commander in 2010. He was also qualified as a Tactical Firearms Commander and Gold Commander.

447 102/142/3-9
448 102/143/7-9
449 104/2/14-21
450 INQ042531/103-104 at paragraph 260
451 104/140/11-24
He replaced Temporary Superintendent Nawaz as Tactical/Silver Commander at 00:00 on 23rd May 2017. He had sufficient training and was competent to operate as a Tactical/Silver Commander.  

12.327 ACC Ford qualified as a public order Gold Commander in 2015. This qualification included multi-agency commander of Major Incidents. She undertook the role of Strategic/Gold Commander on the night of the Attack. She had sufficient training and was competent to operate as a Strategic/Gold Commander. ACC Ford also acted as the Strategic Firearms Commander. I will deal with her firearms training at paragraph 12.332.

Firearms commander training

12.328 Following training in late 2006, PC Edward Richardson accepted his first position as an Authorised Firearms Officer in 2007. In 2008, he qualified as an Operational Firearms Commander. On the night of the Attack, he undertook the role of Operational Firearms Commander. He had sufficient training and was

452 INQ042531/102 at paragraph 255
453 105/25/10-24
454 105/24/21-25/18
455 101/3/22-4/21
456 101/3/3-6
competent to operate as an Operational Firearms Commander.\textsuperscript{457}

12.329 Temporary CI Rachel Buckle qualified as a public order Silver Commander in 2010. In 2014, she qualified as a Tactical Firearms Commander.\textsuperscript{458} She was the on-call Tactical Firearms Commander on the night of the Attack.\textsuperscript{459} She did not take up the role of Tactical Firearms Commander or Ground Assigned Tactical Firearms Commander. She had sufficient training and was competent to function in either role. I shall return to the decisions around Temporary CI Buckle’s role on the night of the Attack in Part 13.

12.330 CI Mark Dexter qualified as a public order Silver Commander in 2015.\textsuperscript{460} The same year, he qualified as a Tactical Firearms Commander. Between 7\textsuperscript{th} and 12\textsuperscript{th} May 2017, he attended a specialist firearms commander course. This course built on the Tactical Firearms Commander course, addressing more complex firearms incidents, and included a counter-terrorism element.\textsuperscript{461} He undertook the role of Ground Assigned Tactical Firearms Commander on the
night of the Attack. He had sufficient training and was competent to operate as a Ground Assigned Tactical Firearms Commander.\footnote{106/108/8-11} By reason of the recent specialist firearms commander course he had attended, CI Dexter was better qualified to act as Ground Assigned Tactical Firearms Commander than Temporary CI Buckle.\footnote{100/109/12-110/25, 106/110/9-111/23}

12.331 By May 2017, Superintendent Craig Thompson had many years of experience as a Tactical Firearms Commander. In June 2016, he undertook the Tactical Firearms Commander course.\footnote{108/4/10-19} Superintendent Thompson relieved Inspector Sexton of tactical firearms command at 00:18 on 23\textsuperscript{rd} May 2017 and undertook the role of Tactical Firearms Commander from that point.\footnote{108/2/3-6, INQ024325/50-51} He had sufficient training and was competent to operate as a Tactical Firearms Commander. By reason of his specialist firearms commander qualification, Superintendent Thompson was better qualified to act as Tactical Firearms Commander than Temporary CI Buckle.\footnote{108/17/4-18/25, 100/110/1-111/1}

12.332 ACC Ford qualified as a Strategic Firearms Commander in 2015.\footnote{105/27/1-4} She attended the same
specialist firearms commander training as CI Dexter.\textsuperscript{468} She undertook the role of Strategic Firearms Commander on the night of the Attack. She had sufficient training and was competent to operate as Strategic Firearms Commander.\textsuperscript{469}

**JESIP training**

12.333 The commanders had all received JESIP training, which had been delivered to them in 2014 by reason of their rank.\textsuperscript{470} JESIP was also included as an element of the public order commander training courses from the end of 2016.\textsuperscript{471} All GMP officers had undertaken e-learning training in JESIP in 2015.\textsuperscript{472}

12.334 The events of 22\textsuperscript{nd} May 2017 demonstrated that the JESIP training which GMP officers had received was insufficient to ensure that important elements of the response were not overlooked. The failure by all those involved at an early stage to declare a Major Incident in a timely way or to provide or seek a METHANE message applies across all levels of seniority. The failure by the commanders to identify an FCP where co-location at the scene could occur was significant. The lack of attempts to conduct a joint risk

\textsuperscript{468} 105/27/8-13, 106/110/9-15
\textsuperscript{469} 105/25/25-27/25, 105/28/21-29/19
\textsuperscript{470} INQ029288/44 at paragraph 230
\textsuperscript{471} INQ029288/45 at paragraph 234
\textsuperscript{472} INQ029288/44 at paragraph 230
assessment with other agencies was a substantial failing.

12.335 While I have identified elsewhere in Volume 2 that some individual officers bear personal responsibility for these failings, I am satisfied there was a failure by GMP as an organisation to embed JESIP in its officers and staff. It may well be a result of the national standards at the time and the general approach to training across all police services.

**Operation Plato training of unarmed officers**

12.336 Knowledge within GMP of what an Operation Plato declaration signified was confined to specialists, particularly from the firearms environment.\(^{473}\) This meant that none of the unarmed frontline officers who deployed into the City Room had been trained in what an Operation Plato declaration would mean. This is in contrast to BTP, which had provided many of its officers, down to PCSO level, with training on what Operation Plato was.\(^{474}\)

12.337 As a result of the way GMP chose to approach Operation Plato, neither Inspector Smith\(^{475}\) nor Temporary Superintendent Nawaz\(^{476}\) knew that it

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\(^{473}\) 130/207/19-208/16
\(^{474}\) 73/38/21-40/5, 74/84/9-16, 92/28/18-29/6
\(^{475}\) 102/170/10-171/11
\(^{476}\) 104/18/5-15
was the response to marauding terrorists with firearms. PC Richardson, the Operational Firearms Commander, thought that it related to a terrorist attack, whatever form such an attack took.\footnote{101/41/20-42/8, 101/62/14-18} This was an unacceptable and dangerous state of affairs. It had the potential to place lives at risk.

12.338 In Temporary Superintendent Nawaz’s case, the responsibility for his lack of knowledge was shared between him and GMP. In Inspector Smith’s case, it was entirely GMP’s fault that he did not know.

12.339 GMP Control staff, other than the FDO, were in the same position as the unarmed commanders. Police Support Staff Supervisor, Ian Randall, who was the Force Duty Supervisor on the night,\footnote{99/187/15-188/2} did not know what Operation Plato was, beyond that it related to terrorism in some way.\footnote{99/166/21-167/11}

12.340 This was not Ian Randall’s fault. It is particularly concerning given that he informed a number of people that Operation Plato had been declared. He would have been unable to answer any questions about it had he been asked.\footnote{99/167/2-6} His lack of knowledge gave rise to a risk that he might
make incorrect assumptions or interpret information incorrectly.

12.341 During the HMICFRS inspection in late 2016, staff in the control room were questioned about their knowledge of GMP’s planned response to a Marauding Terrorist Firearms Attack.\textsuperscript{481} Their knowledge was found to be not good or reassuring.\textsuperscript{482} The HMICFRS Inspector concluded: “\textit{GMP control room staff have not received specific training regarding the force response to an MTFA … This may mean that control room staff do not know immediately what to do in the event of an MTFA.}”\textsuperscript{483}

12.342 A similar discovery was made as part of the same HMICFRS inspection following a group discussion with patrol officers. The HMICFRS Inspector found that none of the officers was aware of GMP’s plans to respond to a terrorist attack. They did not know the details of Operation Plato and zoning.\textsuperscript{484}

12.343 As I have explained, these findings were communicated to Temporary ACC Hankinson by the HMICFRS lead Inspector, Andrew Buchan, during the hot debrief on 3\textsuperscript{rd} November 2016.\textsuperscript{485}
In the course of an email that same day, Temporary ACC Hankinson wrote to the GMP Chief Officer Group: “Our front line unarmed staff have had no specific training relating to MTFA.”

12.344 The HMICFRS report based on the November 2016 visit is dated August 2017. It rehearsed the findings about unarmed officers’ lack of knowledge of Operation Plato. Strikingly, the report records the account of a Tactical Firearms Commander who told the Inspectors: “[T]he unarmed first response is the untested area for the force, that’s where our vulnerability lies … Because of the possible ARV [Armed Response Vehicle] response times, it’s likely that the first officers to the scene will be unarmed, and they have had the least amount of MTFA training.”

Although GMP received this report after the Attack, the Tactical Firearms Commander was stating facts which GMP should have realised for itself. This was readily available information to GMP in the event it had asked the obvious questions.

12.345 The shortcomings in the control room staff and patrol officers’ knowledge were readily established by HMICFRS. It was GMP’s responsibility to ensure all of its staff and officers

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486 INQ041272
487 INQ025071/1
488 INQ025071/31
were adequately trained. HMICFRS drew GMP’s attention to this shortcoming six months before the Attack. It was a significant failing on the part of GMP that so few of its officers who might be affected had any proper awareness of what an Operation Plato declaration would mean.

12.346 That should not have been the position. As HMICFRS acknowledged, unarmed officers will often form the initial response to a terrorist attack.\(^{489}\) If they are to work effectively as part of the response with the firearms officers, they need to understand what the plan involves and what it requires of them. That was not the position in GMP in 2017. It is clear from the evidence of Andrew Buchan that the issue also existed elsewhere.\(^{490}\)

12.347 I recommend that CTPHQ and the College of Policing take steps to ensure that all firearms officers and frontline unarmed officers receive training in Operation Plato. Operation Plato now applies to all Marauding Terrorist Attacks and not just those involving firearms.

**First aid training of unarmed officers**

12.348 The events of 22\(^{\text{nd}}\) May 2017 revealed that the first aid training of frontline unarmed GMP officers could and should be improved.
12.349 ACC Iain Raphael was Director for Operational Standards at the College of Policing.\(^{491}\) In evidence, he explained that all police officers serving within Home Office police services, including GMP, must complete the First Aid Learning Programme (FALP) training. This programme was generated by the College in accordance with the Police Service Quality Assurance scheme. It was endorsed by the National Police Chiefs’ Council and the Health and Safety Executive.\(^{492}\)

12.350 The College sought to ensure that police services complied with the requirements of FALP by requiring each police service to carry out a self-assessment against the guidance framework delivered by the College.\(^{493}\) I am concerned about the adequacy of this quality assurance process for a number of reasons.

12.351 First, a system based on self-assessment is likely to be less robust than a system based on independent inspection, possibly substantially less so.

12.352 Second, at the time of the Attack, self-assessments were required every 12 months. Now they are required only every 24 months.\(^{494}\)
That seems to give rise to a much greater risk that a problem will go unaddressed for a lengthy period. It was clear to me that ACC Raphael saw the benefits in an annual process.\textsuperscript{495}

12.353 Third, in the event that a police service is found to be in default of the requirements of FALP, the College of Policing has no ability to sanction, but instead is dependent upon achieving an outcome through persuasion.\textsuperscript{496}

12.354 The training of frontline police officers in first aid is of the utmost importance. I recommend that the Home Office, together with the College of Policing, introduce a more regular and more robust system for ensuring that all police services meet the needs of their officers in first aid training.

12.355 The evidence revealed that GMP did not meet all of the FALP requirements for a prolonged period covering 2014 to 2020.\textsuperscript{497} At one stage it seemed to me that this might be a matter of considerable significance. However, it proved to be the case that, with the support of its clinical governance group, GMP had structured its training differently from the FALP model.\textsuperscript{498} GMP had drawn this to the attention of the College of Policing in 2014/15

\begin{footnotes}
\item[495] 192/174/13-176/6
\item[496] 192/172/24-173/22
\item[497] 192/176/7-178/11
\item[498] 192/178/12-180/11
\end{footnotes}
but the College had not required GMP to do anything differently until 2020. When the issue was raised in 2020, GMP regularised the situation promptly.\textsuperscript{499} In the circumstances, I am satisfied that GMP had shown a commitment to training its frontline officers in first aid and that the failure to comply with FALP was technical in nature.

12.356 In my view, it was not GMP’s failure to comply strictly with FALP that created a problem on the night. Instead, the problem was with the FALP training itself. It did not equip unarmed officers with the skills they needed to deal with the severity of injuries they encountered within the City Room. They had received no training in life-saving interventions, such as stopping catastrophic bleeding or opening an airway.\textsuperscript{500} The unarmed officers who bravely entered the City Room and did everything they could for the casualties found their lack of skill in this regard extremely frustrating.

12.357 In Part 13, I will deal with the experiences of those unarmed officers in greater detail. In Part 20 in Volume 2-II, I will deal with the steps that I have been assured are being taken to ensure that all officers will receive training in life-saving interventions. I will emphasise at
that stage that I regard it as vital that this be achieved as soon as is reasonably practicable.

12.358 If all officers are to be trained in life-saving interventions, they need to be provided with the equipment necessary to make those interventions effective. So, if officers are to be trained in the application of tourniquets, they need to be provided with the tourniquets themselves. On the night of the Attack, they did not have such equipment. The unarmed officers of GMP were no better equipped to provide first aid than the officers of BTP.

Firearms officer training

12.359 The Policing Experts considered the training for GMP’s firearms officers as part of their review of the evidence. They noted that this training complied with the national requirements. The experts concluded that the GMP firearms officers were qualified and competent.\footnote{INQ035309/10-11}

12.360 I agree that these officers were qualified and competent for their important role of locating and neutralising a threat. Furthermore, as I shall explain in Part 13, the speed and efficiency with which they deployed on the night of the Attack were commendable.
12.361 There are, however, three areas in which the evidence gives rise to concerns about the training of GMP’s firearms officers. I am confident that these concerns are not unique to GMP but instead arise more widely across the country.

12.362 First, the principles of joint working were not sufficiently embedded within the firearms officers. On the night, none of them recognised the absence of GMFRS and the disadvantage this created for the rescue effort. Nor were the principles of zoning that are integral to Operation Plato sufficiently embedded in their response. None of them ever asked the FDO what zoning he had applied or gave him any advice in that regard. I have other connected concerns that I will examine in Part 13. None of this is a criticism of the firearms officers. It does, however, highlight a training need that CTPHQ and the College of Policing should address.

12.363 Second, the firearms officers had enhanced first aid training. There was a lack of understanding on their part of the need for them to provide life-saving interventions while deployed in their firearms capacity. The officers rightly recognised that their primary duty was to locate and neutralise any threat but did not understand that, even during the course of doing so, it was their

502 148/47/18-50/15
503 189/96/12-98/14
role to provide first responder interventions where possible.

12.364 As a result, despite their strong instinct to do so, the firearms officers who initially attended the Arena provided no treatment to any casualty. This does not apply only to those firearms officers who went to contain the City Room but also to the other firearms officers who attended the Victoria Exchange Complex and might have provided medical assistance within the City Room. Again, this is not a criticism of the individual officers but a criticism of the training regime.

12.365 Third, I was concerned that the procedure adopted following the Attack did not produce the most complete and accurate accounts of the firearms officers.

12.366 I will address each of these concerns further in Part 13, and in Parts 19 and 20 in Volume 2-II.

Exercising

12.367 Later in this Part, at paragraphs 12.733 to 12.899, I will deal with multi-agency exercising. At this stage, it is sufficient to say that GMP was involved in over 100 exercises in the two years prior to the Attack. 505

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504 102/98/15-100/9
505 INQ035309/84 at paragraph 4.3.6
12.368 I am satisfied that GMP dedicated an appropriate level of resource, time and commitment to exercising.\textsuperscript{506} GMP’s failure in relation to exercising was in capturing and acting upon the learning points which arose. I will address this in the final section of this Part, at paragraphs 12.751 to 12.759.

\textsuperscript{506} INQ035309/83-84 at paragraph 4.3.1
North West Ambulance Service preparedness

Key findings

• On the night of the Attack, North West Ambulance Service (NWAS) had two Hazardous Area Response Team (HART) crews on duty: one based in Greater Manchester and one covering Cheshire and Merseyside. The HART crews were specialists at working in dangerous areas, including Operation Plato warm zones.

• The NWAS Major Incident Response Plan anticipated that the Operational Commander would co-locate at a Forward Command Post with the Operational/Bronze Commanders of other emergency services.

• Some NWAS personnel used the terms ‘hot zone’, ‘warm zone’ and ‘cold zone’ to apply to Major Incidents in which Operation Plato had not been declared. This had the potential to cause confusion.

• NWAS did not have an action card for the HART Team Leader. It should have done.

• NWAS did not have a site-specific plan for the Victoria Exchange Complex. It should have done.
• At the time of the Attack, NWAS had a draft plan outlining which hospitals in the Greater Manchester area patients should be sent to in the event of a mass casualty incident.

• Commanders on 22\textsuperscript{nd} May 2017 were competent to perform the roles they had.

• The Joint Emergency Services Interoperability Principles (JESIP) were not sufficiently embedded in NWAS frontline personnel.

• NWAS did not have a sufficiently well-developed relationship with Emergency Training UK.

Introduction

12.369 The North West Ambulance Service (NWAS) NHS Trust is the statutory ambulance service with responsibility for the provision of ambulance services in North West England, covering Greater Manchester, Cheshire, Lancashire, Merseyside and Cumbria.

12.370 In the response to a Major Incident, NWAS has responsibility for all NHS responders, the command and control of all health assets, and the pre-hospital management of casualties including treatment, triage and distribution to an appropriate hospital.
12.371 NHS ambulance services in the UK are required to comply with a comprehensive range of standards and national policies in respect of emergency preparedness.

12.372 Having considered the wide range of emergency plans and procedures that NWAS had in place, the Ambulance Service Experts considered that NWAS was compliant with the national standards for emergency preparedness at the time of the Attack. Support for this view is found in the conclusion of the Emergency Preparedness, Response and Resilience annual assurance process and verified through an NHS England sponsored audit.

12.373 While I accept that NWAS met those national standards, I have concluded that there were areas where NWAS’s planning for an emergency could and should have been improved.

12.374 In this section, I shall set out NWAS’s control function arrangement, introduce its specialist personnel, consider its plans, look at its training, address the issue of equipment and summarise its approach to exercising.
NWAS Control

12.375 NWAS divided its control functions into different areas of responsibility. The Emergency Operations Centre was responsible for resource allocation. There was an Emergency Operations Centre control room which covered the Greater Manchester area. Each Emergency Operations Centre control room had a Duty Manager. The Duty Manager was expected to provide support to the Strategic and Tactical Commanders during a Major Incident in his or her area.

12.376 Major Incident response was supported by the Area Operational Co-ordination Centres, which could be activated on an area basis. The Regional Operational Co-ordinating Centres provided regional overview of capacity and resources across NWAS. Hospital monitoring was achieved through the Regional Health Control Desk. The Trauma Cell offered access to senior medical advice to assist in pre-hospital clinical decision-making.

12.377 I shall refer to these collectively as NWAS Control.

509 INQ026738/29 at paragraph 206
510 INQ012913/43
511 INQ012913/18-20
NWAS specialist personnel

12.378 I recognise that all personnel working for NWAS were specialist in their particular roles. In my Report, I use the term ‘specialist’ in a particular way. When applied to NWAS staff it is a reference to the following resources.

12.379 HART operatives were, as their name suggests, specialists in working in hazardous areas. In 2017, NWAS had two HART crews: one based in Greater Manchester (the GM HART crew) and one covering Cheshire and Merseyside (the C&M HART crew). HART operatives were issued with a range of personal protective equipment, including ballistic protection. HART operatives were expected to operate in an Operation Plato warm zone.

12.380 HART is considered to be a national NHS capability. This means that any ambulance service can call on the HART capability of a neighbouring ambulance service when required.

12.381 The range of hazardous areas in which HART operatives are trained to operate is set out in Table 3.
<table>
<thead>
<tr>
<th>Core Capability</th>
<th>Tactical Options</th>
<th>Commissioning</th>
</tr>
</thead>
</table>
| **HART** Hazardous Area Response Teams | **Hazardous Materials** | • Working inside the inner cordon  
• Industrial accidents  
• High-risk infectious diseases  
• Complex transportation accidents |
| | **CBRN(e) Chemical Biological Radiological Nuclear Explosives** | • Specialist, inner cordon response to CBRN(e)/also a component part of the CBRN(e) capability |
| | **MTFA Marauding Terrorist Firearms Attack** | • Specialist support to the wider MTFA response/component part of the MTFA capability |
| | **SWaH Safe Working at Height** | • Man-made structures  
• Natural environment |
| | **Confined Space** | • Substantially enclosed spaces  
• Building collapses  
• Compromised atmospheres  
• Entrapments |

Reference costs are set out in the National Standards produced by NARU. Then commissioned locally via the Ambulance Service baseline funding mechanism.
<table>
<thead>
<tr>
<th>Core Capability</th>
<th>Tactical Options</th>
<th>Commissioning</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HART</strong> <strong>Hazardous Area Response Teams</strong>&lt;br&gt;Unstable Terrain</td>
<td>• Active rubble piles&lt;br&gt;• Rural access/difficult terrain</td>
<td></td>
</tr>
<tr>
<td><strong>Water Operations</strong></td>
<td>• Swift water rescue&lt;br&gt;• Urban and rural flooding&lt;br&gt;• Boat operations</td>
<td></td>
</tr>
<tr>
<td><strong>Support to Security Operations</strong></td>
<td>• Support to security operations&lt;br&gt;• Support to police operations&lt;br&gt;• Illicit drug laboratories&lt;br&gt;• VIP close protection support</td>
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**Table 3: Hazardous Area Response Team capabilities**

12.382 NWAS’s response to a Marauding Terrorist Firearms Attack was via the Ambulance Intervention Team. This comprised members of HART, together with other personnel selected from NWAS’s wider operational staff.

12.383 On the night of the Attack, NWAS had two HART crews on duty: the GM HART crew and the C&M
HART crew. Each crew comprised a Team Leader and five HART operatives.

12.384 On the night of the Attack, HART was mobilised as part of NWAS’s response. Other elements of the Ambulance Intervention Team were not. I shall return to the issue of the Ambulance Intervention Team in Part 14.

Major Incident Response Plan

12.385 The document at the heart of NWAS’s preparation for an event such as the Attack was the Major Incident Response Plan. This comprised a 70-page document, accompanied by 29 action cards.\(^{514}\) The front page of the Major Incident Response Plan stated: “The ACTION CARD section of this plan MUST be used during the response phase of a Major Incident.”\(^{515}\)

12.386 At the time of the Attack, version 5.0 of the Major Incident Response Plan was in force. This had been in effect since 18\(^{\text{th}}\) October 2016.

12.387 The first two objectives of the Major Incident Response Plan were stated to be: “Ensure an effective and co-ordinated response to the incident”, and “Follow the Joint Emergency Services Interoperability Principles (JESIP) ideal
of working together, saving lives, reducing harm.”

12.388 The introduction continued: “The Plan may be exercised alongside site specific plans (e.g. stadia)…” NWAS did not have a site-specific plan for the Victoria Exchange Complex or the Arena.

12.389 Section 2 of the Major Incident Response Plan was entitled “Joint Emergency Services Interoperability Principles (JESIP)” It set out a summary of the five principles for joint working.

12.390 Section 3 of the Major Incident Response Plan was entitled “Major Incident Plan Activation”. It defined a Major Incident. It set out four potential Major Incident messages. The first of these was: “Major Incident – Standby”. This alerts the NHS that a Major Incident may need to be declared. Advanced Paramedic Patrick Ennis used this message on the night of the Attack as he entered the Victoria Exchange Complex. The second Major Incident message was: “Major Incident – Declared”. Seconds after Patrick Ennis’s message, NWAS Control declared a Major Incident for NWAS.
12.391 It is of note that the Major Incident Response Plan had a section addressing a scenario in which NWAS was informed that another agency had declared a Major Incident. However, there was no corresponding section under the Major Incident heading stressing the importance of NWAS communicating its Major Incident declaration to other agencies. While this requirement did appear elsewhere, its absence at this point is a shortcoming in the Major Incident Response Plan which was mirrored by NWAS’s failure to inform other agencies of its Major Incident declaration following the Attack. NWAS did share its Major Incident declaration with all hospitals within the Greater Manchester network.

CSCATT model

12.392 CSCATT stands for ‘Command and Control; Safety; Communication; Assessment; Triage; Treatment; Transport’. The Major Incident Response Plan explained:

“The CSCATT model is the mainstay of the NHS Ambulance response to Major Incident Management and provides a structured approach to ensure NWAS and the NHS maintain an effective coordinated response.

521 INQ012913/12-13
522 INQ041691
JESIP Principles for Joint Working must be reinforced throughout Command and Control process.”

12.393 An illustration of the model and its relationship with JESIP was included in the Major Incident Response Plan and is reproduced in Figure 29.

**Figure 29: CSCATTT model and the JESIP five principles for joint working from the Joint Doctrine**

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523 INQ012913/13
524 INQ012913/13
Commanders

12.394 In relation to command, the Major Incident Response Plan used the terms Strategic, Tactical and Operational Commander. It stated that the Tactical Commander may also be known as the “Ambulance Incident Commander”.525

12.395 The Major Incident Response Plan made clear that each role carries the authority and that takes precedence over the rank of any individual. It also stated: “The individual must have completed NWAS Major Incident Command Training particular to the role allocated to them.”526 I will return to this at paragraphs 12.471 to 12.474 when I consider the Operational Commander role on the night of the Attack.

12.396 The first paragraph for each explanation of the commander role stated that they “must” use their relevant action card during the management of the incident.527 This requirement was not observed by all NWAS commanders during their period of command. It should have been.

12.397 Under the heading “Operational Commander”, the Major Incident Response Plan stated:

“The Operational Commander works at an operational level, and has responsibility for
the activities undertaken at the scene. As such, they will be located at the incident scene, ideally alongside the Operational Commanders of the other responding agencies at a Forward Command Post (FCP). Where this is not possible, the Operational Commander must ensure regular multi-agency face to face briefings take place.”

12.398 The Major Incident Response Plan is not the only place that guidance is given about where Operational Commanders should locate themselves. NWAS’s ‘Incident Deployment Guidance Including On Call’ stated: “The Operational Commander will co-locate with all other agencies’ Operational Commanders to facilitate a safe and efficient multi-agency incident response.”

12.399 Safety at a Major Incident was a subject in its own right within the Major Incident Response Plan. It stated: “The Operational Commander must appoint an appropriate person who ideally has the necessary training, experience and knowledge as the Ambulance Safety Officer early in the Command and Control set up to ensure that health, safety and welfare of all medical personnel are observed.” This important role

528 INQ012913/16
529 INQ023556/11
530 INQ012913/30
was overlooked by the NWAS Operational Commander on the night of the Attack. I shall consider the potential impact of this failure in Part 14.

12.400 The Major Incident Response Plan stated: “Identification of an appropriate interoperability talk-group should be an early consideration for commanders at the scene of an incident.”\(^{531}\)

The NWAS Operational Commander did not do this. No Operational/Bronze Commander from any of the emergency services did. As a result of this and the lack of physical co-location, the Operational/Bronze Commanders did not speak to each other during the critical period of the response.

**Triage**

12.401 The Major Incident Response Plan explained that there are two types of triage: “triage sieve” and “triage sort”. These processes were sometimes referred to as “primary triage” and “secondary triage”.\(^{532}\) In my view, these latter terms make it clearer and I will use them unless I am quoting from documents in use at the time.
12.402 The process of primary triage was described in the Major Incident Response Plan. It is reproduced in Figure 30. The Major Incident Response Plan stated: “All casualties should be clearly labelled with a SMART Triage Tag including the deceased. Any casualty that is found without a label should be triaged immediately in order to ensure and confirm that a clinical assessment has taken place.” Primary triage identified categories of casualty by reference to their level of injury.
Figure 30: Primary triage (also known as the “triage sieve”)\textsuperscript{534}

\textsuperscript{534} INQ012913/38
12.403 Patrick Ennis, who carried out primary triage initially on 22\textsuperscript{nd} May 2017, did not have his SMART Triage Tags with him when he entered the City Room.\textsuperscript{535} This had consequences for the casualties in the City Room, which I will set out in Part 14.

12.404 The categories of patients by injury level set out in primary triage were described by NARU as follows. P1 casualties require immediate life-saving interventions. P2 casualties require surgical or other interventions within two to four hours. Treatment for P3 casualties can safely be delayed beyond four hours.\textsuperscript{536}

12.405 There was a P4 category of “\textit{Expectant}”. This relates to anyone who is expected to die. This categorisation was not used on the night of the Attack. It is reserved for occasions of limited medical resources. The Major Incident Response Plan stated that only the Forward Doctor could categorise people as P4.\textsuperscript{537}

12.406 In relation to any person who has died, the Major Incident Response Plan provided the following guidance. First, it expected that a deceased person should be labelled as such with a SMART Triage Tag. Second, confirmation of death may
only be carried out by a medical doctor. Third, the deceased person should not be moved during the triage process. Fourth, the deceased person should in general be left uncovered. However, where the deceased person is in public view, consideration should be given to covering the body in order to maintain patient dignity.

12.407 The process of secondary triage (triage sort) is expected to take place in an area known as a Casualty Clearing Station. I shall explain what this is in paragraph 12.410. A scoring process made by reference to breathing, blood pressure and level of consciousness is undertaken at this stage. As much clinical information as possible should be recorded for each casualty.

12.408 In Part 20 in Volume 2-II, I will consider a proposal to replace the existing approach to triage with a new structure. As I make plain at that stage, the new structure seems to have significant advantages over the existing approach.

**Structure at a scene**

12.409 There may need to be a number of stages of casualty triage and treatment during a Major Incident. The stages, as depicted in the Major Incident Response Plan, are shown in Figure 31.
Casualty Triage and Treatment

Figure 31: Structure of a Major Incident

12.410 The Casualty Clearing Station aims to provide a treatment place to stabilise a casualty with a view to getting them to a definitive point of care “as soon as possible”. Once it has been established, “all casualties must be directed/transferred from the site or CCP [Casualty Collection Point] to the facility for further triage…” On the night of the Attack, several casualties remained in the Casualty Clearing Station for over two hours.

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540  INQ012913/41
541  INQ012913/42
542  INQ012913/42
12.411 The Major Incident Response Plan stated that “safety considerations such as the integrity of buildings or land, vehicular accessibility”\textsuperscript{543} should be taken into account when selecting the location of a Casualty Clearing Station.

12.412 A Casualty Collection Point is not required at every Major Incident. The Major Incident Response Plan suggested that its use is “commonplace for any multi-casualty incident”\textsuperscript{544}. The Casualty Collection Point is “designed to provide basic care for life threatening injuries prior to a casualty being moved to the CCS [Casualty Clearing Station] or direct to hospital. Equipment to establish the CCP [Casualty Collection Point] is carried by the Hazardous Area Response Team.”\textsuperscript{545} It is of note that the Casualty Collection Point, when established, precedes the Casualty Clearing Station as a place for a patient to receive care.

12.413 One of the issues explored during the Inquiry was whether there should have been a Casualty Collection Point established between the City Room and the station concourse. This could only have been on the raised walkway. I am not persuaded this would have been the right choice. Given the width of the raised walkway, there

\textsuperscript{543} INQ012913/42 \\
\textsuperscript{544} INQ012913/41 \\
\textsuperscript{545} INQ012913/41
would have been a risk that a bottleneck was created. In light of my findings about non-specialist paramedics and the City Room, it was not necessary to establish a Casualty Collection Point on the raised walkway.

Zoning an incident

Inner and outer cordons

12.414 The Major Incident Response Plan identified one area of a scene as “the inner cordon”. It did not provide a definition of this area. It did display it pictorially, as reproduced in Figure 32.
Figure 32: Incident diagram
12.415 The Major Incident Response Plan stated:
“Within the inner cordon, treatment is aimed at preventing further deterioration of life-threatening injuries.”\textsuperscript{547} It went on to state:

“The purpose of a HART response is to provide life-saving medical care within the inner cordon at a range of emergency incidents … Responding within the inner cordon of a scene, particularly at a major, hazardous incident, requires different working practices, equipment and systems of work to a conventional ambulance response. HART personnel have a range of PPE [personal protective equipment] and clinical equipment suitable for use in these conditions, and the skills and knowledge necessary to operate safely within these environments.”\textsuperscript{548}

12.416 It is clear that the Major Incident Response Plan envisaged HART operatives working within the inner cordon. The Major Incident Response Plan did not state that non-specialist paramedics were prohibited from working in that area.

12.417 On the night of the Attack, the City Room was within the inner cordon.
Operational discretion and the inner cordon

12.418 An issue arose as to whether NWAS commanders had a discretion to deploy non-specialist paramedics into the inner cordon. Daniel Smith, who was the Operational Commander on the night of the Attack, stated:

“Certainly part of the decision-making is we do not deploy into, whether you term it warm zone or inner cordon, we do not deploy non-HART operatives into that area.”

12.419 Daniel Smith was asked if there was a discretion. He stated:

“[M]y view, my training at the time is that there was no discretion, that the policies and procedures were clear on that fact, that we do not deploy, we should not, we must not deploy into warm zones.”

12.420 The question referred to “inner cordons”. Daniel Smith’s answer referred to “warm zones”. I shall deal with the relationship between these terms in paragraphs 12.429 to 12.432.

12.421 Patrick Ennis was an Advanced Paramedic. He was the only non-specialist paramedic to go into the City Room. In evidence, he stated: “I don’t believe it [is] an absolute rule. A risk assessment
would need to be carried out and then a decision.” He stated it was a decision for the Operational Commander. He described the risk assessment as needing to be “quite … robust.”

Derek Poland was one of two on-call Operational Commanders contacted on 22nd May 2017. He stated in evidence that it was necessary to be “careful who we deployed within” the inner cordon. Later in his evidence, he was asked about what the policy said about commander discretion in these circumstances. He replied:

“It doesn’t say he can and it doesn’t say he can’t … But what we are taught on our commander training is if you do go outside of policy, you’ve got to have a rationale for that, and also you need to have a robust plan to get yourself back into policy.”

Lea Vaughan was one of the two HART operatives who entered the City Room during the critical period of the response. She stated in evidence: “I do believe there is discretion in the NWAS protocols.”

551 110/13/11-14/2
552 110/13/11-14/2
553 110/43/25-44/11
554 112/27/5-14
555 112/40/11-18
556 113/35/20-36/5
12.424 Stephen Hynes was Deputy Director of Operations for NWAS. He took over from Daniel Smith as Operational Commander on the night of the Attack. He was asked if there was discretion in relation to sending non-specialist paramedics into an Operation Plato warm zone. He replied:

“I think this is where it’s critical for commanders to have that JESIP discussion around about risk and shared situational awareness. It’s a very dynamic – moving incident that we’re dealing with here. And that could lead to discretion, yes. But that needs to be done through a JESIP process.”

12.425 I understood Stephen Hynes’ evidence to be that, through a JESIP-based risk assessment, there was a discretion to send non-specialist paramedics into both the inner cordon and an Operation Plato warm zone.

12.426 Neil Barnes was the Strategic Commander on the night of the Attack. His evidence was that there was a discretion to deploy non-specialists into the inner cordon. He stated that there was an expectation that commanders would make decisions “based on the outcome of [the risk] assessment and the needs at the time.”
His evidence was that the same approach applied to an Operation Plato warm zone.\textsuperscript{559}

12.427 The Ambulance Service Experts’ evidence was that an Operational Commander has a discretion to send non-specialist paramedics to work in the inner cordon following a risk assessment.\textsuperscript{560} In light of all the evidence I heard, I accept the Ambulance Service Experts’ evidence on this point: Daniel Smith did have a discretion to send non-specialist paramedics to work in the City Room on the night of the Attack. In Part 14, I will look at his decision-making around this issue.

12.428 I am not able to say whether Daniel Smith’s belief that there was no discretion was a misunderstanding by him of his training or a failure in the training with which he was provided.

**Major Incident hot, warm and cold zones**

12.429 The Major Incident Response Plan did not refer to the terms “hot zone”, “warm zone” or “cold zone”. As I set out in Part 11, these were terms which were used in JOPs 3 in connection with a Marauding Terrorist Firearms Attack and Operation Plato. However, some NWAS staff were familiar with hot, warm and cold zones being used in connection with Major Incidents that did not involve terrorism or an Operation

\textsuperscript{559} 115/64/7-67/5
\textsuperscript{560} 144/116/1-118/12
Plato declaration. The Ambulance Service Experts stated that it was “commonplace” for hot, warm and cold zones to be used during a non-Operation Plato Major Incident.\textsuperscript{561}

12.430 For convenience, I will refer to non-Operation Plato zones as ‘Major Incident hot zone’, ‘Major Incident warm zone’ and ‘Major Incident cold zone’. This is intended to distinguish them from Operation Plato zoning. This should not be taken to imply that an Operation Plato declaration means that a Major Incident is not taking place.

12.431 Major Incident hot and warm zones equated to the inner cordon; a cold zone equated to the outer cordon.\textsuperscript{562} There was no equivalent to an Operation Plato hot zone under Major Incident zoning, as paramedics were never permitted to enter the Operation Plato hot zone.

12.432 The NARU \textit{NHS Service Specification 2016/17: Hazardous Area Response Teams (HART)} described HART operatives providing “care within the inner cordon or ‘hot zone’ of incidents”.\textsuperscript{563} Hot zone in this context was a reference to a Major Incident hot zone.
Risk of misunderstanding in relation to hot and warm zones terminology

12.433 There was a risk of misunderstanding. Under no circumstances was any paramedic permitted to go into the Operation Plato hot zone.\(^{564}\) However, paramedics could operate within a Major Incident hot zone. If a paramedic were told that an area was a hot zone, but did not know that Operation Plato had been declared, that person might operate in an area in which it was extremely dangerous for them to work.

12.434 An Operation Plato warm zone was governed by JOPs 3. This was focused on the threat from firearms. It rightly drew attention to the need for ballistic protection.\(^ {565}\) A Major Incident warm zone, like a Major Incident hot zone, was broader in terms of the risks it contemplated.

Operational discretion and Operation Plato warm zones

12.435 As I said above, Stephen Hynes and Neil Barnes both considered that non-specialist paramedics could, in certain circumstances, be permitted to work in an Operation Plato warm zone. The Ambulance Service Experts agreed.\(^ {566}\) However, NWAS’s position in its closing submissions to me was that “there was no discretion for

\(^{564}\) 112/32/18-33/9, 112/153/7-154/2

\(^{565}\) INQ008372/17 at paragraph 4.16

\(^{566}\) 144/195/7-25
non-specialist paramedics to enter a [an Operation Plato] warm zone” under paragraph 4.16 of JOPs 3.\textsuperscript{567}

12.436 In my view, paragraph 4.16 of JOPs 3 could have been better phrased for the reasons I gave in Part 11. However, I have concluded that there was discretion for NWAS commanders to deploy non-specialist paramedics into an Operation Plato warm zone. The text of the part in bold in paragraph 4.16 refers to “[e]mergency personnel”\textsuperscript{568} not just police officers. In any event, JOPs 3 stated it was “guidance” and “not prescriptive”.\textsuperscript{569}

12.437 The fact that the application of JOPs 3 permitted the deployment of non-specialist paramedics into the Operation Plato warm zone is not the end of the matter. A close reading of the document is one thing; how it was being taught to commanders may be another.

12.438 As I set out above, Daniel Smith did not believe there was a discretion that permitted non-specialists to be deployed into an Operation Plato warm zone. Derek Poland stated that only HART and the Ambulance Intervention Team could operate in an Operation Plato warm zone.

\textsuperscript{567} 185/170/17-23
\textsuperscript{568} INQ008372/17 at paragraph 4.16
\textsuperscript{569} INQ008372/8
He stated that all other resources were confined to the cold zone.\textsuperscript{570} In its closing submission to me, NWAS said that this was the correct interpretation of JOPs 3.\textsuperscript{571}

12.439 I have looked beyond NWAS to see how JOPs 3 was viewed by GMFRS. Some GMFRS officers thought that only the Technical Response Unit and Specialist Response Team were permitted in an Operation Plato warm zone. These included Specialist Response Team operative and Watch Manager, Andrew Simister, and Station Manager Neil Gaskell.\textsuperscript{572} Station Manager Andrew Berry appeared to allow for the possibility of non-specialist firefighters being deployed to an Operation Plato warm zone but described JOPs 3 as \textit{“quite rigid”}.\textsuperscript{573} Group Manager Ben Levy, Group Manager John Fletcher and Assistant Chief Fire Officer David Keelan all stated that there may be circumstances in which operational discretion permitted an Incident Commander to deploy non-specialist firefighters into an Operation Plato warm zone.\textsuperscript{574}
12.440 GMFRS’s closing statement characterised its position in this way:

“Although said not to be prescriptive, their rigid creation of zones and the categorisation of who could be deployed in them the JOPs strongly discouraged the use of discretion.”

12.441 Bearing in mind that GMFRS specialists trained with NWAS specialists, GMFRS’s view is relevant to consideration of NWAS’s understanding of the Operation Plato warm zone.

12.442 I am satisfied that, while the terms of JOPs 3 did not prohibit the deployment of non-specialist paramedics into an Operation Plato warm zone, the way it was taught to NWAS personnel meant that there was a belief by some that it did. The consequence for some of those who held that belief was that they thought there was no discretion for an Operation Plato warm zone, but there was a discretion for a Major Incident warm zone. Daniel Smith was not in this category as his belief was there was no discretion in either case.

Zoning conclusions

12.443 All of this serves to underline why it is unsatisfactory to have in use the same words which mean different things depending on

575  INQ042436/38 at paragraph 138
whether the person hearing them knows that Operation Plato has been declared. In the course of the response on 22\textsuperscript{nd} May 2017, there was an occasion when this problem occurred. I shall deal with this in Parts 14 and 15.

12.444 Under the title of “Communication”, the Joint Doctrine had a section headed “Common terminology”. Within that section, it stated: “Using terminology that … means different things to different people … is a potential barrier to interoperability … Agreeing and using common terminology is a building block for interoperability.”\textsuperscript{576} I agree. It is important that steps are taken to address this situation, to ensure that definitions are agreed and the words mean only one thing.

Sectors

12.445 The Major Incident Response Plan envisaged the possibility of an incident being divided into sectors. It stated:

“For complex incidents (e.g. rail crash) or multi-sited incidents (e.g. terrorist attack) the incident may be divided into sectors. This will require a separate Commander for each sector. These Commanders, e.g. Sector Commander 1, 2, etc would be subordinate to
the Operational Commander managing the incident scene. Ultimately the Tactical Commander will determine the operational management structure dependent upon the scale or nature of the incident.”

12.446 In relation to the role of Primary Triage Officer and the use of sectors, the Major Incident Response Plan stated:

“Dependent upon the nature of the incident and the area the incident covers, there may be the requirement to have multiple Primary Triage Officers, for example when an incident scene is ‘sectorised’.”

12.447 The Ambulance Service Experts considered that the HART Team Leader should have been assigned the role of Sector Commander for the inner cordon. The inner cordon was the City Room. The Ambulance Service Experts also considered it would have been “preferable” if a Sector Commander had been provided for the P3 casualties on Station Approach around to Hunts Bank.

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577 INQ012913/17
578 INQ012913/23
579 144/121/22-122/12
580 144/166/20-167/6

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Pre-determined attendance

12.448 There was no specific pre-determined attendance for a Major Incident, such as the Attack, suggested in the Major Incident Response Plan. This would have been helpful and should be a consideration for future planning. 581

12.449 It is not clear to me whether a pre-determined attendance would have assisted in relation to non-specialist paramedics on the night of the Attack. But a pre-determined attendance on 22nd May 2017 for the specialist crews may have accelerated the mobilisation process of these assets, which are of critical importance in a Major Incident. 582

Major Incident Response Plan action cards

12.450 The key roles at a Major Incident were introduced in the Major Incident Response Plan and cross-referred to the action card for each key role. 583 The Major Incident Response Plan described the action cards as “an integral part” of the plan. 584

12.451 For its Major Incident Response Plan, NWAS had adopted the action cards drafted by NARU. They were consistent with the national standard and

581 144/23/2-7
582 144/29/12-19
583 INQ013422/1
584 INQ012913/54
requirements at the time. They were fit for purpose.\textsuperscript{585}

12.452 Action cards provided an important aide-memoire, which ensured that key principles and actions were not forgotten in the stress of a mass casualty incident.\textsuperscript{586} The main issue with the action cards is that they were not used effectively on 22\textsuperscript{nd} May 2017. As a result, not all necessary actions were undertaken. In Part 14, I will consider this in further detail.

12.453 There was one notable exception to the adopting of NARU action cards. NWAS had not adopted NARU’s action card for HART Team Leader.\textsuperscript{587} Simon Beswick, who took the role of Team Leader for the GM HART crew, had not received any specific training in this action card.\textsuperscript{588} When undertaking an exercise in 2016 as HART Team Leader, Simon Beswick did not refer to this action card.\textsuperscript{589}

12.454 This was not Simon Beswick’s fault. NWAS had not adopted this action card by 22\textsuperscript{nd} May 2017.\textsuperscript{590} There is no good reason for this. I will return to

\begin{itemize}
\item \textsuperscript{585} INQ032665/29-30
\item \textsuperscript{586} INQ042544/47-48
\item \textsuperscript{587} INQ019194
\item \textsuperscript{588} 76/179/23-180/25
\item \textsuperscript{589} 76/180/5-13
\item \textsuperscript{590} 77/11/3-23
\end{itemize}
this action card and Simon Beswick’s activity in Part 14.

Site-specific plan

12.455 There was no site-specific plan for the Victoria Exchange Complex or the Arena.\textsuperscript{591} There was only a “site information sheet” dated October 2011 for the Arena.\textsuperscript{592} Site-specific plans can provide detailed information, including maps and building plans, which would have assisted command and control planning for establishing an FCP, locating exits, and considering appropriate locations for a Casualty Collection Point and a Casualty Clearing Station.\textsuperscript{593}

12.456 Although not required by NHS England, site-specific plans were not uncommon and NWAS itself had some. NWAS had not chosen to produce or share with another responder agency a plan for the Victoria Exchange Complex. It should have done. The Ambulance Service Experts informed me that site-specific plans for high-risk locations were “commonplace” in 2017. They considered that NWAS should have had such a plan for the Arena.\textsuperscript{594}

\textsuperscript{591} INQ032665/14-15
\textsuperscript{592} INQ041856/26
\textsuperscript{593} INQ032665/27-28
\textsuperscript{594} 144/9/9-10/2
12.457 A particular advantage for NWAS of a site-specific plan would have been dialogue between NWAS and Emergency Training UK (ETUK) and discussion of how they would interact if there were an emergency at the Arena. The lack of interaction between NWAS and ETUK, particularly at command level, was a significant failure on the night of the Attack. I will consider the relationship between ETUK and NWAS further in paragraphs 12.502 to 12.505, and in Part 16.

12.458 NWAS should ensure there is an up-to-date site-specific plan for all large, complex or high-risk locations within its area. These plans should include a floorplan layout so that entrances and exits are marked. It should include relevant contact details for those in charge of the location.\footnote{595}

12.459 While it is open to any single agency to produce its own site-specific plan, good practice would have been to ensure that there was a single multi-agency plan specific to the Victoria Exchange Complex. Fault for the failure to produce or share in such a plan for the Arena does not lie exclusively with NWAS. This was a failure of all of the Category 1 responders in the Greater Manchester area. There was a failure to
collaborate through GMRF. All site-specific plans should be multi-agency with contributions from all categories of responders.

Mass casualty plans

12.460 The ‘Greater Manchester Mass Casualty Plan’ (the GMRF mass casualty plan) was approved on 9th September 2013. It was a GMRF document. Responsibility for activating the GMRF mass casualty plan lay with the NWAS incident commander in conjunction with the on-scene medical adviser. Once activated, the GMRF mass casualty plan set in train a multi-agency response focused on saving and protecting life.

12.461 The GMRF mass casualty plan was scheduled for review on 1st October 2015. This review had commenced, but had not concluded, by the time of the Attack. The GMRF mass casualty plan was not formally activated during the critical period of the emergency response.

12.462 Complementing the GMRF mass casualty plan was the ‘GM Framework for Patient Dispersal in a Mass Casualty Event’ and the ‘GM Casualty
Capability Chart in a Mass Casualty Event’. These were in draft at the time of the Attack. The draft was dated 9th February 2017.

12.463 These documents set out the pre-determined capability of hospitals across the Greater Manchester area and beyond in relation to P1 and P2 patients. A flow diagram was included which was designed to help in the allocation of P1 and P2 patients to hospital.

12.464 Annemarie Rooney, the NWAS Tactical Commander on the night of the Attack, provided Daniel Smith with the numbers in the GM Casualty Capability Chart in a Mass Casualty Event at 23:41.

Training

12.465 The Major Incident Response Plan required all frontline ambulance personnel to undertake generic Major Incident training. Specific training is required at each level of command: strategic, tactical and operational.

12.466 It was a legislative requirement and a mandatory element of NHS England’s 2015 Emergency Preparedness, Resilience and Response Framework that personnel receive regular
training and exercising. There is specific training for specialist teams and commanders. Control staff must also undertake mandatory training in the operation of the medical priority dispatch system, which includes call handling, control procedures and incident response initiation.  

Commander training

12.467 NWAS commanders attended a variety of multi-agency, single-agency and health service focused development courses specific to their role. The Ambulance Service Experts found: “Based on the national standards and guidance in place at the time, the training programme provided to NWAS Commanders was adequate.”

12.468 The Ambulance Service Experts noted: “At least two [NWAS] individuals took on Command roles outside of what would be considered normal for incidents of this type and magnitude.” This was a reference to the two people who undertook the Operational Commander role: Daniel Smith and Stephen Hynes. The Ambulance Service Experts developed this further when giving evidence. They stated that the NWAS command structure did not function appropriately on the night of the
They stated this was illustrative of a broader problem with command in the ambulance service at that time.\(^609\)

12.469 I consider further the decisions taken and the actions of each of the NWAS commanders in Part 14. At this stage, I shall deal with what command level they were trained for and the roles they played on the night of the Attack.

12.470 Each of the commanders on the night had received sufficient instruction in JESIP and Operation Plato based on national standards at the time.\(^610\) Those commanders were Daniel Smith, Annemarie Rooney, Neil Barnes and Stephen Hynes. The difficulty on the night of the Attack was putting that JESIP training into practice.

12.471 Daniel Smith was a qualified Tactical Commander. On the night of the Attack, he took on the role of Operational Commander for approximately an hour from 23:01. He undertook NWAS commander training in 2013 and 2014. The latter of these was titled “JESIP multi agency (Bronze Commander) training course”.\(^611\) He did annual commander refresher training with NWAS in August 2015 and February 2016. In May 2016,
he completed the NARU Tactical Command course. He undertook the role of Operational Commander at four pre-planned events in 2015 and 2016: two events in August 2015, one in February 2015 and one in August 2016.\textsuperscript{612}

12.472 NWAS’s position was that, in May 2017, Daniel Smith was competent in the role of Operational Commander.\textsuperscript{613} The Ambulance Service Experts’ opinion was:

“... we deemed Mr Smith overall to have been competent. He was a qualified and experienced Tactical Commander, but it’s our experience that in practice, a Tactical Commander often retains sufficient knowledge and experience to also function at the operational command level.”\textsuperscript{614}

12.473 Overall, I have concluded that Daniel Smith had been adequately trained to perform the Operational Commander role.\textsuperscript{615} Nevertheless, Daniel Smith made a number of errors on the night. There were deficiencies in his early decision-making in relation to risk assessment and deployment of paramedics to the City Room. He failed to appoint a Safety Officer or an Equipment Officer. He did not call up the mass

\begin{footnotes}
\item[612] INQ041294, INQ042670/1-4
\item[613] INQ042670/4
\item[614] 145/1/25-2/19
\item[615] 145/1/24-2/21
\end{footnotes}
casualty vehicle. He did not create an adequate plan in relation to the removal of casualties from the City Room. 616

12.474 Daniel Smith was a Consultant Paramedic. 617 This meant he had a very high level of clinical skills that he could contribute to the incident. Considering all the various factors, it may have been better for Derek Poland to act as the Operational Commander and for Daniel Smith to have been deployed in a clinical role. Daniel Smith could have been deployed forward into the City Room at an early stage or remained in the Casualty Clearing Station. Alternatively, he could have been designated as the Sector Commander of the City Room. These might have been a better use of his skills.

12.475 Annemarie Rooney was a qualified Tactical Commander. She took on the role of Tactical Commander on the night of the Attack. She had sufficient training and was competent to function at the tactical command level. 618

12.476 Neil Barnes was a qualified Strategic Commander. He took on the role of Strategic Commander on the night of the Attack. He had

616 INQ041856/12-13
617 110/78/3-4
618 INQ041856/2
sufficient annual training and was competent to function at the strategic command level.\textsuperscript{619}

12.477 Stephen Hynes was a qualified Strategic Commander. When he arrived at the scene on the night of the Attack, Stephen Hynes took on the role of Operational Commander, taking over from Daniel Smith. The Ambulance Service Experts stated: “It remains unclear whether Mr Hynes had sufficient up-to-date training and operational level knowledge, particularly of specialist capabilities, to operate at the Operational Commander level.”\textsuperscript{620}

12.478 Stephen Hynes believed that he had maintained sufficient operational-level experience and competence to function in the operational command role.\textsuperscript{621} It was not clear to me why Stephen Hynes took over at this late stage of the operation. Equally, I do not think that his lack of qualification as an Operational Commander had a detrimental effect on the rescue attempt.

12.479 Stephen Hynes did not have an NWAS issue commander bag, without which he may not have been suitably equipped to take on the role.\textsuperscript{622}
12.480 There will be circumstances in which it is appropriate for the Operational Commander to remain in place throughout an incident. There will also be circumstances in which it will be appropriate for an Operational Commander to be relieved. This needs to be set out in a policy. If it is not, then a policy should be drawn up. All commanders should be clear on when and how this will occur according to the policy. The handover should follow an established procedure. Training of commanders should include practising handing over and taking over command.

**Frontline ambulance personnel training**

12.481 The Ambulance Service Experts found that frontline NWAS ambulance personnel were adequately trained to the requisite standard at the time.\(^623\) I accept this evidence.

12.482 All frontline staff, specialist and non-specialist, had to comply with annual mandatory training, which included Major Incident training. The Ambulance Service Experts found that the mandatory training was “sufficient to provide the basic preparations to carry out a range of functional roles at a major incident”.\(^624\) That does not mean that there were not areas where additional training would have been of benefit.

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623  INQ041856/3
624  INQ041856/3
The Ambulance Service Experts further noted that national standards have changed since the Attack. They require ambulance services to provide more comprehensive training.  

12.483 On 29th August 2017, a JESIP assurance visit stated that NWAS had “acceptable standards of preparedness”. I accept that there was official approval for the belief that JESIP was properly understood and being implemented by NWAS. However, what happened on 22nd May 2017 reveals that JESIP requirements had not been sufficiently embedded in NWAS personnel.

**Equipment**

12.484 Significant supplies of NWAS medical equipment were ready and available for emergency mobilisation to support a mass casualty emergency at the time of the Attack. The equipment was available both in vehicles at the scene and held elsewhere ready for deployment. This equipment was not all deployed effectively, and there seems no good reason why it was not. I will address this further in Part 14.

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625 INQ041856/3  
626 INQ014239  
627 INQ032665/77  
628 INQ041856/14  
629 INQ041856/4
12.485 NHS dressings packs, designed for use by first aiders, were held at Manchester Victoria Railway Station, and they were used on the night.\(^{630}\)

12.486 Each of the ambulances at the scene carried a “scoop’ orthopaedic stretcher, advanced and basic life support equipment”\(^{631}\). The evidence of the Ambulance Service Experts and NWAS was that ‘scoop’ stretchers were only suitable to be used by persons trained to use them. GMFRS personnel received training in a variety of forms of casualty extrication.\(^{632}\)

12.487 In my view, in a situation where there were insufficient trained personnel in the City Room, the risk presented of untrained personnel using a ‘scoop’ stretcher needed to be balanced against the alternative use of improvised stretchers. Although I am not critical of those who used such stretchers as they were doing their best, these did not provide a safe way of transporting people down a flight of stairs. Supervision of the use of ‘scoop’ stretchers could have been provided by NWAS personnel in the City Room.

12.488 The HART vehicles also carried stretchers. These were also available for use but were not used on the night of the Attack.\(^{633}\)

\(^{630}\) INQ041856/14
\(^{631}\) INQ041856/14, 109/199/13-16
\(^{632}\) 144/143/15-146/10
\(^{633}\) 144/146/11-20
12.489 Bulk equipment was available on the National Capability Mass Casualty Equipment Vehicle. This vehicle was described in the Major Incident Response Plan as having enough equipment to provide emergency treatment to 100 casualties, either P1 or P2, and up to 250 P3 casualties. It carried mass oxygen delivery systems and a range of specialised drugs and equipment to be used by doctors if required. No consideration was given to deploying this vehicle on the night. It should have been.

12.490 There was also bulk equipment on the HART and other specialist vehicles. The Ambulance Service Experts described the “pre-distribution of equipment across the NWAS area” as significant and demonstrating a “high level of preparedness”.

12.491 Each NWAS paramedic or responding clinician had access to advanced clinical equipment such as clinical response bags, defibrillator/monitors, and clinical ‘consumables’ on each attending ambulance and in the HART response bags.

12.492 Analgesia and controlled drugs were available and could be accessed via the locked vehicle

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634 INQ012913/44
635 INQ042544/71
636 INQ041856/14
637 INQ041856/4
safes. Equipment was also available in “Commander Bags”.

Exercising

12.493 Specific requirements for training and exercising were contained in the 2015 *NHS Emergency Preparedness, Resilience and Response Framework* and NARU documents.

12.494 NWAS staff trained as a single agency and with other agencies on their response to a possible attack. This was done via participation in a wide range of exercises to validate and test plans. Between 31st March 2016 and 16th May 2017, NWAS participated in around 30 exercises. Of these, 23 involved Marauding Terrorist Firearms Attack scenarios.

12.495 The Ambulance Service Experts commended NWAS’s “active participation in a number of large-scale multi-agency exercises in the two years prior to the Arena incident”.

12.496 I accept that NWAS had put in place extensive single-agency and multi-agency training and exercising. The exception to this is that there had not been multi-agency JESIP training for some

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638 INQ041856/15
639 INQ041856/4
640 INQ019165
641 INQ014028
642 INQ032665/56
time prior to the Attack. The events on the night demonstrated that it was needed. To take just one example at this stage, Patrick Ennis, who played a central role in the response, had not taken part in any multi-agency exercising despite having worked for NWAS for over 11 years and, at the time of the Attack, being one of only three Advanced Paramedics in Greater Manchester.

12.497 The training and exercising generated the opportunity to learn lessons, but there was a significant failure to implement changes in accordance with those lessons. The failure to implement change in areas identified as needing improvement is not confined only to NWAS.

12.498 The Ambulance Service Experts stated: “A number of issues identified during exercises were not sufficiently addressed and subsequently reoccurred during the multi-agency response to the incident on the 22\textsuperscript{nd} May 2017.” An example of this was a failure to appoint a Safety Officer in an exercise which occurred prior to May 2017, as was the case on the night of the Attack.
12.499 There had been a failure to learn and embed key lessons from exercises. This was most relevant in the areas of shared situational awareness, joint understanding of risk and co-location. 645

12.500 One further issue that emerged from the evidence was the limited extent to which non-specialists were involved in multi-agency exercises. This is something which I am told NWAS is considering how to improve. 646 I encourage NWAS to address this area for improvement as soon as possible. It is essential that the way specialist and non-specialist ambulance personnel work together and with the other agencies in a Major Incident is tested in multi-agency exercises.

12.501 I will consider the question of multi-agency exercising in further detail in a section at the conclusion of this Part, at paragraphs 12.733 to 12.899.

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645 INQ032665/56, INQ042544/7
646 INQ042544/9-10
Relationship with Emergency Training UK and the Arena

12.502 NWAS attended multi-agency group meetings at the invitation of SMG. These meetings were about forthcoming events. There does not appear to have been a well-developed relationship between ETUK and NWAS about what healthcare provision could be provided and how liaison would take place in the event of a Major Incident.

12.503 While it was open to ETUK to initiate contact, had there been a multi-agency plan of the premises, it is likely that some enquiry would have been made into the amount of healthcare provision that there was on the premises and where it was located. Some liaison could and should have taken place.

12.504 I deal with ETUK in greater detail in Part 16.

12.505 In Part 20 in Volume 2-II, I will consider the proposal for the deployment of Ambulance Liaison Officers at some events.
North West Fire Control preparedness

Key findings

- North West Fire Control’s (NWFC’s) training lacked a sufficient practical, real-life component.

- The Joint Emergency Services Interoperability Principles (JESIP) training was not embedded sufficiently within NWFC staff. This meant that, on the night of the Attack, NWFC staff failed in their core JESIP responsibility to share situational awareness.

- NWFC was not sufficiently involved in multi-agency exercising. This was a significant failure to ensure NWFC gained practical experience.

- NWFC did not have sufficient, or sufficiently clear, written plans and action cards to respond to a Major Incident.

- With better preparation, the failures in NWFC’s response which occurred on the night of the Attack would have been reduced or eliminated.

Establishment of NWFC

12.506 In 2004, the government launched a project to create nine regional control centres. These were to replace the 46 fire and rescue service control
rooms operating at that time around the country. The national project was terminated in 2010, but some regional control centres were still set up. NWFC was one of them.

12.507 NWFC was established in July 2007. It began operating on 14th May 2014. It was a local authority owned company. It was jointly owned by Cheshire Fire Authority, Cumbria County Council, Greater Manchester Combined Authority and Lancashire Combined Fire Authority. Each local authority was a shareholder. Merseyside Fire and Rescue Service withdrew from the project before it went live.

12.508 NWFC had an Agreement for Services with each local authority. The Agreement for Services set out the detail of the services it provided and how it delivered them. The Agreement for Services with GMFRS was dated 28th May 2014. Under the terms of the Agreement for Services, NWFC was required to mobilise resources in accordance with the mobilising policy and procedures.
supplied to it by GMFRS.\textsuperscript{658} NWFC did not provide a command function.\textsuperscript{659}

12.509 The core purpose of NWFC was to handle all fire and rescue 999 emergency calls and to be responsible for mobilising firefighters and fire appliances to incidents in Cumbria, Lancashire, Greater Manchester and Cheshire.

Structure of NWFC

Governance

12.510 NWFC had Articles of Association that governed its structure. It had a board of directors, two from each of its shareholders. The board set the strategic direction of NWFC and managed its financial resources.\textsuperscript{660} The Head of NWFC, Sarah-Jane Wilson, was appointed in October 2016.\textsuperscript{661} She held responsibility for “NWFC meeting its objectives and service standards”, including management of people, financial resources and contracts.\textsuperscript{662} As Head of NWFC, she reported directly to the board.\textsuperscript{663}

12.511 There was no head of NWFC between 2014, when it began to operate, and Sarah-Jane
Wilson’s appointment in 2016. She accepted that the lack of a head of the organisation for such a long period adversely affected the business of NWFC.

12.512 Sarah-Jane Wilson indicated that governance issues arose from the focus on transitioning to a joint control room. At the time of the Attack, the strategic direction of NWFC was dictated by a ten-year business case. This set out the basis for continuing with the transition in spite of the withdrawal of government support for the project. Sarah-Jane Wilson said that opportunities to put in place a robust governance structure were missed.

12.513 The governance problems meant that there was less focus on practical training and exercising by NWFC staff than there ought to have been, particularly joint training with fire and rescue services. This is a point to which I will return in paragraphs 12.534 to 12.554.

Operational roles

12.514 Sarah-Jane Wilson’s role as Head of NWFC was not operational. Tessa Tracey was the Senior
Operations Manager. She had responsibility for overseeing the Operations Managers, who in turn managed the Team Leaders. The Control Room Operators were managed by the Team Leaders.\textsuperscript{670}

12.515 NWFC provided cover for a population in the North West of England of approximately 5.5 million people.\textsuperscript{671} In the course of the six months between January and June 2017, it handled 60,123 emergency calls.\textsuperscript{672} Shift patterns were organised based on anticipated peak and low demand.\textsuperscript{673} Demand was usually at its lowest after 22:00.\textsuperscript{674}

12.516 When it was set up, NWFC managed its work through a regional operational group. This was known as the “Ops Group”.\textsuperscript{675} It met every six weeks with operational representatives from each of the four fire and rescue services it served. NWFC also appointed a Single Point of Contact to work with each fire and rescue service.\textsuperscript{676} The NWFC Single Point of Contact for GMFRS was Janine Carden, an Operations Manager.\textsuperscript{677} Her

\begin{itemize}
\item \textsuperscript{670} 125/187/14-19
\item \textsuperscript{671} https://www.nwfirecontrol.com/about/
\item \textsuperscript{672} INQ035485/5 at paragraph 2.5
\item \textsuperscript{673} 124/108/4-25
\item \textsuperscript{674} 124/108/23-25
\item \textsuperscript{675} INQ023877/5 at paragraph 1.20
\item \textsuperscript{676} 135/87/2-89/14
\item \textsuperscript{677} 124/174/10-15
\end{itemize}
counterpart at GMFRS was Group Manager Levy. They had what was described as an “extremely good, professional relationship”.

Facilities

12.517 NWFC operated from a purpose-built facility in Warrington. The layout of the NWFC control room, as it was on the night of the Attack, is shown in Figure 33.

Figure 33: NWFC control room, with Team Leader and Operations Manager placement highlighted
12.518 The NWFC control room was separated into four desk areas. These were referred to as pods and were organised by the fire and rescue services. The pod to the top of the image was for Lancashire and the pod to the right was for Manchester. The pod at the bottom of the image was shared between Cheshire and Cumbria. The Team Leaders and Operations Manager would sit at the pod to the left-hand side.

12.519 Michelle Gregson, a Team Leader, said that she introduced the pod system as there was previously no order to the way things were being done. Each Control Room Operator was allocated to a pod. Each pod was responsible for ensuring everything was operating correctly in its area and acted as a point of contact for its fire and rescue service. The Control Room Operators answered emergency calls from any area, irrespective of the pod where they were working. The Control Room Operator who answered an emergency call would respond to the immediate request and send the resources required. Having completed the initial ‘mobilisation’ of resources, the call would then be
passed to the relevant geographical pod, which would continue to manage the incident. 687

12.520 I accept that this is a logical way of working, but it is dependent on operational planning, rigorous training and exercising. There was a written plan for how the pod system would work in high-intensity situations, known as “spate condition”. 688 This was for pre-planned events such as Bonfire Night. 689 There was no plan for a no-notice significant event. 690 The failure to have a written plan for a no-notice incident was an oversight on the part of NWFC.

Responding to an incident

12.521 A member of the public dialling 999 who requested the fire and rescue service would have been transferred to NWFC by a BT emergency operator. Other emergency services and organisations could also contact NWFC. They used a dedicated emergency telephone number. 691

12.522 I was told that NWFC used a “state of the art” computer-aided dispatch system. This was designed to handle emergency calls and mobilise

687 124/69/19-71/7, INQ023877/20 at paragraph 4.5
688 124/71/16-19
689 124/71/17
690 124/71/13-72/5
691 INQ023877/19 at paragraph 4.2
fire and rescue resources. Michelle Gregson, who was a Team Leader on the night of the Attack, stated that the technology was better than any she had worked with previously. She also noted there were significant challenges in translating the system to common ways of working across four fire and rescue services. An example of this was that commonly used acronyms had different meanings in different fire and rescue services.

12.523 An automatic call distribution system allocated a call to a Control Room Operator. This required Control Room Operators to indicate when they were ready to answer an emergency call. The Control Room Operator who had been waiting the longest received the next call. Emergency calls appeared on a touchscreen. The Control Room Operator must answer the emergency call within five seconds. An emergency call had a high tone. It appeared as red or amber on the computer-aided dispatch system.

12.524 The computer-aided dispatch system automatically generated a “New Incident Form”
when an emergency call was answered.\textsuperscript{699} The Control Room Operator inputted into the form the location, the nature of the incident and any other useful detail. This in turn created an incident log. Any decisions or actions made by NWFC staff were recorded on the incident log. This process was the same for any incident, and multiple logs were created for larger incidents.\textsuperscript{700}

> 12.525 Four incident logs were generated as a result of the Attack. I heard that it was common practice for there to be more than one incident log for large incidents,\textsuperscript{701} but I consider having this many should have been unnecessary. It caused confusion in NWFC’s mobilisation of the GMFRS response. It led to a failure to capture crucial information in one place. This in turn increased the risk of critical information not being communicated to others.\textsuperscript{702} The Fire and Rescue Expert concluded, and I agree, that having a single source of information would have improved situational awareness within the control room.\textsuperscript{703}

> 12.526 On the computer-aided dispatch system, a Control Room Operator allocated an incident type and a priority. A priority of ‘1’ was the most

\textsuperscript{699} INQ023877/22 at paragraph 4.12
\textsuperscript{700} INQ023877/23 at paragraph 4.13
\textsuperscript{701} 123/64/15-21
\textsuperscript{702} 123/220/9-12, 124/28/23-29/3, 124/32/22-33/7
\textsuperscript{703} INQ041857/13-14 at NWFC14
serious with a significant risk to life or property.\textsuperscript{704} Certain locations and types of incident would have a pre-determined attendance that sets the level of resources sent.

12.527 Once resources were mobilised, Control Room Operators must follow an action plan. These were provided by the fire and rescue services and listed any additional actions that the Control Room Operator must take following the initial mobilisation.\textsuperscript{705} Michelle Gregson explained that NWFC could not use discretion in its application of GMFRS action plans\textsuperscript{706} and that there was a lack of training about how to apply them.\textsuperscript{707} I shall return to the issue of action plans when I consider NWFC’s written plans at paragraphs 12.563 to 12.592.

12.528 Once an emergency call was on the system, the computer-aided dispatch system allocated a radio talk group to the incident. All attending fire appliances must switch to the dedicated talk group. NWFC was able to transmit group messages, and all fire resources attending could communicate directly with each other. NWFC did not constantly monitor these talk groups.\textsuperscript{708}
12.529 Sarah-Jane Wilson conceded that there was not adequate use of the multi-agency radio channels by May 2017. She was not aware of many, if any, incidents where they had been used to communicate between control rooms. Failing to ensure adequate communication between the emergency services was a critical shortcoming in the response by all the emergency services.

Failures in preparedness

12.530 The context for the establishment of NWFC and how it was set up, governed and operated is important for understanding its preparedness, or in places the lack of it, for an incident such as the Attack.

12.531 Despite the detailed and careful work to establish it, when I heard evidence from the Head of NWFC, she began by saying that NWFC was responsible for “significant failures in the management of information” on the night of 22\textsuperscript{nd} May 2017. She was right to say this.

12.532 The response of NWFC fell below what was required. NWFC failed to capture and communicate proper situational awareness. This contributed to the serious and unacceptable
delays in the deployment of GMFRS resources to the scene of the Attack.

12.533 The remainder of this section of the Report will analyse why this happened by looking at the preparedness for a Major Incident of NWFC prior to 22nd May 2017. In common with other emergency services, I will consider a number of areas of preparedness. I will look at the adequacy of the training of NWFC staff. I will then turn to consider NWFC’s role in exercises. Finally, I will examine the written plans and protocols that NWFC had in place for an event of the type which occurred at the Arena.

NWFC staff training

Training generally

12.534 NWFC training was competency based and divided into four phases and pathways. It covered an introductory, four-week course for new entrants. There was further training to develop competent Control Room Operators, Team Leaders and Operations Managers.

12.535 Generally speaking, the NWFC training was conducted to a reasonable and acceptable standard. Sarah-Jane Wilson, however, accepted

711 INQ023877/17 at paragraphs 3.1.1-3.1.7
that NWFC overlooked the practical application of training.\textsuperscript{712} I agree with her.

12.536 One of the Control Room Operators on the night of the Attack, Dean Casey, explained that to pass his Phase 1 training as a Control Room Operator he had four weeks of classroom-based learning. He said that to be confident in his role he needed more real-life training. He said that his training would have been better if there had been practical exercises in the control room.\textsuperscript{713}

12.537 I was told that, after completing the four weeks of classroom-based training, a Control Room Operator was shadowed by a competent member of staff for two weeks. Their calls were monitored, and they would be talked through what to do. After those two weeks, a Control Room Operator was permitted to take calls on their own. Some calls would still be monitored, but they were deemed competent to deal with emergency calls from that point.\textsuperscript{714}

**JESIP training**

12.538 From 2015, Senior Operations Manager Tessa Tracey was the JESIP lead for NWFC. As part of that role, with two colleagues, she attended a national training course on JESIP at the College

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\textsuperscript{712} 135/12/21-13/18  
\textsuperscript{713} 123/145/17-146/11  
\textsuperscript{714} 123/146/12-147/8
of Policing. She then worked with colleagues in the ambulance and police services to deliver regular tri-service training in JESIP.\footnote{125/194/6-196/16}

12.539 Tessa Tracey stated: “\textit{In the light of the training, I personally felt that I had a good understanding of the ways of working and felt confident and prepared should we receive a terrorist incident within our region.}”\footnote{125/197/6-13} She conceded, however, that “\textit{JESIP on the night did not achieve what we were expecting it to achieve in lines of communication there had been practical exercises in.”}\footnote{125/224/12-23}

12.540 Other NWFC witnesses echoed this failure in the application of their JESIP training.\footnote{122/200/12-201/6, 122/217/1-218/6, 125/151/13-152/3}

12.541 Michelle Gregson stated that she was confident in her JESIP training and knowledge. She did not, though, feel confident in applying it in practice.\footnote{123/213/1-10} The training was integrated into a PowerPoint presentation about responding to a Marauding Terrorist Firearms Attack. It looked at the reasons for the inception of JESIP and the principles.\footnote{122/216/10-19}
12.542 Shortly after notification of the Attack at 22:38, Michelle Gregson issued a reminder to her team to use their “JESIP training and multi-agency working”. This was a sensible step to take. She reminded those in the control room that they needed to communicate any relevant information received. Despite this, she recognised when giving evidence that there was an absence of sharing critical information in helping to manage the emergency response. Information-sharing is a key part of JESIP.

12.543 Lisa Owen, who was also a Team Leader on the night of 22nd May 2017, stated that she had only had the PowerPoint presentation on JESIP. She did not attend an external multi-agency training course. She felt that would have given her a different insight. She accepted that a multi-agency response was possibly not her mindset.

12.544 In evidence, the Control Room Operators on duty on the night of the Attack generally stated that they understood JESIP but that they would have welcomed more training. David Ellis felt he needed real-life exercising, particularly on
mobilisation. He explained that would “help manage the room” and “pre-empt a what-if situation”. 726 The training has since been improved and takes a more in-depth approach. 727

12.545 Sarah-Jane Wilson accepted that NWFC had “viewed JESIP as a process and not necessarily a dynamic way of thinking”. 728 That was an appropriate concession to make. Staff were not adequately trained to seek information proactively from other control rooms. I have heard that changes implemented post-Attack have been designed to make the control room more proactive in its response to an incident. 729

12.546 Sarah-Jane Wilson acknowledged that there were substantial problems with JESIP on the night of the Attack. 730 She was asked about the JESIP assurance visit in August 2017. This identified that individuals across all grades had not completed the JESIP e-learning or had an input since 2015. 731 This was an unsatisfactory state of affairs.
Operation Plato training

12.547 Station Manager Gaskell was the Marauding Terrorist Firearms Attack lead for GMFRS. He had held this position since February 2011. Part of this role required Station Manager Gaskell to develop and deliver training to NWFC. In his evidence, Station Manager Gaskell spoke about a PowerPoint presentation on Marauding Terrorist Firearms Attack incidents he gave to NWFC staff.

12.548 The training emphasised that, in a terrorist incident, the police were the lead agency. In a Marauding Terrorist Firearms Attack situation, NWFC staff were trained first to contact the duty National Interagency Liaison Officer (NILO). This was to gather any further information before mobilising fire resources.

12.549 Janine Carden was NWFC’s designated Single Point of Contact with GMFRS. She received Marauding Terrorist Firearms Attack training from Station Manager Gaskell and training about the role of a NILO from Station Manager Michael Lawlor. NWFC Team Leaders and Operations Managers were also present at Marauding
Terrorist Firearms Attack training events. Station Manager Gaskell stated when giving evidence that Janine Carden and other NWFC staff were invited to GMFRS training events because they were relevant to the actions of NWFC. Janine Carden stated that the training was, in the event of a suspected Marauding Terrorist Firearms Attack, to always “tell a NILO”. She said that felt contrary to ordinary instinct within a control room, which was “if in doubt, turn out”.

12.550 The training was clear that, if a Marauding Terrorist Firearms Attack were suspected, NWFC should not mobilise immediately and should instead speak to the NILO. Janine Carden could not recall if written guidance to this effect was issued. The PowerPoint presentation used by Station Manager Gaskell stated, “Should any contact be made to the FRS [fire and rescue service] for assistance or become aware of an incident involving firearms, then the on-call NILO must be contacted.” Janine Carden confirmed that Station Manager Gaskell left his training
package with NWFC so that it could be disseminated to its staff. 741

12.551 Not all NWFC personnel knew that the NWAS HART and the GMFRS Specialist Response Team trained and exercised together. Team Leaders Michelle Gregson and Lisa Owen each stated they were not aware of this. 742 Janine Carden stated that the Marauding Terrorist Firearms Attack training covered who could go into what Operation Plato zone. She knew about HART and the Specialist Response Team working together, and she thought others would be aware. 743 The fact that this does not seem to have been widely known within NWFC is an example of a lack of cohesion in the multi-agency delivery of the Marauding Terrorist Firearms Attack training. Lisa Owen said that, if she had known this, the importance of speaking to NWAS on the night of 22nd May 2017 would have been clearer to her. 744

12.552 In 2016, Janine Carden participated in an audit of GMFRS Marauding Terrorist Firearms Attack policies. 745 The audit was conducted principally by the National Fire Chiefs Council and the Chief

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741 125/4/24-5/12
742 124/46/6-15, 125/159/16-20
743 125/23/11-24/18
744 125/159/21-160/2
745 125/103/19-104/18
Fire and Rescue Adviser. Station Manager Gaskell also participated. He was told that the purpose was “to look at the processes in place, the action cards in place and to ensure that they [NWFC] had the adequate training to respond to an attack of this nature.” As part of the audit, the GMFRS action plans for an Operation Plato incident were inspected. Janine Carden was questioned about her knowledge of Operation Plato and Marauding Terrorist Firearms Attack incidents. The audit findings commended Janine Carden for her knowledge of GMFRS’s mobilising procedures and wider Marauding Terrorist Firearms Attack incident implications.

12.553 This shows that there was, generally, a good system of theory-based training in place for responding to a Marauding Terrorist Firearms Attack incident. A senior NWFC staff member had a good working knowledge of what was expected of them by GMFRS should a Marauding Terrorist Firearms Attack-type incident occur.

12.554 I agree with the view of the Fire and Rescue Expert that NWFC staff were adequately trained to respond to a terrorist attack such as the one that occurred at the Arena on 22nd May 2017.
What was lacking was exposure to testing that knowledge in real-life exercises. This is something that many NWFC witnesses repeated.\(^{750}\) Sarah-Jane Wilson explained that she did not consider asking fire and rescue services to invite NWFC to participate in live training and exercising. She accepted that was a failing.\(^{751}\) As Michelle Gregson put it: “I felt confident with my training and knowledge. What I didn’t feel confident in is perhaps applying that practically because we never had the chance to do that in a simulated situation.”\(^{752}\)

Training deficiencies and failures on the night of the Attack

12.555 The events on 22\(^{nd}\) May 2017 exposed the problems that arose from NWFC not participating in real-life, practical training. This contributed to a failure to understand the importance of sharing critical information about the nature of an incident.

12.556 The duty NILO was not informed of critical information. This information included that, at 22:44, GMP had an officer at the scene and, at 22:46, there were more GMP officers on the...
way. Nor was the NILO informed of GMP Control’s report to NWFC at 22:54 that the “paramedic Bronze has just arrived on scene”. There was a failure to understand the importance of the NILO saying he could not reach the FDO. There was a failure to understand the use of the multi-agency talk group.

12.557 Better training, which includes exercising, would have given NWFC staff more confidence in dealing with a difficult and complex situation. It would have allowed them to maximise the opportunities to share situational awareness.

12.558 In the event, NWFC staff were less proactive than they should have been. They did not interrogate the information they received, they did not seek information proactively and they failed to share information. These failings had consequences.

Incident types and action plans

12.559 NWFC did not provide a command function. It was required to respond to emergency calls by following action plans for pre-determined incidents. Some witnesses referred to these as “action cards”. The action plans determined

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753 125/198/3-199/3
754 125/199/9-202/5, INQ001231/14
755 123/173/24-175/11
756 13/55/25-56/8
how NWFC would respond to any given incident through mobilising pumps, equipment and personnel. 757 Some of the action plans required that NWFC obtained advice or guidance from a GMFRS NILO before mobilising to a scene. 758

12.560 Action plans were provided to NWFC by the fire and rescue services. They set out the pre-determined mobilisation response which NWFC was required to follow under the Agreement for Services with each fire and rescue service. GMFRS was responsible for devising and providing these mobilisation instructions to NWFC for Greater Manchester. 759

12.561 Action plans were linked to incident types. A Control Room Operator could search for action plans or incident types. Once a relevant action plan had been identified, it was added to the log. 760 The Control Room Operator had to confirm any mobilisation prompt before a notification was sent to the relevant fire stations for a crew to deploy. 761

12.562 The action plans were accessed on the computer-aided dispatch system through a drop-down menu. Originally, they were physical cards

757 13/57/11-18
758 13/57/19-58/16
759 122/70/23-71/10, INQ035485/8 at paragraph 5.2
760 122/181/1-182/23
761 122/183/21-184/13
in the control room: the Control Room Operator would flip through to get to the correct one. Over time, the action plans were converted to Word documents and the content uploaded onto NWFC’s system. This meant that the Word document became redundant for NWFC and could not be accessed by the Control Room Operator. However, GMFRS kept the Word version on which updates were marked.\textsuperscript{762}

‘Explosion’ and ‘Bomb-general’ action plans

12.563 There were two types of action plan which were considered in detail during the evidence. The ‘Explosion’ action plan was attached to an incident type of the same name. It was to be used for responding to a suspected explosion. Following the steps on this action plan meant deploying the Technical Response Unit, a number of fire appliances, a Station Manager and the duty NILO directly to the scene of the incident.

12.564 In the Word version of the ‘Explosion’ action plan, under the heading “Triggers”, it stated: “Cause of explosion could trigger different ITAPs [Incident Type Action Plans] – Gas, Bomb, Cylinders, Chemicals, Impact…”\textsuperscript{763} There was no Incident Type Action Plan specific to an explosion caused by a bomb.\textsuperscript{764} This was a failure by GMFRS given

\textsuperscript{762} 122/62/11-64/5
\textsuperscript{763} INQ004404/1
\textsuperscript{764} 124/181/8-186/4
that the Word version of the ‘Explosion’ action plan anticipated that there would be one.

12.565 The ‘Bomb-general’ action plan was attached to an incident type of the same name. It was intended for use where an unexploded bomb had been identified.\textsuperscript{765} An example was given of unexploded ordnance from the Second World War.\textsuperscript{766} This action plan required NWFC first to seek guidance from the duty NILO on the actions to be carried out, before any mobilisation of resources.\textsuperscript{767} This was to ensure the scene was safe of secondary devices and other hazards before personnel were deployed.\textsuperscript{768}

12.566 The Fire and Rescue Service Expert stated that the action plans had the potential to confuse.\textsuperscript{769} I agree.

12.567 NWFC witnesses stated that they were uncertain about when each plan applied.\textsuperscript{770} Michelle Gregson stated that the information on the night of the Attack was “\textit{vast}” and “\textit{vague}”.\textsuperscript{771} She said that she did not know which plan fitted but concluded that she needed to contact the duty NILO. She regarded the duty NILO as the expert

\textsuperscript{765} 119/169/7-12, 123/46/13-17, 124/181/14-24
\textsuperscript{766} 124/181/17-22
\textsuperscript{767} 119/169/13-170/1
\textsuperscript{768} INQ032856/3 at paragraphs 2.2 and 2.3
\textsuperscript{769} INQ041857/8
\textsuperscript{770} 135/61/22-62/23, 123/222/10-224/12, 123/46/6-24
\textsuperscript{771} 124/7/22-8/12
who could help with decision-making. She stated that there was a reliance on and expectation that Control Room Operators had been trained in the detail of the action plan and would remember it.

12.568 Joanne Haslam explained that she had no training on the use of the ‘Bomb-general’ action plan.

12.569 Sarah-Jane Wilson stated that, at the time of the Attack, her understanding was that the ‘Bomb-general’ action plan related to any type of bomb incident; whereas she thought that the ‘Explosion’ action plan was for a non-malicious explosion. Another witness gave the example of a domestic gas explosion.

12.570 GMFRS Group Manager Fletcher accepted that an exploded bomb, with the risk of secondary devices, was a situation in which “you’d be caught between the two action plans”. Station Manager Gaskell acknowledged that there was the possibility for confusion. However, he said

772 124/7/22-8/12, 124/9/6-12
773 123/230/16-19
774 INQ035438/3 at paragraph 15
775 128/127/5-12
776 128/127/5-12
777 117/32/16-33/2
he did not have any feedback from NWFC that the ‘Bomb-general’ action plan was confusing.\textsuperscript{779}

12.571 At the start of the oral evidence hearings, it was accepted on GMFRS’s behalf that the ‘Explosion’ action plan should have been clearer.\textsuperscript{780} I agree. There was clearly considerable room for doubt over which action plan applied and the appropriate steps to take.

12.572 The ‘Bomb-general’ and ‘Explosion’ action plans were not clear enough. They did not make clear the incident type to which they each applied. There was a risk that a Control Room Operator who was told that a bomb had caused an explosion or that a bomb had gone off, would use the ‘Bomb-general’ action plan, rather than the ‘Explosion’ action plan. Responsibility for this issue lies with GMFRS, which owned the action plans.

12.573 Since the Attack, GMFRS has introduced revised action plans. Specifically, the ‘Bomb’ action plan now includes a direction that the ‘Explosion’ action plan must be used if the device has detonated.\textsuperscript{781} The pre-determined attendance for an unexploded bomb is to send firefighters and assets to the incident ground, not to inform the

\begin{itemize}
\item \textsuperscript{779} INQ032830/9
\item \textsuperscript{780} INQ035482/28 at paragraph 78, INQ042436/8 at paragraph 30
\item \textsuperscript{781} INQ032830/9
\end{itemize}
duty NILO and obtain an RVP. If faced with an incident type involving a bomb which has exploded, NWFC are now required to mobilise firefighters and resources to the scene. The requirement for NWFC to obtain instructions from the duty NILO before mobilising has been removed.

**Operation Plato action plans**

12.574 NWFC had three action plans for responding to an Operation Plato incident.

12.575 The first of these, ‘Operation Plato (Standby)’, was used to ensure resources were put into a state of readiness. Station Manager Gaskell referred to it as a “heads up” to get resources standing by for the implementation phase. The first prompt under this action plan was to contact the duty NILO.

12.576 The Word version of the ‘Operation Plato (Standby)’ action plan had text before the prompts which stated: “NWFC Actions upon receiving information from Fire Crews, GMP, NWAS that a firearms incident is on-going.”
12.577 When asked about the ‘Operation Plato (Standby)’ action plan, Michelle Gregson stated she thought Operation Plato was limited. She thought that there had to be a reported firearms incident before the plan could be followed and that Operation Plato had to be called by the police. She went on to say that she could have done with some more training around it.  

12.578 Station Manager Gaskell said that the training focused on JOPs 3. He stated that the key was the attack methodology, namely whether or not it was a deliberate terrorist act. According to Station Manager Gaskell, gunshot wounds or shrapnel in isolation would not be sufficient to use the Operation Plato action plans.

12.579 Sarah-Jane Wilson stated that the Marauding Terrorist Firearms Attack training was designed to help Control Room Operators and Team Leaders recognise an unfolding terrorist incident as opposed to a “normal explosion incident type”.

12.580 GMFRS’s training in relation to the use of the ‘Operation Plato (Standby)’ action plan did not align precisely with the text in the Word version. There was greater focus in the training on identifying whether or not they were dealing with
a terrorist attack than on whether it was a firearms incident. I am not critical of this training, as it better reflected JOPs 3. However, it did give rise to a tension with the ‘Explosion’ action plan, which I will address at paragraphs 12.590 to 12.598.

12.581 The second of the Plato action plans, ‘Operation Plato (Implementation)’, required NWFC to inform the duty NILO and take advice. The Word version of this action plan prefaced the prompts with: “NWFC Actions when informed that a firearms incident is on-going and that the Implementation Phase should be applied.”

12.582 Both Word versions were marked as last updated in December 2015 by Group Manager Levy and Janine Carden, following a meeting with Group Manager Fletcher.

12.583 The third action plan, ‘Operation Plato (Stand down)’, was to be used once the whole scene was a cold zone, and there was no longer a perceived threat.

Tension between two action plans

12.584 The crucial first step of the ‘Operation Plato (Standby)’ action plan was to contact the duty NILO before any mobilisation. This was different

791 117/121/13-122/1
792 119/16/13-18, 122/70/6-22
793 117/123/4-16
from the ‘Explosion’ action plan which involved deploying firefighters straight to the scene immediately.

12.585 Information coming into NWFC at an early stage may be incomplete, inaccurate or may exaggerate the true state of affairs. An example of this occurred at 22:43 on 22nd May 2017 when David Ellis was informed by GMP Control that a “police officer just said injured party with gunshot wound to the leg outside the entrance to Victoria Station”. This information, no doubt given in good faith, was wrong.

12.586 At the heart of the challenge for the staff at NWFC was that an explosion may be a single, isolated incident or it may be the start of a Marauding Terrorist Firearms Attack. According to JOPs 3: “A marauding terrorist firearms attack (MTFA) may involve: … The use of explosives.”

12.587 Station Manager Gaskell stated that it would be “unusual” for NWFC to have information that an explosion was caused by a bomb. The timing of the notification that a bomb was involved appeared to be Station Manager Gaskell’s explanation for why he did not think the two action plans were in tension.
12.588 Station Manager Gaskell stated that he gave periodic training to NWFC staff on Marauding Terrorist Firearms Attack procedures. It included updates on JOPs and mobilisation procedures. Station Manager Gaskell delivered training to NWFC in October 2014 and November 2015. He believed that the training was “well received and well attended”. A PowerPoint presentation entitled ‘Marauding Terrorist Firearms Attack (MTFA)’ was used. It focused on firearms attack methodology. It advised that, if fire and rescue assistance were needed, the duty NILO must be contacted first.

12.589 At 22:35 on the night of the Attack, prior to a mobilisation decision, NWFC was informed by GMP Control that “a bomb has exploded”. The information was that the bomb had exploded at an iconic venue, the Arena. This created the very real possibility that a terrorist attack had occurred. Under JOPs 3, it may have signified that a Marauding Terrorist Firearms Attack was under way. As I said in Part 10, I am not critical of GMP for declaring Operation Plato on the basis of an exploded bomb.

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798 INQ033910/12 at paragraph 48
799 INQ033925/1
800 INQ033925/16
801 INQ001231/3
12.590 On the information it was presented with on 22\textsuperscript{nd} May 2017, NWFC could have followed either the ‘Explosion’ action plan or the ‘Operation Plato (Standby)’ action plan. Given that NWFC was required by the Agreement for Services to follow GMFRS’s mobilisation plan, it is highly unsatisfactory that there were two potentially applicable action plans which required different initial steps.

12.591 One final aspect of this issue is that GMFRS had created guidance on Marauding Terrorist Firearms Attacks entitled ‘MTFA – Mobilisation Emergency Response’. Version 1 is dated February 2017 and authored by Group Manager Fletcher.\textsuperscript{802} Station Manager Gaskell stated it contained “cast iron mobilisation instructions for NWFC to follow”.\textsuperscript{803} If a Marauding Terrorist Firearms Attack were suspected, the guidance directed NWFC to obtain as much information as possible and to inform the duty NILO as a priority.\textsuperscript{804}

12.592 None of these documents made reference to the possibility of an explosion being related to a Marauding Terrorist Firearms Attack, nor did they encourage the same application of operational

\begin{itemize}
  \item[802] INQ004213/1, INQ004213/3
  \item[803] INQ033910/12 at paragraph 51, 117/177/15-178/20
  \item[804] 117/136/21-137/5, INQ004213/5
\end{itemize}
discretion by NWFC staff as permitted to GMFRS officers.\(^{805}\)

**Major Incident Plan**

12.593 On 22\(^{nd}\) May 2017, NWFC did not have a Major Incident Plan. This was a weakness in NWFC’s preparedness to respond to a terrorist attack or other large incident. As a result of the communication failures on 22\(^{nd}\) May 2017, NWFC has now developed a Major Incident Plan.\(^{806}\)

12.594 Sarah-Jane Wilson explained that the purpose of this plan, at its core, is to provide Team Leaders with a prompt “to actively seek out and share information”.\(^{807}\) It directs the co-ordination of communications between the emergency services by providing contact information to NILOs, and monitoring inter-agency communications and fire service involvement at all operational command levels.\(^{808}\)

**NWFC’s involvement in exercises**

12.595 NWFC did not participate in any joint-agency Marauding Terrorist Firearms Attack, JESIP or Operation Plato exercises.\(^{809}\) There was broad agreement from NWFC witnesses that this

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805 117/29/17-30/5
806 INQ035485/28 at paragraph 13.6
807 INQ023877/33 at paragraph 8.6
808 INQ023877/33 at paragraph 8.7
809 124/124/3-23
should not have occurred. One witness described it as “extraordinary” that NWFC was not involved.\textsuperscript{810} I agree.

12.596 Despite incidents usually starting with a telephone call to a control room, NWFC was “overlooked”.\textsuperscript{811}

12.597 In his evidence, Group Manager Fletcher accepted that, prior to the Attack, the ability of the NWFC control room to respond to a Marauding Terrorist Firearms Attack had not been tested. The training which had been conducted by multi-agency partners only ever covered what was to happen from the point of mobilisation onwards.\textsuperscript{812}

12.598 Station Manager Gaskell suggested that NWFC was not involved in exercises because it was under-staffed. It could not, he stated in evidence, carry on business as usual and participate in live exercises.\textsuperscript{813} Janine Carden disputed Station Manager Gaskell’s assertion. She said that NWFC would always want to be involved in exercises and she was passionate about it.\textsuperscript{814}

12.599 Attending live exercises would have allowed NWFC staff a chance to practise in

\textsuperscript{810} 123/213/11-25
\textsuperscript{811} 123/213/11-25
\textsuperscript{812} 63/125/21-126/9
\textsuperscript{813} 117/143/6-23
\textsuperscript{814} 125/20/1-21/14
circumstances that mirrored real life. This would have increased their awareness of potential problems. It would also have involved NWFC in debriefs where issues were discussed. Michelle Gregson stated that participating in a multi-agency exercise would have enabled her to act differently on the night of the Attack: it would have given her the foresight to ask questions, understand communication difficulties and probe issues more. Joanne Haslam, who was a Control Room Operator on the night of the Attack, stated that being involved in such an exercise would have been beneficial and a great advantage: it would have kept actions and information up to date.

12.600 I agree with Michelle Gregson and Joanne Haslam. NWFC should have been involved in multi-agency exercises. Had NWFC been involved in such exercises, it would have allowed for mobilisation to be tested in a multi-agency context. In turn, this is likely to have led to the identification and elimination of the problems that occurred on the night of the Attack.
Conclusion

12.601 NWFC prepared its staff before 22nd May 2017 to meet some of the challenges posed by a terrorist attack. In particular, it had a good training structure to develop staff for working in a control room, and it had modern ways of working with access to good IT systems.

12.602 However, NWFC failed to prepare its staff adequately for the real-world challenges posed by a Marauding Terrorist Firearms Attack or a terrorist attack on the scale of what occurred on 22nd May 2017. It did not participate in multi-agency exercises. As a result, the importance of joint working, information-sharing, a knowledge of how the fire and ambulance services worked together, and an understanding of JESIP were not part of the muscle memory of NWFC staff.

12.603 This preparedness was further hindered by a lack of clarity in crucial action plans for responding to a terrorist attack involving a bomb. This was not solely the responsibility of NWFC. NWFC personnel had a general understanding of how to respond to different types of Major Incident. They were not sufficiently trained to be dynamic in managing a complex emergency response, particularly in gathering and sharing information.
Key findings

• Greater Manchester Fire and Rescue Service (GMFRS) was well equipped to respond to a Marauding Terrorist Firearms Attack.

• GMFRS specialist personnel were adequately trained to respond to a Marauding Terrorist Firearms Attack. There was room for improvement in the Joint Emergency Services Interoperability Principles (JESIP) training.

• GMFRS had an established Marauding Terrorist Firearms Attack capability. It created the Technical Response Unit and Specialist Response Team. These were equipped and trained to respond to a Marauding Terrorist Firearms Attack.

• GMFRS was one of the national leads in creating the National Interagency Liaison Officer role. It worked hard to embed the role as part of its Marauding Terrorist Firearms Attack capability.

• GMFRS was actively involved in leading, preparing and delivering multi-agency training and exercises.
• GMFRS failed, with other organisations, to learn the lessons identified from multi-agency exercises.

• GMFRS failed to involve North West Fire Control (NWFC) sufficiently, or sometimes at all, in multi-agency training.

• GMFRS failed to create sufficiently clear action cards for NWFC to respond to an explosion, such as the one that occurred during the Attack.

• GMFRS failed to embed use of the action cards by NWFC through training and exercises.

Responsibilities, governance and structure

Responsibilities

12.604 GMFRS is one of the largest fire and rescue services outside of London. It covers approximately 500 square miles and the ten boroughs of Greater Manchester, which has a population of 2.5 million. Its core functions are set down in law, supplemented by guidance and policies.

12.605 The Fire and Rescue Services Act 2004 required fire and rescue authorities to make provision for fire safety, firefighting and road traffic accidents,

817 INQ026714/18 at paragraph 70
818 Greater Manchester Fire and Rescue Service, ‘Community Resource Brochure’
and for responding to other emergencies.\textsuperscript{819} The latter was a broad function. GMFRS considered that it included a fire and rescue service responding to a terrorist incident.\textsuperscript{820} Each of the statutory functions required the provision of trained personnel, services and equipment for the fulfilment of its obligations. Arrangements had to be made to deal with emergency calls and to mobilise personnel.\textsuperscript{821}

**12.606** At the time of the Attack, there was no agreement between the Fire Brigades Union and fire and rescue service leadership nationally about whether responding to a terrorist attack was a contractual requirement for a Firefighter. This had no impact on the response by GMFRS on the night. However, there were concerns at the time about ensuring the safety of firefighters in a Marauding Terrorist Firearms Attack situation.\textsuperscript{822}

**12.607** The *Fire and Rescue National Framework* set country-wide priorities and objectives for fire and rescue authorities.\textsuperscript{823} The framework in place in May 2017 dated from 2012. It required collaboration and interoperability with other emergency services.\textsuperscript{824} General reference was
made to terrorism but not, until updated guidance was issued in May 2018, to the need for a Marauding Terrorist Firearms Attack capability.  

12.608 GMFRS was a Category 1 responder under the 2004 Act. This meant that it must participate, together with other Category 1 responders, in GMRF. A core purpose of any resilience forum was to ensure that all Category 1 responders co-ordinated a joint approach.  

12.609 The purpose of GMFRS, set out in its Corporate and Integrated Risk Management Plan 2016-20, was “to save, protect and improve the lives of the people of Greater Manchester”. Its aims, set out in the same plan, were grouped into six themes. They included planning and preparing for emergencies and helping to reduce the risk of them occurring.  

12.610 I will consider the extent to which GMFRS was adequately prepared to meet these responsibilities and, in particular, to respond with partner emergency services to a major terrorist attack. I will consider the structure and governance of GMFRS, its equipment and specialist capabilities, training and exercising,
and the preparation of plans and policies to respond to a terrorist incident.

**Governance**

12.611 The Mayor of Greater Manchester had overall responsibility for the governance, strategic and financial management of GMFRS. The Mayor was the Fire Commissioner for GMFRS. Secondary legislation establishing the responsibility of the Mayor for GMFRS came into force shortly before the Attack, on 8th May 2017.  

12.612 Strategic leadership of GMFRS was provided by a corporate leadership team. In May 2017, this included Chief Fire Officer Peter O’Reilly, Deputy Chief Fire Officer Argyle, and two Assistant Chief Fire Officers, Geoffrey Harris and David Keelan.  

12.613 Concerns were expressed during the Inquiry about aspects of the governance of GMFRS. There were, for example, differences in leadership style between senior GMFRS officers and more junior staff. Chief Fire Officer O’Reilly considered it was a difference that arose from the need for senior officers to focus on fire safety, not operational issues.

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829 INQ026714/5 at paragraphs 22-28 and 64  
830 INQ026714/11 at paragraph 51  
831 133/20/23-24/9
12.614 While there was a failure by GMFRS to respond to the Attack, the evidence did not suggest the corporate leadership team were not competent to lead the organisation.

Rank structure

12.615 Not everyone will be familiar with the rank structure commonly operated within fire and rescue services. The entry rank is that of Firefighter. This can also be used as a general term to describe all members of a fire and rescue service. Above the rank of Firefighter is Crew Manager. A Crew Manager may be in charge of a fire appliance. Senior to a Crew Manager is a Watch Manager. The Watch Manager is in charge of Firefighters and Crew Managers on his or her shift.

12.616 Fire stations are managed by Station Managers. Above Station Managers are Group Managers, who are responsible for a number of fire stations. Senior to Group Managers are Area Managers.

12.617 At the top of the hierarchy are Assistant Chief Fire Officers, Deputy Chief Fire Officer and Chief Fire Officer.\(^{832}\)
Approach to incident command

12.618 GMFRS took a different approach to incident command from other emergency services operating in Greater Manchester. In doing so, GMFRS was acting in accordance with what I understand to be the approach to incident command by other fire and rescue services across the country.

12.619 The approach was for the Incident Commander to be the most senior person on the scene of the incident. To take a simple example, this meant that if a single fire appliance responded, the Crew Manager of that fire appliance would take charge upon arrival. In the event that further resource was required, the arriving Watch Manager would receive a handover once they reached the scene and would assume command. This approach was capable of being extended up the ranks.\(^{833}\)

12.620 The Incident Commander was expected to command the response to the incident. GMFRS had a Command Support Room at its headquarters, which could be staffed by senior officers. However, the role of these senior officers was to provide support and manage the impact of the incident on GMFRS’s other responsibilities. This meant that the Incident Commander was not

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833 121/4/18-6/16
12.621 GMFRS did recognise the Strategic, Tactical and Operational Commander roles. Those terms were applied as follows. Incident Commanders at the rank of Crew Manager and Watch Manager were classed as Operational Commanders. Incident Commanders at the rank of Station Manager and above were classed as Tactical Commanders. As the role of Incident Commander required attendance at the scene, the Tactical Commander was always at the scene.

12.622 There was a duty Assistant Principal Officer and duty Principal Officer for every shift. It was the duty Assistant Principal Officer’s responsibility to decide who would attend any Tactical Co-ordinating Group which might be arranged. It was expected that the duty Principal Officer would attend any Strategic Co-ordinating Group meeting which might be arranged.

12.623 I have no reason to think that this approach is not effective for the vast majority of GMFRS’s work. It gives rise to two issues in relation to an event such as the Attack.
12.624 First, the Incident Commander role was dependent upon arrival at the scene of an incident, as presence at the scene was the trigger for the most senior person present to take up the position. I shall return to this in Part 15 as GMFRS’s approach to incident command played an important part in causing the GMFRS response to stall.

12.625 Second, GMFRS’s approach did not map exactly onto the Strategic/Gold, Tactical/Silver and Operational/Bronze Commander roles operated by other emergency services. GMFRS operated in a silo during the critical period of the response. For this reason, it is not possible for me to reach any view on whether this difference is capable of hindering joint working at the scene.

12.626 However, the fact that GMFRS did not have a Tactical Commander who operated away from the scene meant that there was no automatic deployment of a Tactical Commander to GMP HQ. This was in contrast to the approach of NWAS and GMP on the night of the Attack. Had the deployment of a GMFRS Tactical Commander to GMP HQ happened at an early stage, it is likely that GMFRS would have gained situational awareness much sooner than it did.
NILO

12.627 In 2005, GMFRS created the Interagency Liaison Officer role.836 This role, which required enhanced security clearance, was created to allow sensitive operational information to be shared by the police with the ambulance and fire service.837 Group Manager Fletcher stated that the role was “intended to be to an intelligence led liaison to fast track information through secure channels to enable a swift and co-ordinated response”.838 After the London Fire Brigade, GMFRS was the next fire and rescue service to create this capability.839

12.628 Group Manager Fletcher considered that the Interagency Liaison Officer role at GMFRS was a great success and that greater inter-agency liaison in Manchester paid “dividends”.840 This role became known as the National Interagency Liaison Officer (NILO) when it went nationwide in 2010.841 Station Manager Lawlor was the GMFRS NILO lead and regional lead officer at the time of the Attack. This was a post he had held for around six years.842

836 INQ026734/4 at paragraph 16, 63/51/2-4
837 INQ026734/3 at paragraphs 12-15, 62/21/14-22
838 INQ026734/4 at paragraph 15, 63/50/11-51/1
839 INQ026735/5 at paragraph 20, 63/51/11-20
840 INQ026734/5 at paragraph 19, 63/51/5-10
841 INQ026734/6 at paragraph 26, 63/52/6-9
842 INQ026735/3 at paragraph 13, 62/12/11-13/18, 62/18/3-10
12.629 Station Manager Lawlor explained that the role of the NILO was intended to be a Tactical Advisor to the Incident Commander. In a Marauding Terrorist Firearms Attack incident, the NILO was intended to act as the on-scene commander at the FCP, on the edge of the Operation Plato warm zone. The specialist training given to NILOs was designed to ensure better inter-agency liaison so as to co-ordinate a Marauding Terrorist Firearms Attack response. A key point of information for the NILO would be the police Tactical Firearms Commander.

12.630 A NILO was also mobilised whenever a Strategic Co-ordinating Group was convened. In this situation, the NILO provided tactical advice to the GMFRS Gold Commander and maintained a written incident log.

12.631 GMFRS, together with London Fire Brigade, facilitated the NILO course at the Fire Service College. It was held five times a year. Station Manager Lawlor was a lecturer and facilitator on the course. In that role, he was focused on multi-agency working.

843 62/22/11-23
845 INQ026735/6 at paragraphs 22-23
846 INQ026735/6 at paragraph 24, 62/37/18-38/7
847 INQ026714/25 at paragraph 110
848 INQ026735/9 at paragraph 40
849 INQ026735/9 at paragraph 40
12.632 As the GMFRS NILO lead, Station Manager Lawlor stated that he attended regular security briefings with the police and ambulance service. These provided updates on the current threat level. Station Manager Lawlor stated that all NILOs were aware of the UK’s ‘severe’ threat level. It was known by all NILOs that a terror attack was highly likely.\footnote{INQ026735/7 at paragraphs 34-35}

12.633 GMFRS was well prepared to respond to terrorist attacks, including a Marauding Terrorist Firearms Attack.

12.634 Once every three years, all GMFRS NILOs were required to attend a Technical Response Course at the Fire Service College. Similarly, they attended a training course called Saton Force. This was focused on pre- and post-bomb scene management. It was multi-agency training for organisations in Greater Manchester to ensure a co-ordinated response to a suspicious package.\footnote{INQ026735/9 at paragraphs 43-44, 63/9/19-11/15}

12.635 The NILO role was central to GMFRS’s response to a terrorist attack. It was a Tactical Advisor role that should ensure there was swift liaison with other emergency services. GMFRS played an important part in the national development of the NILO role. It adopted it early and embedded it as
part of its multi-agency planning. GMFRS should have been well prepared to ensure an effective, co-ordinated response with the police and ambulance service to a terror attack in Manchester.

12.636 What had not been intended or planned, as the Fire and Rescue Expert explained, was for a NILO to become the “de facto” Incident Commander in the early stages. As GMFRS acknowledged, this was a specific gap in the procedures governing its response to terrorist incidents. It meant that there was a risk everyone involved thought someone else was in charge when in reality no one was in charge. This is what eventuated on the night of the Attack.

Equipment and resources

12.637 In May 2017, GMFRS had about 1,400 uniformed employees. Of these, 64 were involved in the emergency response to the Attack. In May 2017, there were 41 fire stations with 56 frontline appliances and 44 specialist vehicles. Six of the GMFRS fire stations were within a 4km radius of the Arena, including Manchester Central Fire Station and Philips Park Fire Station.

852 143/153/11-17
853 185/55/19-56/11
854 INQ026714/51 at paragraphs 70 and 218
855 INQ026714/18 at paragraph 70
856 INQ026714/16 at paragraph 68
The latter was designated as a muster point for GMFRS on the night of the Attack. Figure 34 shows the location of these fire stations relative to the location of the Arena. G16 is the location of Manchester Central Fire Station. G18 is the location of Philips Park Fire Station.

Figure 34: Location of fire stations in Greater Manchester
12.638 A standard GMFRS fire appliance had a long board \(^{858}\) and a trauma bag \(^{859}\). The trauma bag provided equipment for basic life support. \(^{860}\) It included a defibrillator, airways, masks for use with an oxygen cylinder, dressings and a tourniquet. \(^{861}\) All firefighters were trained to provide basic life support. Some were trained as trauma technicians to provide enhanced first aid. \(^{862}\)

12.639 Key specialist vehicles available to GMFRS included those operated by the Technical Response Unit and the Specialist Response Team. \(^{863}\) I recognise everyone who works for a fire and rescue service will be specialist in what they do. When I use the term ‘specialist firefighter’ in my Report, I am referring to members of the Technical Response Unit and Specialist Response Team.

12.640 The Technical Response Unit was deployed to a variety of incidents, such as road traffic accidents or a building collapse. \(^{864}\) In common with a standard fire appliance, it had one trauma bag. The Technical Response Unit’s significance for an event such as that on 22\(^{nd}\) May 2017 was that

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858 INQ026714/20 at paragraph 79
859 INQ004317, INQ026714/19 at paragraph 79
860 INQ004314, INQ026714/19 at paragraph 78
861 INQ026714/19 at paragraph 79
862 INQ026714/18 at paragraph 75, 63/69/7-70/12
863 INQ026714/18 at paragraphs 72-75
864 INQ035482 at paragraph 14
it had personnel specifically trained to respond to a Marauding Terrorist Firearms Attack.\footnote{INQ026714/18 at paragraphs 73-74} They received training for operating in an Operation Plato warm zone.\footnote{71/62/13-64/3}

12.641 The Specialist Response Team vehicle was equipped with trauma equipment for blast and ballistic injuries. This included tourniquets, blast bandages and chest seals.\footnote{INQ004319, 63/69/7-14} Personnel on a Specialist Response Team vehicle had enhanced trauma training provided by NWAS HART.\footnote{71/8/7-18, 63/70/3-12}

12.642 Specialist Response Team personnel were trained to work with NWAS HART in an Operation Plato warm zone. The Specialist Response Team were issued with ballistic personal protective equipment. They were trained to treat and remove casualties.\footnote{63/70/3-72/6, INQ026714/19 at paragraph 76} A Specialist Response Team vehicle had five SKED stretchers.\footnote{63/68/24-69/6} A SKED stretcher was designed to permit casualties safely to be dragged away from danger and towards medical help.\footnote{INQ026714/19 at paragraphs 75-76, 63/70/13-19}

12.643 GMFRS had three command support vehicles. They acted as a mobile command base during
larger incidents.\textsuperscript{872} They were not deployed on the night of the Attack.\textsuperscript{873}

12.644 GMFRS had a Command Support Room at its headquarters. The purpose of the Command Support Room was to provide support to the Incident Commander and to the Strategic Co-ordinating Group.\textsuperscript{874} On the night of the Attack, the Chief Fire Officer and a number of other senior officers, including Assistant Chief Fire Officer Harris and Group Manager Fletcher, went to the Command Support Room.\textsuperscript{875}

12.645 Each fire appliance carried up to five handheld radios. These radios were used for communication between firefighters and commanders at an incident. They did not allow communication with non-GMFRS emergency responders.\textsuperscript{876}

12.646 Each fire appliance had an Airwave radio. This allowed two-way communication with NWFC. A duty Fire Officer was equipped with an Airwave radio. This allowed that person to communicate with NWFC and other Airwave radios, including those used by GMP, BTP and NWAS.\textsuperscript{877}

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\textsuperscript{872} INQ026714/19 at paragraph 77
\textsuperscript{873} 71/103/22-104/2, 133/172/19-21
\textsuperscript{874} INQ026714/20 at paragraphs 81-83
\textsuperscript{875} 129/8/9-9/3, 129/28/14-29/5, 130/55/17-56/3, 131/117/9-11
\textsuperscript{876} INQ026714/47 at paragraph 205
\textsuperscript{877} INQ026714/47 at paragraphs 205-207
12.647 GMFRS had all the necessary equipment, personnel and resources to respond to the Attack. In particular, it had specialist equipment and personnel that could be used in an Operation Plato warm zone to assist with the prompt evacuation of casualties.

Training

JESIP training

12.648 GMFRS had a legal duty to train its personnel. Depending on their rank and role, firefighters were expected to undertake a variety of training to prepare for a Major Incident. This included training on immediate trauma care, trauma technician clinical care and Marauding Terrorist Firearms Attack incidents.

12.649 Assistant Chief Fire Officer Keelan stated that JESIP was “at the heart of all GMFRS training”. GMFRS was the lead organisation in Greater Manchester for providing JESIP training to all emergency services. Each GMFRS officer received a pocketbook aide-memoire with the JESIP principles.

12.650 All GMFRS firefighters and operational commanders must complete JESIP level 1

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878 INQ026714/4 at paragraph 21
879 INQ026714/55 at paragraph 236
880 INQ026714/28, paragraph 124
881 INQ026714/28 at paragraph 124
training. GMP and NWAS jointly developed the training with GMFRS. All GMFRS personnel involved in the response to the Attack had received this training. Following the Attack, GMFRS has facilitated refresher training for GMP, NWAS and its own staff.\(^{882}\)

12.651 Generally, GMFRS had an adequate system for training its firefighters in JESIP. However, there was room for improvement. A number of frontline staff did not recall receiving JESIP training or had only undertaken an e-learning package.\(^{883}\)

12.652 The Fire and Rescue Expert noted that non-specialist firefighters had not received the same level of training as their specialist colleagues to respond to an event such as the Attack. This included JESIP training. Despite this, he considered that they were “adequately trained and equipped” to carry out their role on the night of the Attack.\(^{884}\) Although there was evidence of classroom-based practical learning in JESIP, more interactive classroom training would have benefited GMFRS personnel.

Command and other training

12.653 Assistant Chief Fire Officer Keelan gave a detailed statement to the Inquiry explaining the
extensive training provided to the different levels of GMFRS command at Operational/Bronze, Tactical/Silver and Strategic/Gold level. His statement explained that there were four qualifications of command. Any firefighter, from a Crew Manager upwards, must undertake this training. All GMFRS officers in a command role on the night of the Attack had received the appropriate command training.  

12.654 All levels of GMFRS command were trained in operational discretion. This underpinned the training for all safe operating procedures. This policy was introduced in 2014. GMFRS was one of the first fire and rescue services to introduce this. Under the policy, operational discretion was available in circumstances in which following normal procedures would be a barrier to resolving an incident, or when there was no suitable procedure in place.

12.655 Assistant Chief Fire Officer Keelan gave examples of operational discretion being used to save human life or to take immediate and decisive action to prevent an incident escalating. The operational discretion policy

885 INQ026714/31 at paragraphs 138-146, INQ041857/1 at FRS4
886 133/53/6-54/16
887 134/96/12-97/11
888 134/96/12-97/11
889 INQ026714/33 at paragraphs 148-151
is sensible and pragmatic. At key moments during the night of 22nd May 2017, operational discretion was not used when it should have been to break the inertia which set in to GMFRS’s response. This was recognised by GMFRS personnel who gave evidence. 890

12.656 GMFRS issued all staff with ‘Ops Alerts’ and ‘Safety Alerts’. Ops Alerts provided general operational information. Safety Alerts were used to circulate safety-critical information. Alerts were printed at each fire station. It was the responsibility of each Firefighter to confirm they had read the alerts. 891 These alerts were also issued to ensure awareness after Major Incidents and when the national threat level was changed. 892 Five Safety Alerts were circulated in the 12 months before the Attack. 893 This is a good way of disseminating important information to all operational GMFRS personnel.

Marauding Terrorist Firearms Attack training

12.657 Station Manager Gaskell was the GMFRS lead for Marauding Terrorist Firearms Attack training. This was a position he had held since 2011. The GMFRS Marauding Terrorist Firearms Attack

890 70/122/14-123/17, 134/97/8-11
891 INQ026714/59 at paragraph 251
892 INQ026714/54 at paragraph 234, INQ004209
893 63/17/20-25
capability went live in late 2011. A chronology provided by Station Manager Gaskell set out the development of this capability prior to May 2017.

12.658 Station Manager Gaskell described the preparation for the GMFRS Marauding Terrorist Firearms Attack capability as a “very lengthy and intensive programme”. It involved establishing a training programme and procuring equipment and vehicles. NWAS played an important role, for example in developing trauma training, and obtaining SKED stretchers and dressings. By January 2016, GMFRS was assessed to have established a Marauding Terrorist Firearms Attack capability in all areas.

12.659 A three-day initial Marauding Terrorist Firearms Attack training course was delivered for firefighters by GMFRS in December 2016 and January 2017. As a result, all Technical Response Unit personnel, who also had to attend a ten-week modular course, and all the GMFRS NILO cadre were qualified to attend a Marauding Terrorist Firearms Attack incident.

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894 117/97/3-11
895 INQ004528
896 INQ033910/4 at paragraph 18
897 INQ033910/6-8 at paragraphs 26 and 31-33
898 INQ004528
899 INQ033910/5 at paragraph 20, INQ004525/1
12.660 Station Manager Gaskell ran various multi-agency courses to establish the Marauding Terrorist Firearms Attack capability across Greater Manchester.\textsuperscript{900} This included a Marauding Terrorist Firearms Attack enhanced trauma training course, Marauding Terrorist Firearms Attack commander awareness training, Marauding Terrorist Firearms Attack refresher training and Marauding Terrorist Firearms Attack firefighting training.\textsuperscript{901} All the GMFRS officers on duty on 22\textsuperscript{nd} May 2017 had received training on JOPs 3. All the command officers had also attended multi-agency tabletop and live exercises.\textsuperscript{902}

12.661 Watch Manager Jonathan Nolan was a member of the Specialist Response Team on the night of the Attack. He gave evidence that, at the time, he considered his training was “reasonably sufficient” to respond to a Marauding Terrorist Firearms Attack.\textsuperscript{903} He stated it was too formalised and “didn’t deal with the potential chaos that may ensue”.\textsuperscript{904} The training reflected an incident that was stabilised with all the emergency services present. Watch Manager Nolan stated that more training focused on the
start of an incident would have been beneficial. He did not consider that the training was too risk averse.

12.662 GMFRS succeeded in establishing a Marauding Terrorist Firearms Attack capability, maintaining regular Marauding Terrorist Firearms Attack training for its personnel, and working with GMP and NWAS to deliver multi-agency training. However, GMFRS, in common with other agencies, was not ready for the chaos which there will inevitably be at the start of an incident such as occurred on 22nd May 2017. Further, NWFC was not included sufficiently, or sometimes at all, in aspects of this Marauding Terrorist Firearms Attack training. In particular, it did not participate in the multi-agency training. This was a significant failure, for which GMFRS, alongside NWFC, must bear responsibility. It had a substantial impact on the fire and rescue service response on 22nd May 2017.

Planning

12.663 GMFRS had a well-established team involved in planning for a response to a terror attack. It grew from a national programme that GMFRS participated in called ‘New Dimensions’.
This was established after the 9/11 terrorist attacks in the United States. Its purpose was to support a fire and rescue service response to terror threats and natural disasters. Group Manager Fletcher and Station Manager Lawlor were both seconded to the New Dimensions team. It became part of the Contingency Planning Unit within the Emergency Response Department at GMFRS. New Dimensions is now known as ‘National Resilience’.

12.664 The Contingency Planning Unit prepared Standard Operating Procedures (SOPs). It planned and organised exercises, including with other emergency service partners. In describing the importance of the unit, Station Manager Lawlor stated: “In my time in GMFRS we have gone from minimal activity to substantial multi-agency engagement with particular success in planning.”

12.665 GMFRS had a number of SOPs to ensure a co-ordinated response to Major Incidents, including a Marauding Terrorist Firearms Attack. There were four guidance documents: ‘MTFA Mobilisation: Emergency Response’.

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909  INQ035482/5 at paragraph 10
910  INQ035482/5 at paragraph 10
911  62/9/9-16
912  119/32/2-35/21
913  INQ026735/4 at paragraph 15
914  INQ004540
a ‘Firearms’ guidance document,\textsuperscript{915} ‘Major Incident: Emergency Response’\textsuperscript{916} and an ‘Emergency Response and Recovery’ guidance document.\textsuperscript{917} GMFRS had a number of plans that would have helped it to play a resilient and effective role in a co-ordinated multi-agency response to a Major Incident, such as the Attack.

12.666 GMFRS used an operational intelligence system. This provided key information on a location in the event of a fire. GMFRS had an operational intelligence record and risk assessment for the Arena, dated 14\textsuperscript{th} December 2012.\textsuperscript{918} It identified the location of hydrants and other important information to help with firefighting. The operational intelligence record was not prepared with any other type of emergency response in mind. The details of an evacuation strategy would be for each site to implement.\textsuperscript{919}

12.667 I have already commented in relation to BTP, GMP and NWAS on the importance of site-specific plans, prepared or endorsed at local resilience forum level. The conclusions apply equally to GMFRS. A multi-agency site-specific plan for the

\textsuperscript{915} INQ026714/36 at paragraph 163
\textsuperscript{916} INQ004544
\textsuperscript{917} INQ026714/36 at paragraph 164
\textsuperscript{918} INQ026714/37 at paragraph 169
\textsuperscript{919} INQ026714/37 at paragraph 169
Victoria Exchange Complex should have been prepared and used on the night of the Attack.

**Action plans**

12.668 The action plans used by NWFC for the Greater Manchester area were owned by GMFRS. It was GMFRS’s responsibility to ensure they were accurate. As I have already explained, the difference in views between GMFRS and NWFC over which action plans might apply and how to interpret them was unsatisfactory.

12.669 The deficiencies in the action plans revealed a failure by GMFRS to work with NWFC to plan and train on mobilising resources to a Major Incident. It was the responsibility of GMFRS to devise clear action plans and ensure that they were understood by NWFC. As it accepted, GMFRS failed to do this.\(^{920}\)

**Exercising**

12.670 GMFRS participated in and organised a large number of exercises. This included lectures and both tabletop and live exercises.\(^{921}\) Generally, the evidence showed that GMFRS took a rigorous approach to its responsibilities to exercise, but it failed to include NWFC sufficiently, or sometimes at all, in exercises.

\(^{920}\) INQ035482/28-29 at paragraphs 78 and 79, INQ042436/8 at paragraphs 30 and 31
\(^{921}\) INQ026735/9 at paragraphs 41-42
12.671 I will consider GMFRS’s involvement in multi-agency exercising and, in particular, Exercise Winchester Accord at the end of this Part.

Conclusion

12.672 GMFRS was well prepared to meet the challenges posed by a terrorist attack in Greater Manchester. It worked hard in the years before the Attack to develop its Marauding Terrorist Firearms Attack capabilities, to train its personnel in JESIP and to work with emergency service partners. Although there were some problems with its training, it had the necessary equipment and specialist resources to respond to a Marauding Terrorist Firearms Attack. There were, however, failings in its preparation, in particular how it worked with NWFC and the action plans it created for it to mobilise fire resources to an Operation Plato incident. It also failed adequately to consider the role of the NILO at the beginning of an incident and what should happen if a NILO were effectively in charge.
Multi-agency communication

Key findings

• The emergency services operating in Greater Manchester used the Airwave network for radio communications.

• A talk group is a radio channel which permits two or more people to communicate with each other.

• Greater Manchester Police monitored two ‘hailing’ talk groups 24 hours a day, seven days a week. Neither of these were used on the night of the Attack by the other emergency services.

• British Transport Police should have used the police hailing talk group on the night of the Attack.

• At the time of the Attack, the emergency services operating in Greater Manchester were in the process of setting up a multi-agency control room talk group.

• The proposed multi-agency control room talk group should have been operating by the time of the Attack.
Had the proposed multi-agency control room talk group been operating at the time of the Attack: it would have avoided time being spent trying to set one up during the response; it would have led to better communication between emergency services; it is likely Greater Manchester Fire and Rescue Service would have attended sooner than it did; and it may have led to more paramedics being deployed into the City Room.

Airwave

12.673 The Airwave network is a secure, private mobile radio communications network for organisations involved in public safety in the UK. The project to introduce Airwave nationally began in 2000.\textsuperscript{922} By 2010, 300 organisations had access to the Airwave network.\textsuperscript{923}

12.674 Airwave was introduced to GMP in 2003 and to GMFRS and NWAS in 2010/11.\textsuperscript{924}

12.675 The term ‘talk group’ refers to a radio channel which has been identified for a particular purpose or for particular users. It provides a way for two or more parties to speak to each other using the

\textsuperscript{922} Competition and Markets Authority, Mobile radio network for the police and emergency services: Final report and decision on a market investigation reference, 2021 at page 7, paragraph 1.1
\textsuperscript{923} INQ041595/10 at paragraph 1.1.3
\textsuperscript{924} INQ040999/2, INQ040999/8 at paragraph 33
Some talk groups were for use within an organisation. For example, a talk group may be used by all responders from one of the emergency services involved in a particular incident. Multi-agency talk groups, as the name suggests, are radio channels for use by more than one emergency service.

A talk group can be accessed by individuals through handheld radios and by control rooms through their integrated communications system.

A national SOP, dated 2010, governs the use of Airwave talk groups (the SOP Guide). The SOP Guide is agreed between the Chief Officers and Chief Executives of the ambulance, fire and police services nationally. It is designed to “enhance Interoperable Voice Communication between the emergency services”.

The SOP Guide stated that, to ensure consistency in its use, the Airwave system should be managed through local resilience forums. Deputy Chief Fire Officer Argyle, giving evidence as the Chair of GMRF at the time of the Attack, stated that every organisation used Airwave slightly differently. He did not, however, recall any
specific problems being raised about multi-agency use of Airwave in Greater Manchester.  

GMP Airwave Tactical Advisor

12.679 An Airwave Tactical Advisor was a person able to provide advice on the management of the Airwave system. They underwent a three-day, pass/fail intensive training course run by the College of Policing. Those qualified in this role were equipped to manage the Airwave talk group system and network. They understood how the Airwave system worked and what its complexities were. In GMP, the Airwave Tactical Advisor gave advice to the Tactical/Silver Commander and the FDO as required.  

12.680 At the time of the Attack, there were approximately seven qualified Airwave Tactical Advisors within GMP. A list was maintained of those who were qualified. GMP did not operate a system which ensured that there was always an Airwave Tactical Advisor either on duty or on call. Emergency Planning Command Co-ordinator Laura Lewis was one of the Airwave Tactical Advisors. She maintained the list of those who were qualified. In evidence she stated that, if there were no Airwave Tactical Advisor on duty, an FDO who needed one was expected to work
their way down the list and find out who was available to give advice.\textsuperscript{931}

12.681 GMP’s Major Incident Plan identified that an “Airwaves Tactical Advisor” was a Major Incident resource “available” to Tactical/Silver Commanders “via the duty officer, Silver or Gold Control”.\textsuperscript{932}

12.682 The FDO on the night of the Attack, Inspector Sexton, had created an aide-memoire for use during a Marauding Terrorist Firearms Attack. The second item on it was: “Identify an Airwaves TAC asap.”\textsuperscript{933} Inspector Sexton completed a debrief questionnaire following the incident. Under the heading “… what aspects of the overall incident did not go well”, he made the following comment: “No Airwaves TAC on duty or officially ‘On Call’ to assist with … knowledge of the various appropriate secondary channels.”\textsuperscript{934}

12.683 On the night of the Attack, Laura Lewis was not on call or on duty. She was at home. She was contacted by a colleague in GMP Control. She was not contacted as an Airwave Tactical Advisor, but as a Gold and Silver Control Room Manager. She travelled to GMP HQ. Once she was at GMP HQ, Laura Lewis offered direction in relation to

\begin{footnotes}
\item[931] 108/124/17-125/10
\item[932] INQ007279/79
\item[933] INQ007626/1
\item[934] INQ000781/2
\end{footnotes}
Airwave once the Silver Control Room communication staff had arrived. However, through no fault of hers, this was not until after the critical period of the response had ended.\footnote{108/202/4-205/13}

**Existing Airwave talk groups**

**Monitored multi-agency talk groups**

\textbf{12.684} GMP Control monitored the multi-agency hailing channel/talk group and the police hailing talk group 24 hours a day, seven days a week. The multi-agency hailing channel/talk group was available to NWAS and GMFRS on the night of the Attack. It was not used by either service. The police hailing talk group was available to BTP on the night of the Attack. It was not used by BTP.\footnote{108/152/17-155/16}

\textbf{12.685} As I set out earlier in this Part, I am critical of BTP for not using the police hailing talk group given the difficulties that were experienced getting through to GMP Control.

**Unmonitored multi-agency talk groups**

\textbf{12.686} There were a number of unmonitored talk groups which were available for use on the night of the Attack. In the case of each of these, it was necessary for each of the control rooms to be informed of the need to dial in before there could be multi-way communication on any of them.
12.687 One of the unmonitored talk groups was the Tactical/Silver multi-agency talk group. This was originally intended for use by Tactical/Silver Commanders during a Major Incident. This was not a talk group that was much used in the period before the Attack. That was because the Tactical/Silver Commanders tended to co-locate at GMP HQ.

12.688 There were three Operational/Bronze Commander talk groups available for use which were unmonitored. These talk groups were the subject of weekly testing by the emergency services in Greater Manchester.

12.689 Earlier in this Part, I set out the unsatisfactory position GMP had got into with its Operation Plato plans. One of those plans I have referred to as ‘the Whittle Plan’. The Whittle Plan was created shortly before the Attack. It anticipated that the FDO would “[e]stablish 3 way communication” using one of the Operational/Bronze Commander talk groups and “provide a METHANE briefing”.

12.690 The third item on Inspector Sexton’s aide-memoire directed him to nominate a multi-agency

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937 108/166/23-167/5
938 108/168/1-4
939 INQ041227/1
940 INQ040999/3 at paragraph 13
941 INQ029178/4-5
Operational/Bronze Commander talk group from one of three existing options. This item appears under the heading “JESIP – GMFRS/NWAS”. The aide-memoire stated that nomination of the channel would occur when Inspector Sexton contacted “each ILO [Interagency Liaison Officer]”.  

12.691 On the night of the Attack, Inspector Sexton failed to contact the Interagency Liaison Officers for other emergency services. He did not nominate the use of any of the Operational/Bronze Commander talk groups. None of the Operational/Bronze Commander talk groups was used by any emergency service at any point as part of the response to the Attack.

Proposed multi-agency control room talk group

12.692 At the time of the Attack, the emergency services in Greater Manchester were in the process of agreeing the use of a multi-agency talk group for use by control rooms. The plan was to use the existing Tactical/Silver talk group for this purpose. By 22\textsuperscript{nd} May 2017, the arrangements had not been finalised. I shall refer to this as ‘the proposed multi-agency control room talk group’.

\begin{flushleft}
942 INQ040955/1
943 INQ040999/6 at paragraph 25
\end{flushleft}
Joint Operating Principles third edition (January 2016)

12.693 In January 2016, JOPs 3 was published. As I set out in Part 11, it stated:

“The Police will instigate a three-way telecommunication link between the emergency services’ control rooms … The provision of unbroken communication links between the emergency services’ control rooms should enable the timely passing of information and intelligence that will inform deployment decisions.”

12.694 The footnote to this entry stated: “This link may be an interoperable talk group, telephone conference call or other method depending on local procedures.”

12.695 In February 2016, CI Booth completed a Home Office questionnaire about GMP’s arrangements in relation to a Marauding Terrorist Firearms Attack. His response included the fact that NWAS and GMFRS had the ability to contact the FDO directly by telephone. He went on to say that there were talk groups which could be activated as a fallback measure.

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944 INQ008372/10 at paragraph 4.4
945 INQ008372/10
946 INQ032758/12
Her Majesty’s Inspectorate of Constabulary and Fire and Rescue Services (1st November 2016)

12.696 As I set out earlier in this Part, in late October to early November 2016, GMP was subject to an inspection of its counter-terrorism capability by HMICFRS. Immediate feedback from a meeting with the HMICFRS Inspectors was captured in an email dated 1st November 2016 from Chief Superintendent Stuart Ellison to Temporary ACC Hankinson and “HMIC liaison”:

“There’s clearly a recognition that maintaining command and control through that period [the period of Operation Plato] is going to be a challenge, particularly when the learning from other parts of the world suggests that telephone lines will be in melt-down. On that we also talked through the need to protect the Airwaves structure…

…

There was interest in how we liaise with NWAS and GMFRS – the Aide Memoir cards being produced here for staff as prompts when they are under excessive pressure were welcomed, and each week we (FDO’s) test the three way GMP-NWAS-GMFRS talk group
that gets opened after PLATO is declared to ensure that avenue is genuinely open."947

12.697 The situation being described by Chief Superintendent Ellison was that multi-agency communication using Airwave would occur once the talk group "gets opened". By this I understand him to mean that all control rooms are informed that they should dial in and listen to the talk group. This would only happen after Operation Plato has been declared.

Devon and Cornwall Fire and Rescue Service policy (18th January 2017)

12.698 On 18th January 2017, Group Manager Levy was undertaking research in relation to the practices of other fire and rescue services. He came across a publicly available document. That document "set out the locally agreed principles for the use of available interoperable radio channels" within the Devon and Cornwall region.948

12.699 The document Group Manager Levy identified was entitled Multi-agency Airwave Interoperability – Standard Operating Procedure. It was 38 pages. It was owned by the local resilience forum. It was dated 16th March 2011.949

947  INQ040625/1-2
948  122/155/21-157/9
949  INQ034530
12.700 Group Manager Levy sent this material attached to an email to Station Manager Gaskell and Group Manager Fletcher. Two days later, Station Manager Gaskell replied to say: “Some really useful information in there, Ben.” Group Manager Levy replied later that day: “We could do with similar in the LRF [local resilience forum] here.”

12.701 It is not clear to me whether Station Manager Gaskell took any immediate steps in response to this information. Group Manager Fletcher stated that it was possible that he opened the email, but not the attachment. He stated: “I think I missed it.”

Joint Operating Principles third edition training (22nd February 2017)

12.702 On 22\textsuperscript{nd} February 2017, Laura Lewis and PC Jo Hoyte of GMP attended a JOPs commander briefing event hosted by GMFRS. They did so in their capacity as Airwave Tactical Advisors. In the course of the event, they agreed that it would be a good idea to formalise which talk group would be used following an Operation Plato declaration.
12.703 The channel which had been used for the Tactical/Silver multi-agency talk group was identified as being available for use by control rooms on the basis that it was not often used.\(^\text{953}\)

**Exercise Hawk River (1\(^{st}\) March 2017)**

12.704 Exercise Hawk River was hosted by GMFRS on 1\(^{st}\) March 2017. The focus of the exercise was on the application of JOPs 3 and JESIP during a Marauding Terrorist Firearms Attack. Laura Lewis and PC Hoyte attended the event to provide Airwave tactical advice. The use of a three-way communication link between control rooms was discussed.

12.705 In evidence, Group Manager Fletcher stated that part of the debate was around what JOPs 3 envisaged by a three-way uninterrupted communication link.

12.706 The debrief from Exercise Hawk River noted problems with inter-agency communications. The fact that there was no single talk group or ability to broadcast to all agencies was raised. Group Manager Fletcher said of Exercise Hawk River that it was “where the full identification of the tri-service communication link was discussed in earnest”\(^\text{954}\)
12.707 Under the heading “Good Practice”, the Exercise Hawk River debrief advised that an Airwave Tactical Advisor should be appointed at the earliest opportunity during a Marauding Terrorist Firearms Attack. It went on to recommend that a talk group should be used by Operational/Bronze Commanders. The debrief identified the need for an SOP in the event of any Major Incident:

“Create an SOP for appropriate use of Airwaves channels in the event of any major incident all 3 services default to [channel number] (Silver/Tactical) and [channel number] (Bronze/Operational activity) if not co-located.”

12.708 As a result of Exercise Hawk River, it was agreed by GMP, NWAS and GMFRS that a multi-agency control room talk group would be used in the event of a Marauding Terrorist Firearms Attack. It was agreed that GMP would lead on the implementation of this talk group.
Standard Operating Procedure meeting
(15th March 2017)

12.709 Sergeant Whittle instructed Laura Lewis and PC Hoyte to draft an SOP for tri-service communication between control rooms in Greater Manchester (the Greater Manchester SOP). 958 The Greater Manchester SOP was not confined to Marauding Terrorist Firearms Attacks but was intended to cover all Major Incidents. 959

12.710 On 15th March 2017, Laura Lewis and PC Hoyte discussed the SOP with CI Booth. It was agreed that checks needed to be conducted with NWFC and NWAS to ensure they could access the talk group. At the meeting, it was agreed that the existing Tactical/Silver talk group should join the other channels which were tested weekly. 960

12.711 Laura Lewis explained that, as NWFC managed communications for services outside of Greater Manchester, she was concerned to check that the move to the proposed multi-agency control room talk group would be successful. 961

12.712 As a result of the meeting on 15th March 2017, Laura Lewis arranged to visit both NWAS Control and NWFC on 10th April 2017. 962
Westminster Bridge terrorist attack (22nd March 2017)

12.713 On 22\textsuperscript{nd} March 2017, ISIS-inspired terrorist Khalid Masood carried out a terrorist attack on Westminster Bridge. He killed five people and injured many more.

12.714 Laura Lewis agreed when giving evidence that this attack highlighted the need to progress the work on the Greater Manchester SOP as a matter of urgency.\textsuperscript{963}

Email from Sergeant Whittle (30\textsuperscript{th} March 2017)

12.715 On 30\textsuperscript{th} March 2017, Sergeant Whittle emailed Laura Lewis and PC Hoyte. In that email, he stated: “Recent command training session around JESIP working has identified our need to switch to the use of Airwaves channel [the proposed multi-agency control room talk group] for our three-way JESIP communications link”.\textsuperscript{964} Laura Lewis confirmed in evidence that this was a reference to using the existing Tactical/Silver talk group channel.\textsuperscript{965}

12.716 The email went on: “I have met with commanders from NWAS Simon Watson and GMFRS Neil Gaskell and agreed a switch over date of Sunday 30\textsuperscript{th} April 2017 with a test to be conducted by the
duty FDO on that morning.’ Laura Lewis replied later that day to confirm that she and PC Hoyte were attending NWAS Control and NWFC on 10th April 2017.

Following visits to NWFC and NWAS Control (10th and 20th April 2017)

On 10th April 2017, Group Manager Levy met with Laura Lewis and PC Hoyte at NWFC. Following the meeting, Group Manager Levy sent Laura Lewis and PC Hoyte a copy of the SOP from Devon and Cornwall.

On 20th April 2017, PC Hoyte sent an email to Cally Fillingham, the Training Manager for Airwave Tactical Advisors at the College of Policing. In the email, PC Hoyte explained that she and Laura Lewis were:

“hoping to set up a protocol / standard operating procedure whereby each control room automatically monitors [the proposed multi-agency control room talk group] and use this as an initial means of communication between the three agencies as a matter of course, as outlined in the JESIP principles.”
12.719 Later that day, Sergeant Whittle emailed Laura Lewis asking about the visits to NWFC and NWAS Control. He asked whether Laura Lewis thought it feasible for a “change over” to happen on 28th April 2017. Station Manager Gaskell was on copy to this email. He replied saying: “I think with timescales it may be worth postponing slightly so that we can agree everything and make sure we get this right.”

12.720 The following day, PC Hoyte also replied, stating: “I think that 28th April might be a bit ambitious but we are on with it. I’m thinking that around the middle of May might be a bit more realistic due to current workload and a four day course which I need to attend.”

12.721 Cl Booth replied to PC Hoyte the same day: “I agree with the suggestion to wait just a little longer to coordinate all the inter-agency testing that could usefully be undertaken with the control rooms.”

Day of the Attack (22nd May 2017)

12.722 At 13:44 on 22nd May 2017, PC Hoyte emailed Laura Lewis a document which set out the process for a weekly test of the proposed
multi-agency control room talk group.\textsuperscript{975} PC Hoyte suggested a meeting between the two of them on 24\textsuperscript{th} May 2017 with meetings with others with an interest to follow.

12.723 The position at the time of the Attack was that work was ongoing to establish the proposed multi-agency control room talk group as a channel that was monitored by all emergency services in Greater Manchester 24 hours a day, seven days a week.

**Night of the Attack (22nd May 2017)**

12.724 The proposed multi-agency control room talk group was not used during the critical period of the response. It was used briefly for the purpose of establishing who was listening at around 00:00 on 23\textsuperscript{rd} May 2017. I shall return to the detail of this in Parts 13, 14 and 15.

12.725 As Laura Lewis explained, it would have been “as quick as you can make two telephone calls” to set up. Had an Airwave Tactical Advisor been immediately available to Inspector Sexton, this would have been something which that person could have advised needed to be done.\textsuperscript{976}

12.726 There would have been no need for such advice or telephone calls if the emergency services in
Greater Manchester had established before 22nd May 2017 the proposed multi-agency control room talk group as a channel which was monitored by all of the emergency services’ control rooms 24 hours a day, seven days a week.

**Following the Attack (26th May 2017)**

12.727 On 26th May 2017, a meeting took place involving GMFRS, GMP and NWAS. Group Manager Fletcher was present at this meeting. He stated it occurred so as “to ensure that the poor communication issues from the Arena were never repeated”. He estimated that, “in the space of 15 minutes”, an interim solution had been agreed.977 Group Manager Fletcher considered that the necessary background work which had allowed the interim solution to be agreed had been completed by the end of April 2017.978

12.728 At 17:41 on 26th May 2017, Sergeant Stephen Henderson circulated “an interim three service protocol” for use of the proposed multi-agency control room talk group. As the email made clear, under this protocol each emergency service control room was expected to monitor the proposed multi-agency control room talk group at all times.979
12.729 This marked a significant improvement to the way in which the emergency services in Greater Manchester had been operating.

Conclusion

12.730 Having reviewed the timeline relating to the proposed multi-agency control room talk group, I have concluded that it was not progressed fast enough by GMP, NWAS and GMFRS. It should have been obvious that a talk group which was monitored by the control rooms of each of the emergency services 24 hours a day, seven days a week, was a system which would have been significantly better than the one in place at the time of the Attack. The Westminster Bridge terrorist attack should have underlined the need to establish it as quickly as possible.

12.731 The failure lies with the organisations rather than the individuals who were involved. Principal responsibility lies with GMP as lead agency. I recognise that there were existing talk groups which could have been nominated for multi-agency control room contact. However, this approach was reliant on the FDO nominating a talk group and other emergency services being informed of this. GMP was well aware what a busy role that would be in the event of an Operation Plato declaration. This gave rise to a risk that it would be overlooked.
12.732 Given the importance of multi-agency communication and the relative ease with which it would have been possible to achieve earlier what was achieved on 26th May 2017, this work should have been done sooner than it was. It would have led to far better multi-agency communication on the night of the Attack. It is not possible to say with certainty which of the problems it would have addressed. It seems likely that the delay of GMFRS attending would have been shortened. It is possible that the consistent requests for paramedics in the City Room by police officers would have reached NWAS with greater impact.
Exercise Winchester Accord and other exercises

Key findings

- There was a well-run programme of multi-agency exercising in Greater Manchester.
- There was good participation in multi-agency exercises by Category 1 responders.
- Control rooms for the emergency services were not sufficiently involved in relevant multi-agency exercises.
- There was a failure to capture lessons learned accurately, or sometimes at all, from multi-agency exercises.
- There was a failure to implement change based on what was revealed by multi-agency exercises.
- The failure to include North West Fire Control (NWFC) in Exercise Winchester Accord was not sensible. It was a missed opportunity to allow NWFC to get important experience of mobilising resources to a Major Incident.
- Exercise Winchester Accord was too large to be run as a regional, Tier Three exercise. The national interest in it was not matched by the required planning and support to capture the learning from such a large and complex exercise.
• The scale and scope of Exercise Winchester Accord’s objectives did not allow for issues to be identified and lessons learned in an effective way. There was a tension between the different objectives for different organisations.

• Greater Manchester Police’s decision to look at how the Force Duty Officer (FDO) operated in a set-up that was different from the existing one during Exercise Winchester Accord risked taking attention away from the well-known concerns about the FDO role.

• The local objectives set during Exercise Winchester Accord for the FDO were wide enough to look beyond the proposed move and to test the well-known issues with how the role worked.

• The draft action cards were not tested during Exercise Winchester Accord. This was a significant missed opportunity to test and improve known weaknesses in the role of the FDO and the capabilities of the Operational Communications Branch during a Marauding Terrorist Firearms Attack.

• The debrief process on Exercise Winchester Accord was flawed.
Exercise Winchester Accord represented a significant missed opportunity to prepare an adequate and robust response to a Marauding Terrorist Firearms Attack within Greater Manchester.

Introduction

12.733 There were many different types of multi-agency exercise organised in Greater Manchester before May 2017. It is not necessary to include reference to them all in this Report. In the next section, I will analyse one in particular, Exercise Winchester Accord, in detail.

12.734 Before I do, it is necessary to say something about exercising more generally.

Defining an exercise

12.735 An exercise is a simulation of an emergency situation. It helps to check and validate plans. It allows people to practise carrying out their roles and to test well-established procedures.  

12.736 The two types of exercise relevant to this Inquiry were: tabletop and live exercises.

12.737 A tabletop exercise is based on a realistic scenario and timeline. The timeline may be in real time or it may be speeded up. Usually,
tabletop exercises are run in a single room. To simulate the divisions between responders who need to communicate and be co-ordinated, they can be run in linked rooms. The players are expected to know the plan, and they are invited to test how the plan works as the scenario unfolds. 982

12.738 An example of a multi-agency tabletop exercise was Exercise Sherman. I considered Exercise Sherman in Volume 1. It tested a multi-agency response to a Marauding Terrorist Firearms Attack. Inspector Roby described how the format of Exercise Sherman was to distribute attendees between pre-assigned tables. 983 Attendees were from local businesses and emergency services. Everyone was encouraged to participate with those on their table and on other tables. There were discussion points, and observations were invited. There was a plenary session with an open invitation to make further comments and raise questions. 984

12.739 At the conclusion of Exercise Sherman, attendees were asked to complete a feedback form. All feedback was captured on an Exercise Recommendation Tracker and discussed at the

982 Emergency planning and preparedness: exercises and training – GOV.UK (www.gov.uk)
983 INQ036860/2-3 at paragraph 10
984 INQ036860/3 at paragraphs 12-13, 67/94/12-95/1
GMRF Resilience Development Group.\textsuperscript{985} This was an example of a well-organised, inclusive exercise.

12.740 A live exercise is a rehearsal for implementing a plan. Such exercises are particularly useful for testing logistics, communications and capabilities. Guidance on the GOV.UK website indicated: "Live exercises are expensive to set up on the day and demand the most extensive preparation."\textsuperscript{986}

12.741 An example of a live exercise was Exercise Lionheart. This was a series of night-time exercises at the Arndale Centre in Manchester in April and May 2015.\textsuperscript{987} Two of the exercises were multi-agency. The multi-agency exercise objective was to test the Operation Plato response to a Marauding Terrorist Firearms Attack and the application of JOPs 2 by commanders from GMP, GMFRS and NWAS.\textsuperscript{988}

12.742 In Greater Manchester, there were three broad methods of organising the different types of multi-agency exercise which were tested. First, those initiated by GMRF, such as exercising of flood plans. Second, national exercising where GMRF and partner agencies played a role, such as

\textsuperscript{985} INQ036860/3-4 at paragraph 14, 67/95/2-20
\textsuperscript{986} Emergency planning and preparedness: exercises and training – GOV.UK (www.gov.uk)
\textsuperscript{987} INQ033916/1, 63/104/15-105/3, 62/90/12-16
\textsuperscript{988} INQ033916
Exercise Winchester Accord. Third, exercises led by an individual agency which other agencies participated in, such as an exercise on responding to a chemical spill organised by GMFRS. 989

Multi-agency exercises: the positives

12.743 I was assisted on the issue of multi-agency exercising by evidence from all the Emergency Response Experts, from GMRF and from corporate witnesses on behalf of the emergency services.

12.744 All of the Emergency Response Experts agreed that the multi-agency exercise regime co-ordinated by GMRF was well structured and the opportunities available to each service were very good. 990

12.745 There was good participation in multi-agency exercises by emergency services in Greater Manchester. NWAS held subject-specific multi-agency exercises for a Marauding Terrorist Firearms Attack scenario every 6 to 12 months. 991 GMP participated in at least a hundred exercises in the two years before the Attack. A number of these were multi-agency

989 INQ035309/80 at paragraph 4.1.4
990 INQ035372/4 at paragraph 9
991 INQ014100/7
exercises.\textsuperscript{992} As the Ambulance Service Experts observed: “[T]his demonstrates a high level of commitment to the training and exercising obligations placed on a Category 1 responder.”\textsuperscript{993}

12.746 Exercising is very expensive. A live exercise will likely involve hundreds of participants and a substantial investment of time to plan and conduct the exercise. The programme of multi-agency exercising in Greater Manchester was maintained despite significant budget reductions, particularly for GMP.

12.747 As I have already said, from 2010/11 to 2017/18, GMP income fell by over 23 per cent, and the number of its police officers fell by 25 per cent.\textsuperscript{994}

12.748 As all the Emergency Response Experts noted, GMP, GMFRS and NWAS recognised the real importance of exercising. They dedicated an appropriate level of resource, time and commitment to it.\textsuperscript{995}

**Multi-agency exercising: the problems**

12.749 There was a failure to include control rooms in multi-agency exercises sufficiently, or sometimes at all. This was exemplified by the failure to
include NWFC in Exercise Winchester Accord.\textsuperscript{996} During Exercise Lionheart, NWFC was simply informed of the exercise dates and the possibility of gunfire and explosions to avoid the risk of appliances being mobilised.\textsuperscript{997}

12.750 BTP should have been included in the programme for Greater Manchester multi-agency exercising but was not. The Policing Experts concluded: “\textit{Control Room structures, arrangements and the training of staff in a response to serious emergency may have been compromised.}”\textsuperscript{998} This is an assessment with which I agree.

12.751 Although considerable effort was made to maintain a schedule of multi-agency exercises, there was a failure to derive and embed learning adequately from some important exercises. There was a lack of scrutiny of exercise objectives against performance. This was a failure by GMRF to ensure that there was a robust debrief process in place.\textsuperscript{999}

12.752 There was no comprehensive system for maintaining records of exercises or details of who attended. For example, DCC Pilling explained that the exercise records held by GMP were

\begin{itemize}
\item \textsuperscript{996} 117/143/6-23
\item \textsuperscript{997} INQ033916/2
\item \textsuperscript{998} INQ041870/2-3 at paragraph 13
\item \textsuperscript{999} 117/69/15-74/14
\end{itemize}
“fragmented”. He stated that it was “difficult to say with complete accuracy exactly how many exercises have been delivered to officers over a period of time”. 1000

12.753 In the GMFRS feedback from Exercise Lionheart, Group Manager Levy identified that delay in declaring an Operation Plato warm zone resulted in the delayed deployment of Marauding Terrorist Firearms Attack responders. 1001 The College of Policing debrief for the same exercise did not identify this as an area for improvement. Instead, under a heading of “[P]erceptions of What Went Well”, the feedback commented on “introducing a ‘WARM ZONE’ as early as possible”. 1002 It was said that this allowed HART and GMFRS to enter the training area early and was good for training the evacuation of casualties by air, or “casevac training”. 1003 This was a failure to understand and capture an important area of feedback. The issue of zoning arose again in Exercise Winchester Accord 12 months later and during the emergency response to the Attack a year after that. 1004

1000 INQ029288/80 at paragraph 434
1001 INQ033917/1
1002 INQ040131/4
1003 INQ040131/4
1004 INQ026735/11-12, 62/79/22-80/20
12.754 The Policing Experts commented, as there was no comprehensive system for monitoring exercises, it was difficult to understand how organisations could be sure that lessons were learned. Sometimes lessons were not captured at all. Sometimes lessons were simply not recorded accurately.

12.755 This meant that, despite the commitment to planning and participating in multi-agency exercises, critical aspects of the learning that should have been identified were not. This was not an isolated error but occurred repeatedly.

12.756 In the GMRF multi-agency debrief following the Attack, a number of problems were identified which had arisen during earlier multi-agency exercises. First, there was the lack of communication surrounding the declaration of Operation Plato. A similar issue was identified during Exercise Winchester Accord. Second, there was early confusion concerning the establishing of RVPs and the FCP. A similar concern also arose on Exercise Winchester Accord. Third, there was the need for an Airwave talk group to enable the sharing of risk-critical information in real time, a problem that was flagged on Exercise Hawk River.

1005 INQ035309/82 at paragraph 4.2.9
1006 INQ012579/15-19
1007 INQ012579/11-12
12.757 The Ambulance Service Experts explained that the importance of joint understanding of risk and shared situational awareness among co-located police, ambulance, and fire and rescue commanders was a theme of multi-agency exercises in 2015 and 2016. They gave examples of Exercise Dawn Vigil in July 2015, a Counter Terrorism Policing exercise in October 2015 and Exercise Lawman 2 in March 2016. Despite the learning that there were risks in the approach to joint situational awareness, these were issues that arose again in the emergency response to the Attack.

12.758 Exercises uncover problems and identify better ways of working. That is their purpose. It is important not to apply what is now known happened on 22\textsuperscript{nd} May 2017 to the approach to multi-agency exercising from before the Attack. There was a good programme of multi-agency exercising, but there were nonetheless problems with it. Most significant was the inability to identify, record and respond to lessons learned. In the future, a system must be put in place to address this. A candid approach to learning is vital to ensure agencies can work together effectively.
With those comments in mind, I turn now to Exercise Winchester Accord. A number of the people who participated in Exercise Winchester Accord were involved in the emergency response on the night of the Attack. Some were promoted between the two events. Some have been promoted since. As it was an exercise, rank during Exercise Winchester Accord is less important to my conclusions. To avoid confusion, I shall refer to individuals by their rank as at 22\textsuperscript{nd} May 2017, not their rank at the date of the exercise.

**Aims and objectives of Exercise Winchester Accord**

On 2\textsuperscript{nd} November 2015, GMP received a request to host Exercise Winchester Accord in Greater Manchester.\footnote{1009 INQ040633/2 at paragraph 4} I heard a significant amount of evidence about Exercise Winchester Accord, but my investigation into it was not exhaustive or in the same level of detail as was the case for the events on 22\textsuperscript{nd} May 2017.

To many, it foreshadowed critical failures in the emergency response to the Attack. In particular, the overburdening of the FDO, the failure to communicate a declaration of Operation Plato to the fire and rescue and ambulance services, and...
the failure to establish a joint FCP.\textsuperscript{1010} This view was not universally shared, particularly by GMP. GMP did not consider that the exercise showed a catastrophic failure of the FDO or delays at the FCP. GMP cautioned against drawing comparisons between the exercise and the events on 22\textsuperscript{nd} May 2017.\textsuperscript{1011}

12.762 Exercise Winchester Accord took place over three days from 9\textsuperscript{th} to 11\textsuperscript{th} May 2016. It was a “live-play” exercise with over 1,000 “players” and 160 “casualties”.\textsuperscript{1012} It was conducted in three phases. My focus has been on the first phase: the Marauding Terrorist Firearms Attack scenario at the Trafford Centre in Manchester.\textsuperscript{1013} This commenced at 00:00 and went on into the early morning of 10\textsuperscript{th} May 2016.\textsuperscript{1014}

12.763 The primary aim of Exercise Winchester Accord was the relicensing of military assets for domestic purposes.\textsuperscript{1015} Additionally, GMP and other agencies were invited to set their own objectives for the exercise.\textsuperscript{1016} Inspector Roby was the exercise co-ordinator. She led the discussions

\textsuperscript{1010} 84/70/17-22
\textsuperscript{1011} INQ042531/21
\textsuperscript{1012} INQ013559/5
\textsuperscript{1013} 117/50/11-51/12
\textsuperscript{1014} 117/148/14-22
\textsuperscript{1015} 67/27/10-13
\textsuperscript{1016} 67/29/17-19
aimed at setting the local objectives. She described how those objectives were “bolted on” to test particular issues. She explained that she was nearing the end of writing the plan for the Strategic Co-ordination Centre, which became known as the Force Command Module, and the exercise was a prime opportunity to test it.

12.764 About 70 different local objectives were set.

12.765 NWAS objectives included demonstrating the effective evacuation of patients from the Operation Plato warm zone to a Casualty Clearing Station, testing communication links between NWAS commanders internally and with the North West Counter Terrorist Unit (NWCTU) operations room, and demonstrating the ability to provide appropriate clinical care to ballistic injuries sustained in a Marauding Terrorist Firearms Attack.

12.766 GMFRS objectives included testing the integration of the NILO with the Counter Terrorism Commander, testing the use of joint dynamic risk assessment in line with JESIP, testing the GMFRS management at a Marauding

1017 INQ034427/4 at paragraph 17
1018 67/29/22-30/9
1019 67/28/24-29/13
1020 146/104/21-105/3
1021 INQ013559/7
Terrorist Firearms Attack in line with JOPs and the wider incident support GMFRS could offer.1022

12.767 GMP set over 50 force-specific objectives.1023 These were wide ranging and included local objectives for the GMP Operational Communications Branch where the FDO worked, the Operational Planning Unit, the Press Office, Scene Management and partner agencies in a Strategic Co-ordination Centre.1024 More details about the FDO objectives will be set out at paragraphs 12.779 to 12.792. Separate objectives were also set for NWCTU and regional armed policing.1025

Role of NWFC during Exercise Winchester Accord

12.768 Despite the breadth and ambition of local objectives, NWFC was not invited to participate in the exercise.1026 It played no role in mobilising any GMFRS resources. Rather, the NILO was given the role to mobilise GMFRS to the exercise.1027 NWFC was simply made aware that the exercise was happening so that it did not impact on its
own management of fire resources while the exercise was under way.\textsuperscript{1028}

12.769 In an email dated 25\textsuperscript{th} March 2016, Group Manager Levy explained to NWFC Operations Manager Janine Carden that he had enquired about NWFC involvement in the exercise, "\textit{both for operational / logistic mobilising, and also as a training / assurance opportunity for you}".\textsuperscript{1029} Group Manager Levy said that he recognised that there was a clear need for NWFC involvement in mobilising resources and engagement in multi-agency communications.\textsuperscript{1030}

12.770 There was a suggestion that staffing levels in the NWFC control room played a part in the reason NWFC were not involved in Exercise Winchester Accord. This was incorrect.\textsuperscript{1031} Station Manager Gaskell explained that the view was that Exercise Winchester Accord did not "\textit{lend itself to a dynamic mobilisation exercise}".\textsuperscript{1032} He stated that there was no benefit to NWFC being involved as the starting point of the exercise was from the pre-arranged RVP.\textsuperscript{1033}
12.771 During the Attack, just 12 months later, the breakdown in communication between the duty NILO and NWFC was a significant feature of the failures to deploy GMFRS personnel to the Arena. In that context, the failure to involve NWFC in a large, multi-agency exercise such as Exercise Winchester Accord was not sensible. It was a missed opportunity to allow NWFC, a relatively new organisation, to get important experience of mobilising resources to a Major Incident.

Planning of Exercise Winchester Accord

12.772 Despite the failure to include NWFC, Exercise Winchester Accord was an ambitious exercise. Inspector Roby said that, in planning it: “We were desperate to exercise a lot of structures that we had not had a chance to.”

1034 An NWAS planning document for the exercise described it as “one of the largest staged in the UK”. Yet, despite its size, Exercise Winchester Accord was organised as a Tier Three exercise. This meant that the exercise was organised, run and debriefed at a regional level, not nationally.

12.773 The Policing Experts observed that a Tier Three exercise did not have the “same support
mechanism” compared with a Tier One national exercise.\textsuperscript{1038} A Tier One exercise would receive central government support, and there would be a rigorous focus on the evaluation of each exercise objective.\textsuperscript{1039} In contrast, in a Tier Three exercise the debrief process would be more open and generic, without evaluating specific objectives.\textsuperscript{1040}

12.774 The Policing Experts believed that Exercise Winchester Accord was probably too large to be managed as a Tier Three exercise.\textsuperscript{1041} This is a view with which I agree. The NWAS planning document noted: “\textit{[T]here is national interest in the outcomes.}”\textsuperscript{1042} That national interest was not matched by the required planning and support to capture the learning from such a large and complex exercise.\textsuperscript{1043}

12.775 Exercise Winchester Accord had a mix of national and local objectives.\textsuperscript{1044} Inspector Roby acknowledged that planning and policy-making were “\textit{hit very badly}” by budget cuts from 2011.\textsuperscript{1045} She said it impacted on the ability of her

\begin{itemize}
\item \textsuperscript{1038} 146/113/20-115/5
\item \textsuperscript{1039} 146/104/4-20
\item \textsuperscript{1040} 146/105/4-9
\item \textsuperscript{1041} 146/113/20-115/5
\item \textsuperscript{1042} INQ013559/5
\item \textsuperscript{1043} 146/112/11-113/7
\item \textsuperscript{1044} 67/29/22-30/9
\item \textsuperscript{1045} 67/68/21-69/5
\end{itemize}
planning team to do their jobs. Cl Booth also observed that there was a reduction in staff numbers at the Operational Communications Branch because of budget cuts. He said it was a “very demanding time” and staff were under pressure.

12.776 It is understandable therefore that, where there was an opportunity to plan a large, live exercise, there was a temptation to include many different objectives. As Inspector Roby acknowledged, she “threw everything at it”. It was the responsibility of GMRF and the agencies involved in planning multi-agency exercises to plan exercises in an effective and coherent way. An organisation needed to have overall responsibility for the conduct and the content of the exercise. Even now, there is not agreement as to who this was for Exercise Winchester Accord. As was shown by the confusion in the evidence about who was responsible for organising, participating in and reviewing Exercise Winchester Accord, the scale of the objectives did not allow for issues to be identified and lessons to be learned in an effective way.

1046 67/8/25-9/13
1047 84/117/6-118/2
1048 INQ034427/3 at paragraph 16
1049 INQ024271/31, 146/116/4-7
1050 184/90/7-92/5
12.777 This was exemplified by the evidence of the GMRF Chair, Deputy Chief Fire Officer Argyle. On the first occasion he gave evidence, he referred to Exercise Winchester Accord as two exercises. He said that GMRF was involved in a separate exercise to test a Strategic Co-ordination Centre.\textsuperscript{1051} This was explored again with Deputy Chief Fire Officer Argyle when he gave evidence for the second time. He said he thought that Exercise Winchester Accord was an “exercise running two separate ways”.\textsuperscript{1052} Deputy Chief Fire Officer Argyle said that the exercise provided the opportunity to test the plan of GMRF members in setting up a Strategic Co-ordination Centre at GMP HQ and how a Strategic Co-ordinating Group would run.\textsuperscript{1053}

12.778 Exercise Winchester Accord was one exercise, albeit large and with involvement from many different organisations, each testing different and sometimes overlapping issues. The fact that the Chair of the local resilience forum was not able to say with certainty whether it was one exercise or two and was focused on a particular aspect of it, suggests that there were problems in how large-scale, multi-agency exercises were managed. In the future, more resources and robust processes

\begin{footnotesize}
\begin{enumerate}
\item 1051 58/86/17-87/16
\item 1052 117/50/12-51/18
\item 1053 117/62/13-63/19
\end{enumerate}
\end{footnotesize}
should be put in place where large, regional exercises are planned with multiple objectives.

**Force Duty Officer objectives during Exercise Winchester Accord**

12.779 Ten local objectives were set to test the role of the FDO. These included: identifying information leading to the correct declaration of Operation Plato; ensuring Operation Plato protocols were followed; identifying sufficient command and control structures to deal with an ongoing incident; notification protocols within GMP and to other agencies; and examining the structures for the proposed relocation of the FDO to GMP HQ. Some other GMP local objectives also appeared to touch on the role of the FDO, such as an objective for examining the immediate command and control to establish who was informed of an incident and who had operational command.

12.780 Inspector Roby explained that a purpose of the FDO objectives was to replicate what would happen in real life. She spoke to relevant people, including an FDO, CI Booth, who was working at a senior level in the Operational
Communications Branch, and Laura Lewis, who was the control room manager. Inspector Roby said she asked them, “what was going to cause problems if we had this type of incident in reality”. The answers fed into the type of objectives that were set. They contributed to the sequencing of the exercise.

12.781 The Marauding Terrorist Firearms Attack role play began at 00:00. A minute later, calls were to be placed from role-playing shoppers, residents and others to play out the scenario of an active terror attack. Calls to the FDO telephone line were scheduled to continue for a further 19 minutes. The calls were scripted and included press queries, and calls from GMP officers, other police and emergency services, members of the public and others.

12.782 The sequence of events for the exercise noted that, by 00:03, three minutes after the simulation started, callers “[m]ay struggle to contact FDO due to number of phone calls coming in. Need to keep trying.” The FDO was expected to declare Operation Plato at 00:09, while the calls

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1058 INQ034427/4 at paragraph 18
1059 INQ034427/4 at paragraph 19
1060 INQ034427/4 at paragraph 19
1061 INQ033910/13 at paragraph 52, INQ034427/6 at paragraph 30, INQ034454/2-4
1062 67/80/25-81/11
1063 INQ034454/3
were being received. Inspector Roby said this was “to replicate the sheer volume of calls that would be coming in”. She emphasised that the FDO’s telephone line was like a switchboard system with flashing lights. It was expected that other staff would be in a position to answer calls.

Inspector Roby also said that the set-up of the FDO during Exercise Winchester Accord and during a real Major Incident at the time were not comparable. She explained that the exercise was not meant to be a real test of the FDO’s capacity in the way the role was performed at the time. Inspector Roby said that it was a test of proposed capacity in the event that the FDO moved to GMP HQ.

Inspector Roby said she did not think that proposal would work. She believed that, if the FDO were moved out of the Operational Control Room, it would vastly reduce their ability to delegate. She said that, if the FDO were working remotely, they would not get a feel for

1064 INQ0344454/3
1065 67/62/13-63/2
1066 67/62/13-63/2
1067 67/66/22-67/12
1068 67/35/22-36/3, INQ034427/6 at paragraph 32
1069 67/36/4-18
1070 INQ034427/6, 67/36/2-3
1071 67/30/15-31/3
1072 67/31/4-32/3
the room; they would have to be told that something was happening.\textsuperscript{1073}

12.785 CI Booth, who was involved in planning the exercise, similarly said: \textit{“Winchester Accord, from an FDO perspective, had been about testing the FDO in a new location, FHQ [Force Headquarters – GMP HQ], with reduced support.”}\textsuperscript{1074} It was proposed that there would be a small team of radio operators with the FDO working from an area within GMP HQ called ‘the Force Hub’.\textsuperscript{1075} CI Booth was concerned that, by reducing the number of staff, the \textit{“criticality around being overwhelmed was more likely to bear fruition [sic]”}.\textsuperscript{1076} As a result, a local objective was added to Exercise Winchester Accord to test the proposed Force Hub.\textsuperscript{1077}

12.786 Although not directly involved in Exercise Winchester Accord, DCC Pilling explained that it was not a test of the FDO working in the Operational Control Room with the level of support which would have been available on the night of the Attack. Rather, the exercise placed the FDO in an unfamiliar environment at GMP

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{1073} 67/31/4-32/3
\item \textsuperscript{1074} 186/79/3-19, 83/201/13-25
\item \textsuperscript{1075} 83/175/11-24
\item \textsuperscript{1076} 83/175/25-176/12
\item \textsuperscript{1077} 83/176/23-177/1
\end{itemize}
\end{footnotesize}
HQ, without the support of the wider Operational Communications Branch.¹⁰⁷⁸

12.787 During Exercise Winchester Accord, the FDO was supported by nine people. Four were radio operators and four were Operational Communications Branch staff.¹⁰⁷⁹ These details can be seen in Figure 35 at the two desks in the lower half of the diagram. During the Attack, the FDO was supported at the Operational Control Room by 34 people.¹⁰⁸⁰ This can be seen in Figure 36. DCC Pilling said that these differences in the support for the FDO, “inevitably impacted on the lessons that were drawn from the exercise about the FDO: they primarily concerned the proposed moved of the FDO to FHQ [Force Headquarters – GMP HQ]”.¹⁰⁸¹
**Figure 35:** Force Duty Officer team on Exercise Winchester Accord\textsuperscript{1082}
**Figure 36:** GMP Operational Control Room as at 22nd May 2017

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1083 INQ035484/1
12.788 Inspector Roby and CI Booth were overly focused on testing a scenario they knew would fail. Their firm views that the move of the FDO to the Force Hub in GMP HQ would not work confused the wider opportunity that the exercise offered to test the role of the FDO and their capacity to deal with a Marauding Terrorist Firearms Attack. The local objectives set for the FDO went beyond simply testing the proposed relocation from the Operational Control Room to GMP HQ. The objectives tested the role of the FDO in a number of different ways, not least around the handling of a declaration of Operation Plato.

12.789 Irrespective of whether the core local objective for GMP was to test the role of the FDO at a different location, the recognition of the need to test the role of the FDO and the support around them was logical. It showed that there was an understanding at GMP about the likely pressure that the FDO would be placed under during a terrorist attack, wherever he or she was based.

12.790 The decision to look at how the FDO operated in a set-up that was different from the existing one risked taking attention away from the well-known concerns about the FDO role.\textsuperscript{1084} To understand

\textsuperscript{1084} INQ034427/7 at paragraph 40
that, it is important to look at Exercise Winchester Accord in its wider context.

12.791 GMP accepted that it was “well known”\textsuperscript{1085} that the FDO would be under pressure during a Marauding Terrorist Firearms Attack.\textsuperscript{1086} On behalf of Counter Terrorism Policing Headquarters, CI Thomas said that it was “a well-understood fact that the FDO was a potential single point of failure”.\textsuperscript{1087} This was known before and after Exercise Winchester Accord.

12.792 The Policing Experts observed that Exercise Winchester Accord should therefore not have masked what was already known about the vulnerabilities of the FDO.\textsuperscript{1088} I agree with this view. The local objectives set for the FDO were still wide enough to look beyond the proposed move to the Force Hub in GMP HQ and to test the well-known issues with how the role worked. It is regrettable that the exercise failed to do so.

**Background to the Force Duty Officer role**

12.793 The phrase ‘catastrophic failure’ was used during the Inquiry’s hearings to reference problems with the FDO during Exercise Winchester Accord. It is an evocative phrase. It was used in questioning

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\textsuperscript{1085} INQ042531/32 at paragraph 88
\textsuperscript{1086} INQ042531/32 at paragraph 88
\textsuperscript{1087} 60/29/24-30/4
\textsuperscript{1088} 148/84/19-85/12
witnesses and in closing statements. No witnesses volunteered this phrase by reference to the FDO in Exercise Winchester Accord. Some witnesses were asked to agree whether there was such a failure of the FDO during that exercise.\(^\text{1089}\) The question of whether or not there was a failure of the FDO and, if so, whether that failure was catastrophic must be approached with care.

12.794 In order to understand the role of the FDO for Exercise Winchester Accord, it is necessary to set out first some background to that role.

12.795 Between February 2016 and September 2018, CI Booth worked in GMP’s Operational Communications Branch. In that role, he had responsibility for the FDO. This was a role he had performed in the past.\(^\text{1090}\) He said that it was “undoubtedly” an important skill for an FDO to have the ability to communicate with other emergency services.\(^\text{1091}\) A key element of the FDO role in a Major Incident involving a firearms deployment was to act as the Initial Tactical Firearms Commander. This meant that the FDO would decide whether the deployment of firearms officers was necessary and, alongside a Tactical

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\(^{1089}\) 83/207/24-208/12, 84/67/7-17, 141/129/1-130/2

\(^{1090}\) 83/138/25-139/7

\(^{1091}\) 83/145/13-18
Advisor, decide how best to deploy firearms officers to deal with the incident.\textsuperscript{1092}

12.796 In February 2016, three months before Exercise Winchester Accord, CI Booth contributed to a National Resilience Capability Assessment. The purpose of this assessment was to examine the capability and capacity to respond to a Marauding Terrorist Firearms Attack.\textsuperscript{1093} On the assessment questionnaire, it was noted that control room staff had “no specific training around the identification of MTFA [Marauding Terrorist Firearms Attack] attacks” but had received situational awareness inputs around the current threat level.\textsuperscript{1094} For the FDO, it was said that they had “received limited training … around MTFA scenarios”.\textsuperscript{1095} CI Booth agreed that this was less than ideal. Prior to the Attack, GMP had done nothing to remedy the situation.\textsuperscript{1096}

12.797 In February 2016, at the time of the National Resilience Capability Assessment, the Operational Communications Branch did not have action cards in place to deal with a Marauding Terrorist Firearms Attack.\textsuperscript{1097} CI Booth was given the task to produce action cards for

\textbf{\textsuperscript{1092} 83/146/2-11}
\textbf{\textsuperscript{1093} 83/152/8-17, INQ032758/1}
\textbf{\textsuperscript{1094} 83/153/6-154/2}
\textbf{\textsuperscript{1095} 83/154/6-20, INQ032758/7 at paragraph 9}
\textbf{\textsuperscript{1096} 83/154/21-155/1}
\textbf{\textsuperscript{1097} 83/155/18-20}
the Operational Communications Branch that could be used by staff during a Marauding Terrorist Firearms Attack and in other Major Incidents. A rough first draft of the action cards was produced by 12th April 2016, just under four weeks before Exercise Winchester Accord. A further draft was circulated by email to the senior leadership team of the Operational Communications Branch on 26th April 2016, just under two weeks before Exercise Winchester Accord. Feedback on the action cards was invited. CI Booth could not recall that any was received.

12.798 CI Booth said that, at the stage the action cards were being produced, he knew from his own experience that there was a “distinct possibility” of the FDO not being able to cope during a Marauding Terrorist Firearms Attack. He felt that there was more being asked of the FDO in the initial co-ordination with firearms officers. The action cards would mitigate some of that risk in the set-up of communications within the Operational Communications Branch, but there was still “potentially a problem”.

1098 83/157/7-12
1099 83/159/1-17
1100 83/167/13-25
1101 83/172/24-173/5
1102 83/166/8-13
1103 83/166/14-167/12
1104 83/166/14-167/12
intended that the action cards would be circulated to communications staff who were working on Exercise Winchester Accord and refined as a result.\footnote{1105}

12.799 On 3\textsuperscript{rd} May 2016, the week before Exercise Winchester Accord, CI Booth circulated the action cards to Mark Gallagher, who was responsible for resource management in the Operational Communications Branch. The email asked Mark Gallagher to circulate the action cards to staff working on Exercise Winchester Accord and further requested that feedback be provided following the exercise. On the same day, CI Booth also provided the action cards via email to the Silver Control Room Manager assisting on the exercise. The email again explained that the action cards should be tested during the exercise and thereafter feedback should be provided.\footnote{1106}

12.800 There was no evidence that the action cards were tested during Exercise Winchester Accord, and debriefs from Operational Communications Branch staff suggested they were not used.\footnote{1107} This was a significant missed opportunity to use Exercise Winchester Accord to test and improve known weaknesses in the role of the FDO and the capabilities of the Operational
Communications Branch during a Marauding Terrorist Firearms Attack. The focus of GMP staff was to prove the adequacy or not of the proposed move to the Force Hub in GMP HQ rather than to test proposed improvements and better ways of working for the FDO.

Multi-agency response during Exercise Winchester Accord

12.801 What happened and when during the critical aspects of the Marauding Terrorist Firearms Attack phase of Exercise Winchester Accord is a matter of contention. During the Inquiry there was particular disagreement about how the role of the FDO functioned and whether there was a delay in deploying NWAS and GMFRS into the Operation Plato warm zone to treat casualties.

12.802 The trigger for the multi-agency response was intended to be the shared declaration by the FDO of Operation Plato. This would be the signal for NWAS and GMFRS to move forward to the FCP.\(^{1108}\) The individual RVPs for the agencies were agreed in advance.\(^{1109}\) The FCP was located in a car park adjacent to the Orient entrance to the Trafford Centre.\(^{1110}\)

\(^{1108}\) 67/54/9-15
\(^{1109}\) 67/54/25-55/12
\(^{1110}\) INQ041661/2 at paragraph 7
12.803 Superintendent Graeme Openshaw was the Ground Assigned Tactical Firearms Commander for Exercise Winchester Accord. The FDO was Inspector Marcus Williams. He was a very experienced firearms officer but relatively new to the FDO role.

12.804 The exercise sequence of events indicated that, at 01:00, the Ground Assigned Tactical Firearms Commander would “[t]ake control of staff” at the Trafford Centre and “attend scene, direct firearms assets accordingly”. The sequence of events gave no further detail of plans at the Trafford Centre except for one further entry at 01:40 about checking cordons. It is uncontentious that events on the ground at the FCP did not happen according to the exercise plan. It is not agreed why that occurred.

**GMFRS’s view**

12.805 Station Manager Lawlor and Station Manager Gaskell were involved in planning the exercise. Station Manager Lawlor was the exercise co-ordinator for GMFRS. Station Manager Gaskell explained that it was a very well-planned
exercise.\textsuperscript{1115} The planning started in late 2015.\textsuperscript{1116} Until the evidence was presented to the Inquiry, Station Manager Gaskell said he was unaware that one of the local objectives of Exercise Winchester Accord was to investigate the relocation of the FDO.\textsuperscript{1117} It was something he felt he ought to have known about, particularly if it was going to have a significant effect on the exercise.\textsuperscript{1118} This is a sensible observation. It is important that all partners in a multi-agency exercise are aware of all the objectives.

12.806 GMFRS and NWAS were told in advance the location of the RVP and the FCP.\textsuperscript{1119} In my view, it would have been helpful if Exercise Winchester Accord had required the agreement on an FCP during the exercise rather than having a pre-determined one.

12.807 Station Manager Lawlor said that “the exercise did not run smoothly”.\textsuperscript{1120} He said this was because neither the FDO nor the Ground Assigned Tactical Firearms Commander were in contact with other agencies.\textsuperscript{1121} The FDO was provided with contact numbers for the GMFRS

\textsuperscript{1115} INQ033910/13 at paragraph 53, 117/151/25-152/19
\textsuperscript{1116} INQ033910/13 at paragraph 53
\textsuperscript{1117} 117/151/16-24
\textsuperscript{1118} 117/151/16-152/3
\textsuperscript{1119} INQ033910/13-14 at paragraph 57, INQ026735/11 at paragraph 55
\textsuperscript{1120} 62/77/7-22
\textsuperscript{1121} 62/77/7-22
NILOs. Station Manager Gaskell explained that this was important as the fire and rescue service do not self-deploy. GMFRS personnel are taught to “maintain discipline and to wait for instructions from other agencies”.1123

12.808 Station Manager Gaskell said that the exercise began at 00:00. He stated that the initial 30 minutes were purely for the police to organise their response to the simulated attack. His expectation was that at 00:30, there should have been a declaration of Operation Plato that came into GMFRS and NWAS so they could progress from the RVP to the FCP to carry out the “function that we trained for excessively”.1125

Station Manager Lawlor said that GMFRS was expecting to be informed by the FDO about events unfolding at the Trafford Centre and to give them the location of the pre-defined FCP.1126 He accepted that GMFRS was not given a timeframe for specific actions by the exercise co-ordinator.1127

12.809 Station Manager Gaskell explained that, on the night of the exercise, specialist GMFRS resources were put on standby. GMFRS officers
attended GMP silver command.\textsuperscript{1128} Stretford Fire Station was used as the GMFRS RVP and muster point.\textsuperscript{1129} His expectation was that the police would enter the Trafford Centre, identify a terrorist threat, declare Operation Plato and allocate zones. He thought this would then be shared by the FDO with GMFRS and NWAS who would mobilise from their RVP to the FCP.\textsuperscript{1130}

12.810 Station Manager Gaskell stated: “\textit{In fact we [GMFRS] were not notified of the declaration of Operation Plato at all.}”\textsuperscript{1131} His evidence was not entirely consistent with the view of Station Manager Lawlor about the order of deployments to the RVP and FCP. Even so, there was an expectation by both of them that three commanders for GMP, GMFRS and NWAS would come together at the FCP and that somebody from the police, ideally the Ground Assigned Tactical Firearms Commander, would meet them to help assess risk so they could move forward to carry out rescues.\textsuperscript{1132}

12.811 Station Manager Lawlor explained that there was an agreement between the GMFRS and NWAS exercise players to “\textit{run with it}” when they were

\textsuperscript{1128} INQ033910/13 at paragraph 55
\textsuperscript{1129} 62/84/22-85/16
\textsuperscript{1130} INQ033910/13-14 at paragraph 57
\textsuperscript{1131} INQ033910/14 at paragraph 59
\textsuperscript{1132} 62/86/5-19
not informed by the FDO about the need to move to the FCP. He said that it would have been a “false response” to move to the FCP without contact from the FDO. However, there came a point when it was recognised that the FDO was not going to inform them about the FCP, and a decision was made to move forward to it.

12.812 At that point in the exercise, Station Manager Lawlor recalled that either he, or someone from NWAS, contacted the GMP exercise planner to confirm the decision to move forward. Station Manager Lawlor said that this meant there were “very lengthy delays” in deploying resources. He explained that, as they were part of a national exercise of significant importance, they did not want to be the cause of that delay.

12.813 Station Manager Gaskell stated that GMFRS personnel spoke to NWAS personnel while GMFRS personnel were still at their muster point. He stated it was discovered that NWAS had not had any contact from the FDO either. He went on to state that attempts to reach the Ground Assigned Tactical Firearms Commander, who was believed to be at the Trafford Centre at that

1133 INQ026735/11-12 at paragraphs 54-57
1134 62/77/23-79/12
1135 62/77/23-79/12
1136 62/77/23-79/12
1137 62/77/23-79/12
1138 62/79/22-80/20
time, were also unsuccessful. Station Manager Gaskell’s recollection was that it was at this point that both NWAS and GMFRS decided to move forward.\footnote{INQ033910/14-15 at paragraph 60}

12.814 Station Manager Lawlor stated that once NWAS and GMFRS personnel moved forward to the FCP, it was anticipated that they would be met there by the GMP Ground Assigned Tactical Firearms Commander to undertake a joint assessment of risk and define the zonings and limit of exploitation.\footnote{62/77/23-79/12} However, he stated that they were not met by anyone from GMP to carry out the “over the bonnet” co-location and co-ordination so they could mobilise and commit resources to the zones.\footnote{62/79/22-80/20}

12.815 Station Manager Gaskell said that the fact that GMFRS and NWAS did not deploy for “two hours meant that some of the police functions on that exercise had been completed”.\footnote{117/148/14-149/15} He recalled that as GMFRS and NWAS personnel were being deployed, some police officers were walking back from the exercise. It was, said Station Manager Gaskell, “an opportunity lost” to observe fire and
rescue and ambulance services’ capability under the governance of the police.\textsuperscript{1143}

12.816 Station Manager Lawlor stated that at the FCP, it was not possible to make contact with the Tactical Firearms Commander. This contact at the FCP was, according to Station Manager Lawlor, considered “vital” in order to undertake a joint assessment of risk and identify zones and the limit of exploitation.\textsuperscript{1144} His recollection was that at the request of GMFRS and NWAS, the Tactical Firearms Commander was directed by an exercise co-ordinator to make contact with other agencies. There was, it was stated, an overall delay of one and a half hours in NWAS and GMFRS deploying into the Trafford Centre.\textsuperscript{1145}

12.817 Station Manager Lawlor said that a Police Inspector at the inner cordon would not allow GMFRS and NWAS to enter.\textsuperscript{1146} However, Station Manager Gaskell said: “[O]nce the actual commanders got together at the FCP, then the exercise actually went very well.”\textsuperscript{1147}

12.818 Station Manager Gaskell said that GMFRS was left “disgruntled” by the experience of Exercise

\textsuperscript{1143} INQ026735/11-12 at paragraph 56
\textsuperscript{1144} INQ026735/11-12 at paragraphs 54-57
\textsuperscript{1145} INQ026734/12 at paragraph 57
\textsuperscript{1146} INQ026734/12 at paragraph 57
\textsuperscript{1147} INQ026734/12 at paragraph 57
Winchester Accord.\textsuperscript{1148} He said that GMFRS felt overlooked and that the role of the fire and rescue and ambulance services in a Marauding Terrorist Firearms Attack was not appreciated. Station Manager Gaskell felt that the exercise did not deliver, as GMFRS was not used in a timely fashion or in accordance with national guidance.\textsuperscript{1149}

12.819 Group Manager Levy was also present on Exercise Winchester Accord. He acted as an observer to support NILOs in development and to advise on the application of JESIP.\textsuperscript{1150} He was present with the resources that were not being called forward. At the time, he did not observe and was not aware that the FDO had become overwhelmed. His recollection was more with regard to the location of Incident Commanders and their capability to bring the ambulance and fire and rescue teams to the scene.\textsuperscript{1151} Group Manager Levy said he was unaware of any problem with the FDO\textsuperscript{1152} until March 2018, when the independent review of the preparedness for and emergency response to the Attack by Lord Kerslake was published.\textsuperscript{1153}
12.820 Group Manager Carlos Meakin was one of the development NILOs who observed Exercise Winchester Accord.\textsuperscript{1154} He attended the initial briefing for GMFRS personnel at the RVP and then went to the Force Command Module at GMP HQ to observe silver command.\textsuperscript{1155} Group Manager Meakin said that there was a “\textit{substantial delay}” of around an hour in deploying GMFRS and NWAS responders into the Trafford Centre.\textsuperscript{1156} He believed that this was due to the absence of the Tactical Firearms Commander at the FCP, who placed himself in the control room at the Trafford Centre “\textit{cutting himself off from face-to-face communications}”.\textsuperscript{1157} This was evidence that Superintendent Openshaw disputed.\textsuperscript{1158}

12.821 Group Manager Meakin described a feeling of frustration as a result of Exercise Winchester Accord. He was watching remotely but understood that the communication with the Tactical Firearms Commander was so delayed that it severely impacted the deployment of resources into the exercise.\textsuperscript{1159} He said that could potentially have resulted in the loss of life in a

\textsuperscript{1154} 121/17/11-19  
\textsuperscript{1155} INQ026731/7, INQ026731/8 at paragraphs 34-35  
\textsuperscript{1156} 121/18/14-19/2, INQ026731/8 at paragraph 36  
\textsuperscript{1157} INQ026731/8 at paragraph 36  
\textsuperscript{1158} INQ041661/5 at paragraph 19  
\textsuperscript{1159} 121/18/14-19/2
real-world scenario.\textsuperscript{1160} A lot of preparation had gone into the exercise, but it did not play out as expected because of the lack of communication.\textsuperscript{1161}

12.822 Area Manager Paul Etches was embedded on the exercise in the Silver Control Room at GMP HQ. His role was to act as a liaison for information-sharing in a multi-agency partnership.\textsuperscript{1162} Area Manager Etches initially said his perception was that there was a “\textit{lengthy delay}” in asking the fire and rescue and ambulance responders to move forward.\textsuperscript{1163} He said that GMFRS did not have situational awareness about what activity was due to take place, and when, in order to raise the issue.\textsuperscript{1164}

12.823 With the benefit of hindsight, Area Manager Etches said that, rather than “\textit{delay}”, he thought a better description was that the police moved forward to carry out their primary objective, but GMFRS and NWAS services did not get an opportunity to move behind them to carry out the recovery procedures.\textsuperscript{1165} He did not think that the communication had gone well between GMP and GMFRS. The problem was a gap in the

\textsuperscript{1160} 121/19/3-14
\textsuperscript{1161} 121/18/10-21/10
\textsuperscript{1162} 129/158/23-160/15
\textsuperscript{1163} 129/160/16-161/3
\textsuperscript{1164} 129/161/4-20
\textsuperscript{1165} 129/161/24-162/8
communications on scene, but there was also an opportunity in the Silver Control Room to have better communications.\textsuperscript{1166}

12.824 Group Manager Fletcher was an observer on Exercise Winchester Accord. He was based in the management suite at the Trafford Centre.\textsuperscript{1167} He said he was “surprised” by the length of time it took to deploy GMFRS and NWAS personnel. He was only able to watch the response on CCTV without any sound. He later found out that a Police Inspector would not permit GMFRS and NWAS crews into the cordon.\textsuperscript{1168}

12.825 Group Manager Fletcher agreed that there was a significant JESIP failure. It appeared to show a lack of understanding about GMFRS capabilities.\textsuperscript{1169} The JESIP lead at Merseyside told him that JESIP did not work on the night.\textsuperscript{1170} Group Manager Fletcher said that it was fed back to him that the delay at the FCP was a failure of the FDO to call the emergency services forward. He acknowledged that this was not something he saw or heard in the management suite.\textsuperscript{1171}
12.826 A key learning point for GMFRS from Exercise Winchester Accord was the need for multi-agency commander training. Station Manager Lawlor explained that there was no one in GMP trained to act as a liaison with GMFRS and NWAS.\textsuperscript{1172} Station Manager Gaskell said that the focus of this further training was to educate police commanders on the role of specialist responders from other agencies through the JOPs commander course that was introduced in January or February 2017.\textsuperscript{1173} Station Manager Lawlor said the training was also targeted at GMFRS and NWAS NILOs, the Tactical Firearms Commander, and commanders and Tactical Advisors from all three agencies.\textsuperscript{1174}

NWAS’s view

12.827 The NWAS planning document for the exercise set out an anticipated timetable of events. On day one, it was planned that the FDO would contact the NWAS Exercise Co-ordinator, Paul Bailey, to declare Operation Plato at approximately 00:05.\textsuperscript{1175} HART crews, the Ambulance Intervention Team Commander and the Operational Commander were to mobilise to the Trafford Centre at 00:25. At 01:00, NWAS senior

\textsuperscript{1172} INQ026734/13 at paragraph 58
\textsuperscript{1173} 62/86/23-88/16
\textsuperscript{1174} INQ026735/12 at paragraph 60
\textsuperscript{1175} INQ013559/10-11
commanders were to support the Tactical Co-ordinating Group and Strategic Co-ordinating Group. These timings broadly corresponded with those set out by GMFRS.

12.828 NWAS’s view on the Marauding Terrorist Firearms Attack phase of Exercise Winchester Accord was summarised in its exercise report issued on 3rd August 2016. NWAS’s exercise report noted that there was on-scene co-location between GMFRS and NWAS commanders, but that the “lack of police presence did not allow for a JDR [joint dynamic risk assessment] to take place”. These views were repeated in an undated document entitled ‘Winchester Accord – Observations’. It recorded a “significant delay” in deployment into the scene to treat injured casualties.

12.829 The NWAS debriefs commented that there was a “huge delay” in the deployment of GMFRS and NWAS personnel to triage and treat casualties. It said that the triage teams were only deployed at 02:20. This was 2 hours and 20 minutes after the simulated “attack”. The NWAS debrief said that NWAS and GMFRS personnel should have

1176 INQ013559/11
1177 INQ013847/1
1178 INQ013847/13
1179 INQ013675/1
1180 INQ013669/1
been able to deploy to the Operation Plato warm zone outside of the building within 30 minutes of the attack. It concluded: “This delay would unequivocally have resulted in unnecessary loss of life.”

12.830 In its exercise report, NWAS made a recommendation for further joint exercises to include joint agency working. The basis of this recommendation was said to be: “Part of the decision making process could not be made at the operational scene due to one of the agencies missing.” This in turn was said to have led to a time delay in getting to patients.

GMP’s view: Forward Command Post

12.831 GMP’s view of Exercise Winchester Accord was starkly different to those of GMFRS and NWAS. It developed over the course of the Inquiry.

12.832 In its opening statement, GMP accepted that, during Exercise Winchester Accord, the FDO was overstretched and at times impossible to contact. These weaknesses were identified through debriefs after Exercise Winchester Accord. Although GMP said that the exercise was not comparable to real-life conditions, it accepted that insufficient steps were taken before the
Attack to provide extra support for and better access to the FDO.\footnote{1184}{12/118/19-119/11} It was agreed that the fact an FDO might be overwhelmed was widely known.\footnote{1185}{INQ035886/2 at paragraph 7}

12.833 When GMP made its closing statement, its analysis was that there was no evidence of a catastrophic failure of the FDO. It submitted that there was evidence that the FDO’s performance during the exercise was very positive.\footnote{1186}{INQ042531/9 at paragraph 21(iv)} It was also said that there was no delay in deploying NWAS and GMFRS into the Operation Plato warm zone to treat casualties, and there was no JESIP failure detrimental to the wellbeing of casualties.\footnote{1187}{INQ042531/9 at paragraph 21(iii)} As the FDO was not working from his normal location in Exercise Winchester Accord, it was suggested it was difficult to draw any meaningful parallels with the emergency response to the Attack.\footnote{1188}{INQ042531/32 at paragraph 89}

12.834 A critical reason for the development of the GMP position was a July 2021 statement from Superintendent Openshaw, the Ground Assigned Tactical Firearms Commander for Exercise Winchester Accord on day one.
In his statement, Superintendent Openshaw explained that, in order to inject some reality into the exercise, he waited for a call to activate him as the Ground Assigned Tactical Firearms Commander. He stated that this was supposed to be from the Cadre Tactical Firearms Commander at GMP HQ. However, he explained there was a delay of up to an hour in him receiving that call. He believed this was because the activation of the Ground Assigned Tactical Firearms Commander was not included in the GMP planned sequence of events for the exercise: it had been “overlooked”. He said that he was eventually activated to attend by the Firearms Tactical Advisor, Sergeant Frederick Warburton, and arrived at the Trafford Centre about ten minutes later. On arrival, Superintendent Openshaw stated he had briefings with the Operational Firearms Commander and a military commander in the CCTV control room. This took no more than 15 minutes.

Superintendent Openshaw said that he then made his way to the FCP. This took a couple of

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1189 INQ041661/1-2 at paragraph 4
1190 INQ034454
1191 INQ041661/4 at paragraph 14
1192 INQ041661/2 at paragraph 5
1193 INQ041661/2 at paragraph 6
minutes.\textsuperscript{1194} As an estimate, based on an arrival time of about 01:30, this would mean that Superintendent Openshaw arrived at the FCP at the earliest between 01:45 and 01:50. The sequence of events for Exercise Winchester Accord indicated that Superintendent Openshaw should have been at the FCP at 01:00.\textsuperscript{1195}

12.837 When he arrived at the FCP, Superintendent Openshaw said he could hear gunfire coming from the direction of the Trafford Centre. NWAS and GMFRS commanders were already present. There were no senior GMP officers.\textsuperscript{1196} Superintendent Openshaw said about the GMFRS and NWAS commanders that he “gained the impression they had been at the FCP waiting for me to arrive”. They had received information from the Silver Control Room that the area outside the Trafford Centre was potentially an Operation Plato warm zone with casualties and wanted to move forward.\textsuperscript{1197}

12.838 Superintendent Openshaw said this information was different from the briefing he had received from the Operational Firearms Commander. He believed that Silver Control was “slightly ahead of where the exercise actually was on the
1198 The Operational Firearms Commander had told him that the area immediately around the Orient entrance was an Operation Plato hot zone as the terrorists were positioned so they could fire down into the area. GMP firearms officers were in the Operation Plato hot zone.1199 Superintendent Openshaw shared that information with the NWAS and GMFRS commanders. He stated that this took about 10 to 15 minutes.1200 Taking the shorter estimate, this would take the time to approximately 02:00 or 02:05.

12.839 As that briefing finished, Superintendent Openshaw stated that the military moved into the Trafford Centre through the Orient entrance. This allowed GMP firearms officers to move in and sweep the lower floor. A joint assessment of risk was undertaken, and the area outside the Orient entrance was declared an Operation Plato warm zone.1201 The GMFRS and NWAS specialist responders moved in to treat and extract the casualties.1202 NWAS commented in its debrief that its triage teams deployed into the Trafford Centre at 02:20. About 30 minutes later, the terrorists were neutralised and the whole of the

1198 INQ041661/3 at paragraph 8
1199 INQ041661/3 at paragraph 9
1200 INQ041661/3 at paragraph 10
1201 INQ041661/3-4 at paragraphs 11 and 12
1202 INQ041661/4 at paragraph 12
Trafford Centre was declared an Operation Plato warm zone.1203

12.840 Superintendent Openshaw accepted that his delayed arrival caused “some initial difficulties”.1204 He estimated that it took him about 30 minutes to establish control once he arrived at the Trafford Centre. He said there was a “fractured communications picture” due to “Silver” being ahead in the exercise scenario. Overall, he said the multi-agency response worked very well.1205 Superintendent Openshaw did not agree that there was a JESIP failure, apart from that caused by his late arrival.1206 Superintendent Openshaw also stated that the delay in him reaching the FCP did not delay GMFRS and NWAS moving forward to casualties. That was because, at the point of his arrival, the Trafford Centre was still an Operation Plato hot zone.1207

12.841 What is clear from Superintendent Openshaw’s statement is he was delayed in joining the exercise. This delay was because he was not notified by the Tactical Firearms Commander, and not because of any issue with the FDO.

1203 INQ041661/4 at paragraph 13
1204 INQ041661/4 at paragraph 15
1205 INQ041661/4 at paragraph 15
1206 INQ041661/4 at paragraph 15
1207 INQ041661/5 at paragraph 16
However, Superintendent Openshaw’s statement does not address the timing of NWAS and GMFRS being notified of the Operation Plato declaration or the calling forward of NWAS and GMFRS to the FCP.

12.842 In the course of his statement, Superintendent Openshaw referred to a sequence of events for Exercise Winchester Accord. In that document, at 00:09 the FDO was identified as declaring Operation Plato. Under the list of anticipated actions was: “Inform GMFRS and NWAS NILO.” That document anticipated that the FCP would be established by firearms officers at 00:22. At 00:40, it indicated that the FDO should “ensure someone nominates a FCP and informs all necessary staff.”

12.843 Based on the accounts of those from GMFRS who were involved, these were not communicated to them either at or near the time they were supposed to be.

GMP’s view: Force Duty Officer

12.844 CI Booth was the duty officer umpire for the FDO. This role was to ensure that certain actions on the exercise happened at particular points and to ensure that, if the FDO failed to

1208 INQ034454
1209 83/173/6-10
complete a task, he could step in to allow the exercise to continue.\textsuperscript{1210} If an error was made which needed to be corrected during the exercise, that could be dealt with later through feedback.\textsuperscript{1211} The FDO for the exercise, Inspector Williams, was “relatively” experienced and a former firearms officer, which meant he was familiar with that aspect of the role.\textsuperscript{1212}

12.845 CI Booth said that he could not recall in great detail what happened during the exercise, but that it highlighted that the FDO needed more staff if the move to the Force Hub at GMP HQ was to work.\textsuperscript{1213}

12.846 During the exercise, the FDO was based in the Force Command Module, partitioned off from the rest of the Silver Control Room.\textsuperscript{1214} CI Booth said he was only aware of delays at the RVP and FCP after the exercise. Within the control room, he was not aware of those problems.\textsuperscript{1215} He was not informed in the planning for the exercise that the FDO was expected to contact the GMFRS and NWAS NILOs within the first nine minutes.

\begin{footnotesize}
\begin{tabular}{ll}
\textsuperscript{1210} & 83/179/1-23, 84/65/12-66/2  \\
\textsuperscript{1211} & 84/66/8-25  \\
\textsuperscript{1212} & 83/180/2-16  \\
\textsuperscript{1213} & 83/181/4-14  \\
\textsuperscript{1214} & 83/181/20-182/1  \\
\textsuperscript{1215} & 83/182/17-183/22  \\
\end{tabular}
\end{footnotesize}
CI Booth said that did not “sound an unreasonable element of the exercise”.\textsuperscript{1216}

12.847 CI Booth agreed that, in simple terms, the FDO was overwhelmed during the exercise.\textsuperscript{1217} He was careful to say that he could not recall in great detail what happened during the exercise, but it was seeking to test proposed changes, not the system in place. CI Booth recalled that the FDO coped reasonably well but was frustrated by the inability to delegate tasks.\textsuperscript{1218} He agreed, in further questioning, with a suggestion that there was a catastrophic failure because there was a failure to declare Operation Plato to GMFRS and NWAS and a failure to call them forward, and that this delay would have likely contributed to a loss of life.\textsuperscript{1219}

12.848 CI Booth said he could not recall any issue that was raised about such a significant delay. He felt that he would have stepped in as the exercise would have come to a “grinding halt” and that the exercise co-ordinators would have corrected the situation.\textsuperscript{1220} It was only after the exercise he became aware of such a huge delay.\textsuperscript{1221} He accepted that the failures in Exercise Winchester

\begin{itemize}
\item \textsuperscript{1216} 84/38/11-39/2
\item \textsuperscript{1217} 83/182/12-16
\item \textsuperscript{1218} 83/180/21-182/11
\item \textsuperscript{1219} 84/67/7-17
\item \textsuperscript{1220} 84/69/9-21
\item \textsuperscript{1221} 84/67/22-68/9
\end{itemize}
Accord were very similar to those that occurred 12 months later in the response to the Attack.\textsuperscript{1222} This evidence was provided by CI Booth in March 2021, four months before the statement of Superintendent Openshaw was provided to the Inquiry.

12.849 Inspector Roby described herself as a “roving problem solver” based at GMP HQ.\textsuperscript{1223} As she had written the majority of the exercise, she was the overall co-ordinator. Umpires were allocated to each of the individual areas, so they were close by to deal with anything that went wrong and note down good and bad points.\textsuperscript{1224}

12.850 Inspector Roby said that, as she was walking around, somebody told her that they had not received an activation call from the FDO. While it was her impression that the FDO “managed extremely well under the circumstances”, she agreed that this did not in fact appear to be the case.\textsuperscript{1225} She understood that communication between agencies went wrong at some point during the exercise, and this identified a need for more JESIP training.\textsuperscript{1226}
12.851 Inspector Roby said that she only learned later that there was a lack of communication at the FCP and problems with the Ground Assigned Tactical Firearms Commander going there.\(^{1227}\) She said that, if she had known, she would have got involved to help sort it out. It was a major part of the exercise, Inspector Roby said, but: “Unfortunately, the ODU [Operational Development Unit] were more interested in military relicensing than they were in multi-agency exercising.”\(^{1228}\) Inspector Roby was not the only witness to refer to such issues. The tension between the different objectives for different organisations from the exercise was a recurring theme. It was inevitable that this fed into tension between which objectives had the greater priority and the overall efficacy of the exercise.

12.852 CI Booth explained that an important lesson he took from the exercise was that the proposed move of the FDO to the Force Hub at GMP HQ would not work. He also accepted that the fact that the Exercise Winchester Accord arrangements had failed did not necessarily mean that the existing provision for the FDO, with 30 or 40 staff, would work. The outcome of Exercise Winchester Accord was not, as CI Booth
stated, “an automatic pass” for the existing arrangements.\textsuperscript{1229} He agreed that there was no guarantee that more people would make it any better.\textsuperscript{1230} However, he explained that it was impossible to replicate the control room in a real-life scenario as they needed to keep working 24 hours a day. To do so would leave GMP “dangerously vulnerable”.\textsuperscript{1231} CI Booth accepted that it was less than ideal that there was no way of testing whether the FDO was going to succeed with the existing system.\textsuperscript{1232}

12.853 Inspector Roby said that, at the time, she was not aware that there had been such a big delay in deploying ambulance and fire and rescue personnel into the Operation Plato warm zone. She said that she “agree[d] entirely” with the debrief comments made by NWAS about them not being deployed into the warm zone within 30 minutes and the delay potentially leading to an unnecessary loss of life.\textsuperscript{1233} She agreed that was a learning point from the exercise.\textsuperscript{1234} There were no surprises in the outcome of the exercise for Inspector Roby. It established that the FDO could not work in isolation.\textsuperscript{1235} The risk of the FDO
being overwhelmed would only increase by moving the FDO to GMP HQ. 1236

12.854 As a result of Exercise Winchester Accord, a review was undertaken of the proposed move of the FDO to GMP HQ. The move was only considered feasible once the remainder of the Operational Communications Branch had also transferred across. On the night of the Attack, the FDO was still located in the Operational Control Room. 1237 Inspector Roby said that she was not aware of the actual set-up of the FDO in the control room being tested before the Attack. 1238

12.855 It is telling that the outcomes of Exercise Winchester Accord told Inspector Roby exactly what she expected to hear. Her focus and that of her GMP colleagues was on the Force Hub proposal. It is unfortunate that the acknowledged problems that the FDO experienced on Exercise Winchester Accord did not flag the need for more testing of the existing arrangements of the FDO working from the Operational Control Room.

12.856 There were problems that arose during the exercise with the capacity of the FDO and joint working with NWAS and GMFRS. The extent of those problems needed to be more thoroughly

1236 67/39/4-10
1237 83/210/3-18
1238 67/41/12-19
understood and could not simply be explained by testing the FDO role from the Force Hub at GMP HQ. The failure to conduct a more critical and searching analysis of the lessons from Exercise Winchester Accord will be considered in the following section on debriefs from the exercise.

Debriefs following Exercise Winchester Accord

12.857 Joint Organisational Learning was introduced as part of JESIP in 2015. This mechanism was introduced because the emergency services were frequently identifying issues, but they were not being shared nationally for wider learning or leading to changes in local practice.\textsuperscript{1239} JESIP promoted a framework of hot debriefs led by commanders immediately after an event and formal, structured debriefs co-ordinated by lead agencies.\textsuperscript{1240} The Policing Experts said that debriefs should “capture aspects that were positive alongside those aspects that did not go so well”.\textsuperscript{1241} The debrief process on Exercise Winchester Accord fell below these aspirations.

12.858 On 11\textsuperscript{th} May 2016, CI Booth received an email from an Operational Communications Branch Trainer, Kelly Chilton, with feedback on the

\begin{itemize}
\item \textsuperscript{1239} INQ024271/66 at paragraph 4.15.3
\item \textsuperscript{1240} INQ024271/66 at paragraph 4.15.3
\item \textsuperscript{1241} INQ024271/66 at paragraph 4.15.4
\end{itemize}
performance of call handlers. She said: “The stress levels in the room were intense.”\textsuperscript{1242} She said that call handlers needed a reference document to help them to know what to do during a Marauding Terrorist Firearms Attack.\textsuperscript{1243} CI Booth agreed that this feedback appeared to indicate that the action cards were not tested by call handlers during Exercise Winchester Accord.\textsuperscript{1244}

12.859 On 13\textsuperscript{th} May 2016, Group Manager Fletcher emailed GMP Superintendent Giladi about Exercise Winchester Accord. Joe Barrett from NWAS was on copy.\textsuperscript{1245} The email identified that an issue from the exercise was “the linkage in particularly [sic] in the initial stages of the incident, with the Tactical Firearms Commander and the GMFRS/NWAS Commanders.”\textsuperscript{1246} It said that only a marshalling officer was deployed to the initial RVP and linkage with the Tactical Firearms Commander was very limited. This led to an “excessive delay” in GMFRS and NWAS resources moving forward. The email said this delay was approximately two and a half hours.\textsuperscript{1247} Group Manager Manager Fletcher later stated that it was a

\textsuperscript{1242} 83/189/13-190/21  
\textsuperscript{1243} 83/190/22-25  
\textsuperscript{1244} 83/191/1-11  
\textsuperscript{1245} INQ004520  
\textsuperscript{1246} 63/100/11-102/5  
\textsuperscript{1247} INQ004520
“slip of the keyboard” and the email should have said one and a half hours.\textsuperscript{1248} He suggested arranging a one-day joint awareness course for commanders.\textsuperscript{1249}

12.860 Inspector Williams emailed CI Booth on 14\textsuperscript{th} May 2016 with his “[t]houghts re Ex Winchester Accord”.\textsuperscript{1250} He said, “you have to know your limits … what you can achieve before you become overloaded”.\textsuperscript{1251} The email continued that there was a need to prioritise actions and get support to the FDO as soon as possible. He said that “the reality is the FDO will be frazzled”.\textsuperscript{1252} CI Booth accepted that this was a reference to the overloading and overwhelming of the FDO.\textsuperscript{1253}

12.861 Inspector Williams provided further feedback in his email that the process would run more smoothly if staff had an understanding of Operation Plato, the use of language and what a Marauding Terrorist Firearms Attack response looked like.\textsuperscript{1254} CI Booth agreed that this was a further indication that the draft action cards he

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\textsuperscript{1248} 63/100/23-102/5
\textsuperscript{1249} 63/102/18-103/17
\textsuperscript{1250} INQ034457/2
\textsuperscript{1251} 83/191/12-22
\textsuperscript{1252} 83/192/12-19
\textsuperscript{1253} 83/192/12-19
\textsuperscript{1254} INQ034457/3
\end{flushleft}
had prepared were not used or tested during the exercise.  

12.862 Inspector Williams also commented that a lot of people will think they are the most important unit but “the truth is, it is all about getting our guns down there”.  

When setting out his priorities, Inspector Williams listed “getting ARVs [Armed Response Vehicles] to the scene” first, “[t]hen we can start to look to mobilise the Fire and HART, although they are likely to have already heard and been in contact”.

12.863 From his perspective, CI Booth considered that the fire and rescue and ambulance role in casualty treatment needed to be deployed as soon as they were able. He agreed that “it certainly appears” that there was a preoccupation with the deployment of firearms officers to the detriment of deploying the fire and rescue and ambulance services. This indicated a lack of understanding of the need for a multi-agency response to a Marauding Terrorist Firearms Attack. Operation Plato is far more than an armed response, and this comment should have
been a flag that more training was needed for the FDO role in JESIP and multi-agency working.

12.864 The GMP structured debrief took place on 16th May 2016.\textsuperscript{1260} The debrief team was one GMP officer, PC Hughes, and two GMFRS officers. It was attended by 14 key personnel from the Strategic Co-ordination Centre who were activated during the exercise, including Superintendent Openshaw. Inspector Williams did not attend, but a questionnaire he completed was read out.\textsuperscript{1261} There was no evidence whether the email feedback provided by Inspector Williams was also available, but it seems unlikely as CI Booth did not participate in the structured debrief.

12.865 The GMP structured debrief report identified over 50 areas for improvement. Feedback was provided on the \textquotedblleft[c]onfusion between the role of TFC [Tactical Firearms Commander] in Silver and ground TFC\textquotedblright and that there was \textquotedblleft[n]ot enough information at the FCP as to what was happening inside the building\textquotedblright.\textsuperscript{1262} There was also a comment that the Tactical Firearms Commander was called in too late and \textit{always playing catch up} as the military assets had already deployed before the Ground Assigned

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\item \textsuperscript{1260} INQ007697
\item \textsuperscript{1261} INQ007697/1
\item \textsuperscript{1262} INQ007697/4-5
\end{itemize}
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Tactical Firearms Commander was in place.¹²⁶³ Fifteen areas that went well were identified, including: “The FDO did a great job, was knowledgeable and knew what to do” and “JESIP worked well, three blue lights speaking the same language at the FCP in the warm zone. No C&C [command and control] issues.”¹²⁶⁴

GMP debrief questionnaires

¹²⁶⁶ Seventeen questionnaires were prepared for the GMP structured debrief.¹²⁶⁵ Participants were asked to say what aspects of the Strategic Co-ordination Centre did not go well and what recommendations they would make. The questionnaires included references to the Ground Assigned Tactical Firearms Commander being assigned too late, the need for a better understanding of the acronyms used during the deployment and the need to keep better track of who had been contacted. The questionnaires also identified the need for more clarity around the communication by the FDO on the command and control structure for the response.

¹²⁶⁷ The questionnaire from a Ground Assigned Tactical Firearms Commander, CI Sarah Morton, who shadowed Superintendent Openshaw,¹²⁶⁶

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¹²⁶³ INQ007697/4
¹²⁶⁴ INQ007697/5
¹²⁶⁵ INQ034462/2
¹²⁶⁶ INQ041661/1 at paragraph 3
referred to “confusion” between the role of the Tactical Firearms Commander in the Silver Control Room and the Ground Assigned Tactical Firearms Commander and “management of partners at FCP”. She suggested there was “someone at FCP to co-ordinate and communicate with partners” but that the “response from partners on the ground was good”. 1267

12.868 The questionnaire from Superintendent Jim Liggett, the Tactical/Silver Commander for the exercise, noted that “contact from FDO came late in the day” and a “significant amount of activation had already taken place (66 pages of FWIN [Force Wide Incident Number])”. 1268 Superintendent Liggett queried the definition of the Operation Plato warm zone if there was an Improvised Explosive Device (IED) on a body. This issue should have been resolved as part of the debrief. This might have forestalled some of the issues on 22nd May 2017. Superintendent Liggett linked this comment to an observation about “managing expectations of NWAS and GMFRS to attend the Orient before declared a ‘warm zone’”. 1269
12.869 CI Lisa Wroe, the Tactical Firearms Commander in the Silver Control Room, commented: “Immediate actions completed by FDO, however slow to contact. TFC [Tactical Firearms Commander] – I had to contact.” She commented that it was not obvious that she had taken command and control. It was communicated “on air” but not picked up by the FDO so she had to interject.

12.870 CI Wroe commented: “Ambulance informed at 00:01 that they could enter warm zone, however clearly not communicated properly as they asked later on.” She said that she was “[a]sked countless times / pressure re warm zones when the venue was not safe.” CI Wroe concluded that it was a “great learning exercise”, it was “invaluable for interoperability and partners” and it highlighted the “complexities of such an incident”.

GMP debrief recommendations

12.871 Recommendations arising out of the GMP debrief were allocated to named individuals. The 19 recommendations listed included: JESIP training needed for officers and commanders; the need for a police liaison at the FCP to co-ordinate and
communicate with partners; and additional support for the FDO would be necessary in the event of a real incident.\(^{1274}\) There was no evidence to indicate that such additional support was provided.

12.872 The recommendation relating to the support for the FDO was assigned to CI Booth.\(^{1275}\) CI Booth explained that he thought the support already in place for the FDO was sufficient to discharge this recommendation, and no action was taken. In hindsight, he agreed that assessment was mistaken.\(^{1276}\) There was no evidence about steps taken to implement other recommendations about the police liaison at the FCP and JESIP training.

12.873 The GMP structured debrief, questionnaires and email observations were collated within a week of Exercise Winchester Accord.\(^{1277}\) This was commendable, but there were significant gaps in the learning captured on the structured debrief.\(^{1278}\)

12.874 Nothing appears to have been captured about the emailed feedback from the FDO to “\textit{know your limits}”, and that the FDO would be “\textit{frazzled}”

\(^{1274}\) INQ007697/7-8
\(^{1275}\) INQ007697/8
\(^{1276}\) 83/202/1-13
\(^{1277}\) INQ007697/1
\(^{1278}\) 184/90/7-24
and “overloaded”. Nothing was done to capture his observations on prioritising the deployment of the armed response. Observations from control room staff about the need for a reference document were not highlighted on the structured debrief report. There was also nothing to indicate an analysis of the 62 local objectives set for GMP against the areas for improvement and recommendations.

12.875 On the information available, the GMP structured debrief lacked focus. It failed to scrutinise properly problems that arose during Exercise Winchester Accord. This represented a significant missed opportunity to capture learning from the exercise. If GMP had done so, the problems that did arise with the FDO, whether or not catastrophic, and the issues that arose at the FCP would have been captured and understood much better.

Greater Manchester Resilience Forum multi-agency debrief

12.876 A GMRF multi-agency structured debrief took place on 23rd May 2016. Representatives from GMFRS, NWAS and GMP were present, together with other agencies involved in the exercise. The
structured debrief report identified over 40 areas for improvement.\textsuperscript{1280}

12.877 Six participants in the GMRF debrief commented they had been “\textit{informed late into the incident}”\textsuperscript{1281} and two participants said they “[n]ever received a call out”.\textsuperscript{1282} Three participants said that an effective assessment of risk was hampered by a “\textit{lack of tri-service commanders coming together}” and poor communication at the scene.\textsuperscript{1283} GMFRS was not aware of the set-up of the warm zone, and it was noted: “\textit{If the FDO is busy the person who answers the phone may not know what to do, we need a different route to the FDO for the setting up of the SCC [Strategic Co-ordination Centre]}.’’\textsuperscript{1284}

12.878 The GMRF debrief report identified 25 areas that went well, including good multi-agency partner working. The FDO and Tactical/Silver Commander were praised.\textsuperscript{1285} Nineteen recommendations were made. None of the recommendations focused on the role of the FDO or JESIP working at the FCP. One recommendation commented on the need to ensure key personnel were present at exercises,
such as IT, media and BTP. No reference was made to NWFC. Only four of the recommendations had named individual owners to implement them.  

12.879 It is difficult to be confident about how robust the analysis conducted for the GMRF debrief was. There did not appear to have been a check back against all the local objectives or consistent ownership of the recommendations. It appears that the GMRF debrief was conducted at least before the final NWAS debrief report. I do not have access to a structured debrief report from GMFRS to understand when its debrief took place, if at all.

12.880 NWAS provided the Inquiry with “debrief points” from the exercise. These were undated and have previously been summarised to set out the NWAS view of the exercise. The notes included two very short positive comments: “good triage by AIT team [Ambulance Intervention Team]” and “positive attitude by team”. The notes identified 17 “negatives”. These included reference to a “huge delay” to having a tri-service meeting, and delays to deployment of NWAS and GMFRS to triage and treat. It was said that there was a lack of direct police on-site liaison with NWAS and GMFRS. The negatives also included issues that

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1286 INQ012539/7-8
1287 INQ013669
arose between GMFRS and NWAS in respect of co-ordination and leadership around triage, treatment and recovery of casualties.\footnote{1288}

12.881 Following the GMRF structured debrief, the next significant staging post in the debrief process from Exercise Winchester Accord was a meeting of the Blue Light Forum on 28\textsuperscript{th} June 2016. This was attended by representatives from GMP, GMFRS and NWAS.\footnote{1289} The minutes from the Forum noted that “[t]he main issue was the delay in getting NWAS and Fire Service resources to the incident scene”.\footnote{1290} It was said that this resulted in a two-hour delay in deployment. The possibility of further awareness training was discussed for Tactical Firearms Commanders.\footnote{1291}

12.882 The following day, a meeting was arranged between Superintendent Giladi, Joe Barrett from NWAS and Group Manager Fletcher. This was to discuss Group Manager Fletcher’s email sent shortly after the exercise on 13\textsuperscript{th} May 2016.\footnote{1292} Superintendent Giladi said he engaged positively with the email because he was concerned about what was being raised and had a good relationship with GMFRS and NWAS.\footnote{1293}
Superintendent Giladi’s daybook recorded a brief note of the meeting.\footnote{INQ040927} A note with an asterisk read: “\textit{Co-location!! – same mistake every time.}”\footnote{INQ040927/3} He said that this point was “\textit{clearly of concern}” and that it had been an issue during several exercises.\footnote{INQ040922/11 at paragraph 49}

12.883 In his evidence, Superintendent Giladi stated that he had understood from Group Manager Fletcher that JESIP probably was not applied during Exercise Winchester Accord. He understood that, “\textit{there was certainly what appeared to be a lack of communication on the ground to ensure that Fire and Rescue and Ambulance Service resources were used to their best ability}”.\footnote{84/158/18-160/14} Superintendent Giladi said that such an excessive delay would have had potentially “\textit{horrendous consequences}”.\footnote{84/160/15-21} He said that it was agreed to set up training on command and control. This became the JOPs commander training that took place in January and February 2017.\footnote{INQ040922/12}

12.884 The NWCTU debrief report from Exercise Winchester Accord was finalised on
5th July 2016. The report provided important insight into what happened during the exercise at the FCP.

12.885 Dealing with the designation of the FCP, the report noted that, when military assets arrived, there was no Ground Assigned Tactical Firearms Commander. As a result, the Operational Firearms Commander performed the role. The Operational Firearms Commander designated the FCP and briefed the military to agree a tactical plan. It was said that, at this stage, the FDO handed over command to the Cadre Tactical Firearms Commander, but they were uncontactable.

12.886 On the delayed declaration of the Operation Plato warm zone, it was said that the Tactical Firearms Commander was unsighted on the process of neutralising “subjects” and clearing areas. Therefore, the Tactical Firearms Commander was not confident in declaring the warm zone until the Operational Firearms Commander had provided tactical advice to her. At this point, “JESIP partners deployed in a casualty management role”. These are important points. They are not
reflected in the GMP or GMRF structured debriefs. This reinforces the concern about the quality and consistency of the debrief process and learning lessons.

12.887 On 7th July 2016, Superintendent Giladi chaired GMP’s Major Incident Public Order and Events Group meeting. One of the attendees was Superintendent Openshaw. An update was given on the recommendations from the GMP structured debrief. It was highlighted that, “[t]he exercise had been run specifically to test whether the FDO could work in isolation and it had been established that this did not work”. Despite the meeting that Superintendent Giladi had with Group Manager Fletcher only the week before, it seems unlikely that the issues relating to co-location were referred to at that meeting. It would have been helpful if this was discussed, particularly with Superintendent Openshaw present at the meeting, to embed learning on this critical issue with all the emergency services.

12.888 On 21st July 2016, there was a meeting of the GMRF Resilience Development Group. This was attended by Superintendent Giladi and Inspector Roby for GMP, Group Manager Fletcher and Station Manager Berry for GMFRS,
and two representatives for NWAS. The NWCTU debrief report on Exercise Winchester Accord was presented to the meeting.\(^{1308}\) It is not apparent that the problems of co-location were raised at the meeting.

12.889 The overall debrief process identified many learning points from Exercise Winchester Accord. However, it was disjointed and lacked the rigour that is necessary to track each exercise objectively against lessons learned and recommendations. Too often, opportunities were missed to reflect on issues that arose during Exercise Winchester Accord because the importance of the information was not understood or was simply not shared with all agencies. This applies to the debriefs conducted by all the emergency services and GMRF. Improvements must be made to debrief properly from large exercises and to ensure an appropriate level of resource is provided to achieve this.

12.890 The Policing Experts recommended that local resilience forums “should be more closely involved in managing the lessons to be learned from major exercises, or serious incidents, in their areas and for the specific debriefing of those events”. They noted that local resilience forums currently have “no audit or assessment mandate

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\(^{1308}\) INQ012471/5
to ensure that multi-agency arrangements are effective or are supported adequately by single agency plans or capability”. 1309 This is a sensible recommendation, and consideration should be given by central government as to how to make the debrief process more effective.

Exercise Winchester Accord conclusions

12.891 Exercise Winchester Accord was an ambitious exercise. 1310 It offered an important opportunity to conduct a live exercise of a Marauding Terrorist Firearms Attack scenario. Ultimately, the exercise tried to do too much. There were too many local objectives and, without the funding and support available for an equivalent national exercise, it was inevitable that Exercise Winchester Accord could not deliver on all its objectives.

12.892 Important learning was identified from the exercise. It was apparent that the proposed move of the FDO to the Force Hub at GMP HQ would not work. 1311 Yet Exercise Winchester Accord cannot be regarded as a success. It foreshadowed some of the problems in the emergency response that were to arise on 22nd May 2017. Although the role of the FDO was tested in a different location from where they

1309 INQ042283/1
1310 147/121/2-5
1311 INQ034427/7 at paragraph 40
worked on the night of the Attack, parallels can still be drawn between the failures in Exercise Winchester Accord and problems that arose a year later at the Victoria Exchange Complex.

12.893 The FDO’s performance cannot be described as a catastrophic failure. There is, however, evidence that he was overwhelmed during the exercise, particularly the early stages. This contributed to the failures to communicate the Operation Plato declaration and the delays in deployment to the FCP. These were problems which are relevant to what was to go wrong on 22nd May 2017.

12.894 Based on Superintendent Openshaw’s statement, the reason why NWAS and GMFRS thought they had been delayed in reaching casualties was because he was not deployed to the FCP when he should have been. In its closing statement, GMP recognised why that perception would have arisen at the time the exercise was under way.1312

12.895 I find it remarkable that this did not emerge during the debrief process in a way that meant all participants were aware of it. This is particularly so given the concern about delay that NWAS and GMFRS had at the time. An effective debrief process would have resolved this. It had a direct

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1312 INQ042531/16 at paragraph 43
bearing on what conclusions could, and could not, be drawn.

12.896 Agreement as to what went wrong and why should have been reached at the time. A shared understanding of what took place is vital to the process of making improvements. Once there was agreement about what occurred, a constructive discussion should have taken place in relation to the learning that was to be derived. That would have formed a platform for positive change in this difficult and important area of an emergency response. As it was, those involved went their separate ways holding different views about what needed to change.

12.897 Each organisation was focused on its own objectives for the exercise. Everyone had put a great deal of preparation into its organisation. It seems likely that this exaggerated failings when individual aspects of the exercise did not play out as anticipated. GMFRS, in particular, felt aggrieved by the failures at joint working. GMP officers were satisfied that the exercise had proved what they already knew, that moving the FDO to a Force Hub would not work, but failed to look at other reasons why the FDO was overwhelmed during the exercise.
12.898 More generally, the debrief process on the exercise was inadequate. It failed to track objectives against what happened during the exercise and identify consistent lessons. The process of structured debriefs was therefore not robust and did not offer a forum to identify the systemic problems which were repeated in the Attack 12 months later.

12.899 Exercise Winchester Accord represented a significant missed opportunity to prepare an adequate and robust response to a Marauding Terrorist Firearms Attack, or similar incident, within Greater Manchester.
Manchester Arena Inquiry
Volume 2: Emergency Response

Volume 2-Ib
Report of the Public Inquiry into the Attack on Manchester Arena on 22nd May 2017

Chairman: The Hon Sir John Saunders
November 2022
Part 13
Police services response to the Attack

Introduction

13.1 In Part 10, I set out key events on the night of the Attack in a broadly chronological order. I identified a number of failings that occurred during the critical period of the response, by which I mean the period from the explosion at 22:31 to the removal of the final living casualty from the City Room at 23:39. In this Part, I will look at each of the police services in turn: British Transport Police (BTP) and Greater Manchester Police (GMP).

13.2 The final section of this Part looks at the response of the Counter Terrorism Policing Headquarters (CTPHQ). CTPHQ had an important role on the night of 22nd May 2017 and in the aftermath of the Attack. Inevitably, because CTPHQ was based in London, its contribution was minimal during the critical period of the response.

13.3 So far as is possible, each section is structured chronologically. Together, they are not an exhaustive rehearsal of everything that was or
was not done by the police services. I have focused on the commanders, other decision-makers and key personnel. This is with a view to drawing out further detail around the failings I identified in Parts 10, 11 and 12.
Key findings

• British Transport Police (BTP) frontline officers responded immediately to the explosion and reports of the explosion.

• BTP declared a Major Incident at 22:39. BTP failed to pass on the Major Incident declaration to Greater Manchester Police (GMP), North West Fire Control or Greater Manchester Fire and Rescue Service.

• A METHANE message was passed from the Victoria Exchange Complex to BTP Control between 22:58 and 23:03. It should have been provided sooner than it was.

• The person who was identified by the Silver Commander to take up the Bronze Commander role agreed to act in that capacity at 23:15. He did not arrive at the Victoria Exchange Complex until after 01:00 on 23rd May 2017. This left BTP without a Bronze Commander until that time.

• The Chief Inspector who arrived at the Victoria Exchange Complex before 00:00 on 23rd May 2017 did not view herself as the Bronze Commander and did not undertake key Joint Emergency Services Interoperability Principles (JESIP) actions.
• The Silver Commander did not create a written tactical plan. He should have.

• The Gold Commander had not read or received any training on the BTP Major Incident Manual.

• The issue of whether BTP or GMP were the lead agency was not formally resolved until 01:16 on 23\textsuperscript{rd} May 2017. This should have been resolved sooner than it was.

Introduction

13.4 In Part 7 in Volume 1, I set out BTP’s approach to policing at the Victoria Exchange Complex. As I explained, because of the Ariana Grande concert, a number of BTP officers were assigned to police the Victoria Exchange Complex on 22\textsuperscript{nd} May 2017. They comprised an experienced Police Constable, a Police Constable in her probationary period and two Police Community Support Officers. A third Police Community Support Officer, who was undergoing tutoring, attended because his tutor was one of the other Police Community Support Officers.

13.5 The experienced Police Constable had not arrived at the Victoria Exchange Complex by the time the explosion occurred.
13.6 In addition to those who had been assigned to police the Victoria Exchange Complex, BTP had other officers on duty in the Greater Manchester area that night.

13.7 BTP did not have a firearms capability in Greater Manchester in 2017. It had one explosives detection dog in the Greater Manchester area.

**Officers at Victoria Exchange Complex**

13.8 Figure 37 depicts the layout of the Victoria Exchange Complex. When the bomb exploded at 22:31, four BTP officers were standing at the War Memorial entrance to the station concourse: Police Constable (PC) Jessica Bullough, Police Community Support Officer (PCSO) Mark Renshaw, PCSO Lewis Brown and PCSO Jon Paul Morrey.\(^1\) Within seconds of hearing the explosion, they began to move in the direction of the City Room.\(^2\)

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1. INQ035612/3
2. INQ035612/3-7
Figure 37: The Victoria Exchange Complex

<table>
<thead>
<tr>
<th>Victoria Exchange Complex</th>
<th>Platform overbridge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raised walkway and staircase</td>
<td>Fifty Pence staircase</td>
</tr>
<tr>
<td>Fifty Pence Piece</td>
<td>Trinity Way link tunnel</td>
</tr>
<tr>
<td>Lower Trinity Way entrance</td>
<td>War Memorial entrance</td>
</tr>
</tbody>
</table>
13.9 At 22:32, PCSO Renshaw broadcast a radio message on an open BTP channel, \(^4\) stating: “We need more people at Victoria, we just had a loud bang.”\(^5\) Seconds later, he was following PC Bullough into the City Room via the Fifty Pence staircase. In the same group were two TravelSafe Officers, Philip Clegg and Niall Pentony. Also with them was probationary PCSO Brown.\(^6\)

13.10 When the explosion occurred, Sergeant David Cawley was a short distance from the Victoria Exchange Complex at the Peninsula Building, together with Sergeant Peter Wilcock.\(^7\) Sergeant Cawley heard the explosion and began running towards the Arena.\(^8\) At 22:33, he responded to PCSO Renshaw’s message by saying: “To officers at Victoria, give me a sitrep as soon as you can … I heard the bang, try and establish what it is as soon as you can.”\(^9\) Within a minute, BTP Control received two important messages from PC Bullough. PC Bullough broadcast from inside the City Room: “It’s definitely a bomb, people injured, at least twenty casualties.”\(^10\) She followed this up with: “[W]e are going to need
ambulances as well, we have a female bleeding – much blood.”\textsuperscript{11}

13.11 At 22:34, BTP Control responded: “[W]e’re already calling ambo to get multiple ambulances en route, we’re also calling GMP.”\textsuperscript{12}

13.12 At this point, fewer than four minutes had passed since the explosion. The response from BTP had been exemplary. Junior officers had, without any delay, made their way to the seat of the explosion. They had communicated clearly and accurately what had happened, and they had identified the immediate need for ambulances.

13.13 BTP Control had responded by immediately trying to contact North West Ambulance Service (NWAS) and GMP. At the same time, BTP officers had mobilised in numbers and had begun to make their way to the Victoria Exchange Complex with the first vehicle arriving at 22:34.\textsuperscript{13}

13.14 Realising that first aid equipment was needed, PCSO Renshaw and PCSO Brown left the City Room\textsuperscript{14} and retrieved first aid kits from the patrol car parked on Station Approach.\textsuperscript{15} At 22:37, as they were re-entering the City Room with first aid
PCSO Renshaw broadcast to BTP Control: “In the box office, we need as much first aid as you can bring.”

13.15 PCSO Renshaw’s broadcast was followed up by PC Bullough, who was in the City Room at the time: “Ambulances need to get to the main … the main entrance because there’s loads of casualties.” This was a request from a BTP officer at the scene for ambulances to come straight to the Victoria Exchange Complex. The first request from BTP Control to NWAS Control for ambulances to go to Victoria Exchange Complex was nearly 20 minutes later.

13.16 By 22:38, there were nine BTP officers in the City Room or on the raised walkway. They were PC Bullough, PCSO Renshaw, PCSO Brown, PC Jane Bridgewater, PC Dale Edwards, PC Stephen Corke, PC Simon Trow, PC Matthew Martin and PC Carl Roach. Some had brought first aid bags with them.

13.17 At 22:39, PC Trow made a request for the “orange bags out [of] the van, all the first aid kits”. He went on to say, “we’ve got about 60 casualties”, and confirmed the location as being
“the ticket office in the Arena, near where the McDonald’s used to be”.

13.18 One minute later, Sergeant Neil Wildridge, who was in Liverpool, raised the issue of a Rendezvous Point (RVP): “Obviously … there’s going to be a lot of emergency vehicles turning up at that location, can we start looking for an RV[P] please and closing down the actual station for an inner cordon and an outer cordon.” This was a timely intervention from Sergeant Wildridge.

13.19 Sergeant Cawley, who was at the Victoria Exchange Complex at this point, replied: “Re last broadcast, at the moment that is not possible because there’s multiple that we’re all treating.” Sergeant Cawley was one of two supervisors present at the scene at this time. The other was Sergeant Wilcock, who entered via the Trinity Roller entrance at 22:40, a couple of seconds before Sergeant Cawley’s response.

13.20 Sergeant Cawley was in a very difficult position. Quite naturally, he wanted to help those he had encountered who were injured and in distress. He had come across a badly injured casualty in
the NCP car park.\textsuperscript{26} He had then run down the Trinity Way link tunnel to wait for an ambulance on Trinity Way.\textsuperscript{27} However, there was also a need for someone to take a step back and ensure that the incoming emergency services personnel knew where to go. This is an important part of bringing order to chaos.

13.21 Sergeant Cawley should not have dismissed the request for an RVP. Had he been too occupied to suggest one himself, he should either have not replied to Sergeant Wildridge’s request or he should have encouraged other officers on the scene to provide one. His training should have ensured that, even in the terrible circumstances he was facing, he kept in mind the importance of establishing a co-ordinated and ordered response.

13.22 At 22:41, BTP Control called NWAS Control. I will address the contents of this call in greater detail in Part 14. In this call, BTP Control did not pass on to NWAS Control PC Bullough’s request at 22:37, from the scene, for all ambulances to come to “the main entrance”, which was a request for ambulances to come directly to the station entrance of the Victoria Exchange

\textsuperscript{26} INQ028932/5, 73/49/17-50/3
\textsuperscript{27} 73/49/17-50/14
Complex. BTP should have passed this on in this call.

First officer at scene

13.23 BTP’s Major Incident Manual provided for the initial actions of the first officer on the scene. It stated: “The first officer at the scene must not become personally involved in the rescue work. The priorities must be to assess, inform, establish a Rendezvous Point (RVP) and maintain effective contact with FCR(L) or (B) [Force Control Room, London or Birmingham].”

13.24 It also set out the responsibilities of the first officer on scene. There was an expectation that this person would provide a formal report to BTP Control. Because it had not been updated to incorporate the Joint Emergency Services Interoperability Principles (JESIP), BTP’s Major Incident Manual set out the predecessor form of report to METHANE. I set out the parts of the METHANE message in Figure 23 in Part 11. There was an expectation that this person would also: declare a Major Incident if appropriate; complete a dynamic risk assessment; assume interim command until relieved by an officer of more senior rank; and establish a Forward Command Post (FCP).
13.25 PC Bullough was the first officer on scene in the City Room.\textsuperscript{31} She did provide a number of reports to BTP Control on the situation she was facing. Other colleagues who were with her or were elsewhere in the Victoria Exchange Complex also made reports of what they could see.

13.26 None of those present at the Victoria Exchange Complex volunteered a METHANE message. None of those present relayed the result of a dynamic risk assessment to BTP Control. No command structure was established at the scene for the first 20 minutes.

13.27 None of the above occurred because no BTP officer took a step back for that purpose. At 23:03, Sergeant Cawley was asked by Inspector Benjamin Dawson “\textit{to take a step back and be my eyes and ears there and give me updates}”.\textsuperscript{32} By this time, over 30 minutes had passed.

13.28 Sergeant Cawley spoke in evidence about the overwhelming situation he was facing. When asked why he had not sought out the GMP Operational/Bronze Commander, Inspector Michael Smith, he said: “\textit{Within the areas I was, there were still lots and lots of people and families and people seeking people and people wishing to speak to police officers, lots of external

\textsuperscript{31} INQ035612/14
\textsuperscript{32} INQ028932/61-62
inputs, so basically under the pressure and the different inputs I was getting at the time, I didn’t think to do that.”

I have no doubt that many others felt similarly given the magnitude of the situation. I do not criticise Sergeant Cawley for this.

13.29 This gives rise to whether or not the Major Incident Manual’s expectation of the first officer at the scene was unrealistic. I do not think that it was. What Sergeant Cawley’s evidence demonstrates is the need for practical training. As Sergeant Cawley stated: “[R]eferring back to the e-learning we do, it’s quite clean and clinical and sterile and posed situations that there are solutions to.” Real life is different. In Part 20 in Volume 2-II, I will consider high-fidelity training, which aims to address this difference.

13.30 The fact that none of the BTP officers undertook the responsibilities of first officer on the scene until Inspector Dawson insisted, reveals a significant training deficit that BTP needs to address.

On-scene command

13.31 During the ten minutes following the detonation, there were a number of messages over the BTP
open radio channel to the effect that the City Room was the seat of the explosion. A significant number of junior BTP officers converged on the City Room. Someone needed to take charge of them. The obvious two people for this role were the two supervisors on site: Sergeant Cawley and Sergeant Wilcock.

13.32 The BTP junior officers in the City Room had to wait a further seven minutes, until GMP’s Inspector Smith entered via the raised walkway at 22:47, for there to be a command presence.\(^{36}\) Despite not having anyone to direct them during the first 17 minutes, the junior BTP officers in and around the City Room showed commendable initiative: responding to the sound of the explosion or a call for support; recognising the need for first aid kits and collecting them from vehicles; and providing what assistance they could to the casualties they encountered.

13.33 Also showing initiative in that time, PC Roach, recognising that Sergeant Cawley did not feel in a position to provide an RVP, at 22:44 nominated the Fishdock car park.\(^\text{37}\) This was in response to a repeated request by Sergeant Wildridge.\(^\text{38}\) Having nominated the Fishdock car park, PC Roach asked “\([i]f \text{ we can get that checked}\)
as well just for secondary devices.” He did this as part of “the natural course of procedure. You don’t assume anything.”

13.34 At 22:45, Sergeant Wildridge asked: “Who’s at the RV point as incident commander at the moment to book us all in …?” He did not receive a direct response to this enquiry. PC Roach did go to the RVP to check on who was there at 23:20. He found no one had attended it. When I address the response of the firearms officers, at paragraphs 13.274 to 13.335, I will deal with the contribution that PC Roach made to their actions. He made a positive contribution at an early stage of the response.

13.35 BTP’s policy on command requires a person to hold the rank of Inspector or above in order to be approved as a Bronze Commander. During the critical period of the response, BTP did not have anyone of Inspector rank present at the scene. Because it is a national police service, understandably it had far fewer Inspectors in the region than GMP.

13.36 This is something to which BTP needs to give careful consideration. It should not be the case that during a Major Incident there is any
substantial period where there is no commander on scene to co-ordinate the efforts of BTP with the other emergency services. While a Tactical/Silver Commander may be able to operate away from a scene, there needs to be someone with situational awareness, derived from being present on the incident ground, who is directly co-ordinating the junior officers in the overall response.

13.37 Shortly after GMP’s Inspector Smith arrived in the City Room, at 22:49, he was joined by BTP Sergeant Wilcock. This meant that the junior BTP officers in the City Room now had a supervisor present.

13.38 I shall return to the issue of on-scene command when considering the appointment of the Bronze Commander from paragraph 13.77.

Involvement with casualties

13.39 The BTP officers in the City Room, on the raised walkway and in the area of the NCP car park did what they could for those who had been directly affected by the explosion. I heard evidence of officers using defibrillators, performing CPR, applying dressings and, in one case, improvising tourniquets. Junior BTP officers worked well with others and did their best.

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43 INQ035612/122
44 158/151/16-153/13
13.40 BTP officers were involved in the removal of casualties from the City Room using improvised stretchers. They also offered reassurance and what comfort they could.

13.41 We should be grateful to all the BTP officers who participated in this way. As I explained in Part 12, their first aid training was inadequate for the situation with which they were presented. Despite this, they showed great compassion, resourcefulness and resilience. In doing so, I have no doubt they made a positive difference to the effectiveness of the response.

**Involvement with those who died**

13.42 A number of BTP officers sought to give help to those who were dying or had died.

13.43 PC Bridgewater gave CPR to Alison Howe.  

13.44 PC Bullough can be seen on video footage standing over Marcin Klis. Sergeant John Whitaker was shown on video footage appearing to check Marcin Klis for a pulse. PC Corke also checked Marcin Klis for a pulse.

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45 152/12/16-25
46 150/108/5-11
47 150/109/3-15
48 150/108/14-21
13.45  PC Bridgwater\(^49\) and PC Trow\(^50\) both gave CPR to Elaine McIver.

13.46  Medic PC Ben Davidson assisted Georgina Callander.\(^51\)

13.47  PC Bullough assisted Jane Tweddle.\(^52\) PC Corke covered Jane Tweddle when attempts at resuscitation were unsuccessful.\(^53\)

13.48  PC Bullough assisted John Atkinson.\(^54\) PC Thomas Campbell applied a bandage to John Atkinson,\(^55\) as did PSCO Morrey.\(^56\) Detective Sergeant (DS) Christopher Broad also assisted John Atkinson.\(^57\) PC Corke, PC Mark Emberton, PC Bridgewater, PC Bullough, PC Edwards and PC Michelle Johnson were among those who helped with John Atkinson’s evacuation.\(^58\)

13.49  PC Danielle Ayers gave CPR to Kelly Brewster.\(^59\) PC Edwards,\(^60\) PC Richard Melling,\(^61\)
PC Lee Owen\(^{62}\) and PC Johnson also assisted Kelly Brewster.\(^{63}\) Later, PC Johnson\(^{64}\) and PC Corke\(^{65}\) covered Kelly Brewster.

13.50 PC Bullough assisted Michelle Kiss.\(^{66}\) PC Corke covered Michelle Kiss.\(^{67}\) PC Bullough assisted Philip Tron.\(^{68}\) PC Bullough believed that it was likely she also covered Philip Tron.\(^{69}\)

13.51 Sergeant Wilcock asked off-duty nurse Bethany Crook to assist Saffie-Rose Roussos.\(^{70}\) Temporary Detective Constable (DC) Mark Haviland was involved in finding a makeshift stretcher for Saffie-Rose Roussos.\(^{71}\) PC Trow helped carry Saffie-Rose Roussos from the City Room to Trinity Way.\(^{72}\)

13.52 PC Johnson helped to give CPR to Sorrell Leczkowski and later covered her.\(^{73}\)

13.53 Sergeant Wilcock checked on Wendy Fawell following the explosion.\(^{74}\)

\(^{62}\) 154/14/24-25
\(^{63}\) 154/10/17-18, 154/11/3-16/10, 154/11/4-13/4, 154/14/24-25
\(^{64}\) 154/11/3-16/10
\(^{65}\) 154/15/1-16/17
\(^{66}\) 151/23/14-24/12
\(^{67}\) 151/24/16-25/3
\(^{68}\) 151/9/3-7
\(^{69}\) 151/9/14-24
\(^{70}\) 174/24/7-11
\(^{71}\) 174/29/25-30/19
\(^{72}\) 174/33/8-23
\(^{73}\) 153/76/23-77/17
\(^{74}\) 152/19/4-8
Force Incident Manager

13.54 As more and more people from the emergency services became involved, and more information began to come in, the need for a commander increased. While the police officers could trust in their generic training and discipline, what was required was that the incident be gripped by someone. At 22:35, the Force Incident Manager, Inspector Dawson, appointed himself as incident commander. This was in accordance with the expectation for his role. Under the Major Incident Manual, the Force Incident Manager took the role of initial Silver Commander. I was impressed with the evidence Inspector Dawson gave. Although there were things he could have done better, he acted calmly and professionally in the early stages of the response.

13.55 At 22:39, within minutes of becoming the initial Silver Commander, Inspector Dawson had declared a Major Incident. This declaration was recorded on the BTP incident log. It was passed on to NWAS in a call which began at 22:41. It was not passed on to GMP or Greater Manchester Fire and Rescue Service (GMFRS). It should have been.

75 INQ002000/27
76 INQ025700/15 at paragraph 2.7
77 INQ002000/30
78 INQ028932/11
13.56 The most significant effect of this oversight was on GMP. GMP did not declare a Major Incident until 00:57 on 23rd May 2017. Had GMP been told that BTP had declared a Major Incident, it may be that this would have acted as a prompt to anyone at GMP who was notified of this fact.

13.57 I will consider GMP’s approach to Major Incident declaration in the next section.

METHANE message

13.58 At 22:50, having requested a METHANE message on a number of occasions, Inspector Dawson broadcast over the radio: “All units on scene … is there someone who can … I can speak to … to obtain a METHANE report at this time?” Sergeant Cawley replied saying he was available. Following some difficulty connecting on a different radio channel because it was “too busy”, Inspector Dawson decided that Sergeant Cawley should use his mobile phone. This was unsuccessful.

13.59 At 22:57, seven minutes after Sergeant Cawley agreed to provide the METHANE message, he and Inspector Dawson were able to speak properly via a separate radio channel. Inspector

79 INQ028932/21
80 INQ028932/26
81 INQ028932/36, INQ028932/43
82 INQ028932/43, 73/67/14-68/4
Dawson began by saying: “All I need is somebody just to take a step back, give me a sitrep of everything that’s going on down there, that means I can help … It will help me co-ordinate … the support you get down there.”\(^3\) He then asked for a METHANE message.

13.60 Sergeant Cawley asked to be talked through the categories of required information. Over the following four minutes, he provided the information Inspector Dawson needed. At the conclusion of the METHANE message, Inspector Dawson said: “[A]t the moment we’re just going to get as many ambulances and fire and all that to you as we can.”\(^4\) The METHANE message was entered into BTP’s incident log by Inspector Dawson three minutes later, at 23:04.\(^5\) It was not passed on to any other emergency service. There was no concerted effort from BTP to get GMFRS to the scene. This was a failure by BTP.

13.61 The ‘H’ in METHANE stands for ‘Hazards’.\(^6\) Sergeant Cawley’s report for this entry, as recorded by Inspector Dawson on the BTP incident log, was: “None seen other than bomb. Lights and water on.”\(^7\) Sergeant Cawley provided

\(^{3}\) INQ028932/43-44
\(^{4}\) INQ032071/3
\(^{5}\) INQ002000/46
\(^{6}\) INQ004542/9
\(^{7}\) INQ032071/2
this information 30 minutes after the bomb had detonated. He did so having been at the Victoria Exchange Complex for 20 minutes. He had heard the detonation himself and had had access to the BTP radio traffic since the explosion. He had heard the reports from a number of colleagues within the City Room. He had been into the NCP car park, through the Trinity Way link tunnel, onto the station concourse and had spoken to GMP officers there.\textsuperscript{88}

13.62 Sergeant Cawley was well placed to provide a reliable report of the identifiable hazards. His report was to the point. It was accurate.

13.63 As Sergeant Cawley was providing this information to Inspector Dawson, GMFRS was mustering at Philips Park Fire Station. They were doing so for two related reasons. First, because when he was initially told of the incident, Station Manager Andrew Berry, the GMFRS duty National Interagency Liaison Officer (NILO), considered it prudent to mobilise the GMFRS assets to what he regarded as a safe distance away. Second, because Station Manager Berry had not then managed to speak to the Force Duty Officer (FDO), whom he hoped would provide him with further information. Station

\textsuperscript{88} 73/48/14-16, 73/51/23-52/6, 73/56/10-15, 73/61/4-9
Manager Berry intended to use that further information to review his initial decision.

13.64 If BTP had passed on Sergeant Cawley’s METHANE message to NWFC, it could have been relayed to Station Manager Berry. It could also have been provided to the two other GMFRS NILOs who were mobilised only minutes after Sergeant Cawley concluded his message. It was not passed on. It should have been. It was to be another 70 minutes before GMFRS considered it sufficiently safe to deploy firefighters to the scene.89

13.65 Before leaving the topic of METHANE messages, there is one more matter that merits comment. The second ’E’ in METHANE stands for ‘Emergency Services’. The prompt in Joint Doctrine: The Interoperability Framework (the Joint Doctrine) next to this entry was: “Which, and how many, emergency responder assets and personnel are required or are already on-scene?”90 This part of the message requires two pieces of information: which responders are required; and which responders are present already.

89 132/33/6-34/24
90 INQ004542/9
13.66 Inspector Dawson’s entry on the log was: “LAS/LFB – GMP firearms on scene assisting.”91 ‘LAS’ stands for the ‘London Ambulance Service’ and was intended to indicate the ambulance service. ‘LFB’ is an initialism for the London Fire Brigade and was intended to indicate the fire and rescue service. The London-centric references are unfortunate, but were unlikely to cause significant confusion on their own.

13.67 When the incident log entry is laid alongside the conversation with Sergeant Cawley,92 it is clear that Inspector Dawson was intending to indicate that the ambulance service and fire and rescue service were required; whereas GMP firearms officers were already present. This was not sufficiently clear from the log entry alone. The entry also failed to record the obvious, namely that BTP was present. Nor did it record that GMP unarmed officers were present. Inspector Dawson should have recorded both of these in his entry.

13.68 I did not receive any evidence that any person at BTP was misled by the ‘E’ entry in Inspector Dawson’s record of the METHANE message. As a result of this METHANE message not being relayed to partner agencies, no one at GMP, NWAS, NWFC or GMFRS could have been

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91 INQ002000/46
92 INQ032071
misled by it. But it is important in the future that any METHANE message should clearly record which services are required and which services are already present. Otherwise, there is a risk that it will be read that a Category 1 responder is present, when they are not.

**Senior Duty Officer**

13.69 The Senior Duty Officer served an important purpose supporting the Force Incident Manager when acting as incident commander. Inevitably, the Force Incident Manager will have a lot to do when in that role. This support can include: providing advice when needed; checking that important actions have not been overlooked; and contacting more senior members of BTP to ensure that they are aware of what is going on.93 All this allows the Force Incident Manager to focus on acting in a command capacity, knowing she or he has immediate access to support. It is a sensible approach to take.

13.70 The Senior Duty Officer role was relatively new at BTP at the time of the Attack. It had been introduced in 2015.94 It had not been incorporated into the Major Incident Manual.

13.71 On the night of the Attack, the Senior Duty Officer was Chief Inspector (CI) Antony Lodge. He struck

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93 93/4/6-7/2
94 INQ041112/1, 93/2/8-3/7
me as being a thoughtful witness, who was candid about where improvements could be made. In a number of important respects, Cl Lodge did not provide the support to Inspector Dawson that was required. He failed to identify that the Major Incident declaration was not shared with all emergency service partners. He did not take steps to ensure it was. He failed to identify that the METHANE message was not shared. He did not take steps to ensure it was. He did not prompt Inspector Dawson to appoint a commander on scene. He did not prompt Inspector Dawson to seek to contact the GMFRS or NWAS commanders.

13.72 Cl Lodge attributed the above to the fact that JESIP was not embedded sufficiently well. He also stated in evidence that following an action card would have assisted him.95 I accept his assessment.

Silver command

13.73 I have addressed the actions of the initial Silver Commander, Inspector Dawson, above. He was relieved of this role at 23:34 by Chief Superintendent Allan Gregory, who became the Silver Commander at that point.96
Chief Superintendent Gregory was the divisional commander for C Division, within which the Victoria Exchange Complex was located. He was on call that night. At 22:44, he was telephoned by CI Lodge. He was in his hotel room in Birmingham, having concluded an Office of Rail and Road stakeholders’ event at the same venue.

In the telephone call, Chief Superintendent Gregory was told that there had been an explosion at the Arena, that there were four reported fatalities and about 100 casualties. He made his way to Force Control Room Birmingham, which was approximately ten minutes from his hotel. At 23:05, he received a telephone call from Assistant Chief Constable (ACC) Robin Smith, the on-call Gold Commander. At that point, he was within Force Control Room Birmingham. Chief Superintendent Gregory informed ACC Smith that he would be taking up the Silver Commander position. He confirmed to ACC Smith he was best placed to perform that role.
13.76 I am not critical of Chief Superintendent Gregory for his decision to travel to Force Control Room Birmingham rather than the scene. At Force Control Room Birmingham, he was able to use the facilities available to him to participate in the command of the incident effectively. The alternatives available to him were to appoint someone else to act as Silver Commander or travel to the scene. Neither of these were better than the decision he made.

Appointment of Bronze Commander

13.77 At 23:08, Chief Superintendent Gregory tried to contact Superintendent Edward Wylie in order to appoint him as the Bronze Commander. Superintendent Wylie was the subdivisional commander for the Pennine subdivision. The Arena fell into this subdivision. Superintendent Wylie lived about 25 miles from Manchester. Superintendent Wylie did not answer the call, and Chief Superintendent Gregory left a message.

13.78 Having been unsuccessful in his attempt to contact Superintendent Wylie, at 23:12 Chief Superintendent Gregory called Superintendent Kyle Gordon, whom he understood was the next most proximate Superintendent to the Arena.

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105 94/79/7-20
106 93/167/19-168/24
107 93/173/9-12
108 93/167/19-168/24
Chief Superintendent Gregory’s intention was to appoint Superintendent Gordon as the Bronze Commander.\textsuperscript{109}

13.79 Chief Superintendent Gregory recognised: “\textit{[T]here was a need to move quickly to establish a command structure.}”\textsuperscript{110} He agreed that, if the Silver Commander does not travel to the scene, it is essential that there is a Bronze Commander at the scene at the earliest opportunity.\textsuperscript{111} He accepted that the first appointment does not necessarily need to be the perfect person, as they can always be relieved when a more appropriately qualified person arrives.\textsuperscript{112} I agree with these statements.

13.80 Chief Superintendent Gregory knew that Superintendent Gordon was in Blackpool.\textsuperscript{113} Blackpool is approximately 50 miles from the centre of Manchester. This was not a location that would result in Superintendent Gordon being able to be on scene quickly.\textsuperscript{114} Chief Superintendent Gregory should have considered appointing someone more junior than a Superintendent as Bronze Commander.\textsuperscript{115}

\begin{flushleft}
\begin{itemize}
\item[109] 93/169/4-12, 95/33/6-19
\item[110] 93/170/15-19
\item[111] 93/143/7-144/2, 93/127/23-129/8
\item[112] 93/143/7-144/2
\item[113] 93/171/9, 95/39/15-24
\item[114] 93/172/8-20
\item[115] 93/173/18-176/6
\end{itemize}
\end{flushleft}
He could then have mobilised Superintendent Gordon who could relieve that person when he arrived.

13.81 At the time of Chief Superintendent Gregory’s call, over 35 minutes had passed since the detonation. Chief Superintendent Gregory expected Superintendent Gordon’s journey to take him about an hour.\textsuperscript{116} This would mean that he would not arrive before 00:15.\textsuperscript{117} This was far too long a period for the junior BTP officers to be left without a Bronze Commander. In the event, Superintendent Gordon did not arrive until much later. I will consider this further at paragraphs 13.95 to 13.110.

Taking up the Silver Commander role

13.82 Having spoken to Superintendent Gordon, Chief Superintendent Gregory again spoke to ACC Smith.\textsuperscript{118} He also spoke to the Force Incident Manager, Inspector Dawson.\textsuperscript{119} At 23:34, BTP’s incident log records that Chief Superintendent Gregory became the Silver Commander, relieving Inspector Dawson.\textsuperscript{120} This was at the very end of what I have described as the critical period of the response.

\textsuperscript{116} 93/172/8-20
\textsuperscript{117} 93/172/21/24
\textsuperscript{118} INQ041120/1
\textsuperscript{119} 93/189/18-190/23
\textsuperscript{120} 92/123/10-20, INQ002000/60
13.83 It took Chief Superintendent Gregory over 30 minutes from his arrival at Force Control Room Birmingham to relieve Inspector Dawson. There were a number of tasks he undertook during this period as set out above. He also reviewed the incident log so as to familiarise himself with what was recorded there.

**Silver command actions**

13.84 According to the Major Incident Manual, as Silver Commander, Chief Superintendent Gregory was responsible for developing “a tactical plan in order to achieve the strategic intentions of the Gold Commander, to deliver the plan, review and amend as appropriate to the circumstances.”  

The Major Incident Manual also stated: “Bronze Commanders must have a clear understanding of the Silver Commander’s tactical plan.”

13.85 Chief Superintendent Gregory did not write a tactical plan down or develop one. He took the view that a tactical plan would be developed after “the initial hours.” I accept that a lengthy document was not appropriate in the circumstances. I also accept the presence of GMP, the issue of which police service was the lead agency and communication difficulties made it difficult for one to be developed.

121 INQ025700/66  
122 INQ025700/16  
123 93/221/21-25
13.86 These were not good-enough reasons for a tactical plan not to be developed by Chief Superintendent Gregory. He should have done so. He had sufficient time to do so before he formally took up the Silver Commander role. As it was, with no Bronze Commander on scene to implement the tactical plan until after 01:00, the absence of a tactical plan did not affect the operational decision-making of the Bronze Commander. However, the act of creating a plan may have caused Chief Superintendent Gregory to recognise the absence of an on-scene commander to communicate it to. This, in turn, may have caused one to be appointed pending the arrival of Superintendent Gordon.

13.87 JESIP expected that different agencies’ commanders would communicate with each other. The Major Incident Manual required that the Silver Commander contact the Tactical/Silver Commanders from the other emergency services.

13.88 Chief Superintendent Gregory did not speak to the GMP Tactical/Silver Commander at any point during that evening. He asked a member of BTP Control staff shortly before 00:00 on 23rd May 2017 to establish who the GMP Tactical/Silver Commander was and inform GMP that he wished

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124 95/9/17-11/17
125 INQ025700/66
to speak to that person. This did not result in any contact between the two commanders.  

13.89 At no stage during the evening did Chief Superintendent Gregory become aware that GMP had declared Operation Plato. The Operation Plato declaration by the GMP FDO at 22:47 signified that it was suspected that a Marauding Terrorist Firearms Attack was under way at the Victoria Exchange Complex. Had Chief Superintendent Gregory spoken to the GMP Tactical/Silver Commander, he may have been told of the declaration. I say ‘may’ because there is considerable uncertainty about this given that the GMP Tactical/Silver Commander did not tell the NWAS Tactical Commander about the Operation Plato declaration when they spoke in person at around 23:15.

13.90 Chief Superintendent Gregory’s message that he wanted to speak to the GMP Tactical/Silver Commander was not relayed using the police hailing talk group. This was a method of communication of which Chief Superintendent Gregory was only vaguely aware at the time of the Attack. He stated that he relied upon others in BTP Control to advise him in relation to such matters.
13.91 The fact that BTP did not use all available communication routes was a significant part of the cause of BTP’s communication failures on the night of the Attack.

13.92 It was not the only reason for BTP’s communication failures. Chief Superintendent Gregory did not make any attempt to contact his counterpart at GMFRS.\textsuperscript{128} His sole focus was on contacting GMP. This was an unacceptable omission.\textsuperscript{129} Had Chief Superintendent Gregory made direct contact with his equivalent within GMFRS, he would have been able to share situational awareness that was capable of bringing GMFRS resources to the scene much sooner than they in fact arrived.

13.93 Similarly, Chief Superintendent Gregory did not make any attempt to contact the NWAS Tactical Commander. This was also an important task that he should have carried out. Given the time at which Chief Superintendent Gregory took up the Silver Commander position, this failure was not capable of making any difference to the treatment of casualties in the City Room.

13.94 In due course, at 00:40 on 23\textsuperscript{rd} May 2017, Chief Superintendent Gregory directed that CI Susan Peters should attend GMP
Headquarters (GMP HQ) to act in a liaison capacity.\textsuperscript{130} CI Peters was recorded as arriving at GMP HQ and being \textit{“imbedded in”} the Silver Control Room at GMP HQ at 01:53.\textsuperscript{131}

**Bronze command**

**Superintendent Gordon**

13.95 In the course of the conversation between Chief Superintendent Gregory and Superintendent Gordon at 23:12, there was no discussion of how long it would take for Superintendent Gordon to be in a position to be an effective Bronze Commander. They did not discuss how Superintendent Gordon was going to travel to the Arena. They did not discuss how long Superintendent Gordon thought it would take him to get there. They did not discuss how Superintendent Gordon would gain situational awareness as he travelled.\textsuperscript{132}

13.96 It took Superintendent Gordon over two hours from first being notified that he was Bronze Commander to his arrival at the Victoria Exchange Complex.\textsuperscript{133} This was over twice as long as Chief Superintendent Gregory assumed it would take when he appointed him.

\begin{itemize}
  \item \textsuperscript{130} INQ002000/82, 93/224/13-17
  \item \textsuperscript{131} INQ002000/102
  \item \textsuperscript{132} 93/177/3-179/12
  \item \textsuperscript{133} 95/33/7-19, 95/65/18-66/4
\end{itemize}
13.97 The principal explanation for the additional delay was that Superintendent Gordon did not have access to a vehicle. He had been notified of the incident at the Arena about 20 minutes before he spoke to Chief Superintendent Gregory.\textsuperscript{134} He booked himself a taxi to take him to Manchester.\textsuperscript{135} Superintendent Gordon then called Superintendent Wylie and left a voicemail message when he did not answer.\textsuperscript{136}

13.98 When Chief Superintendent Gregory called, Superintendent Gordon was waiting for the taxi to arrive. Chief Superintendent Gregory did not recall this being mentioned in their call.\textsuperscript{137} Superintendent Gordon thought he had mentioned it, but deferred to Chief Superintendent Gregory’s recollection.\textsuperscript{138}

13.99 A Bronze Commander using a taxi to travel from Blackpool to a Major Incident in Manchester is sufficiently striking for it to be likely to have been remembered by Chief Superintendent Gregory. Chief Superintendent Gregory told me he regarded the use of a taxi as not being acceptable in the circumstances.\textsuperscript{139} I accept

\textsuperscript{134} 95/26/12-27/12
\textsuperscript{135} 95/30/3-21
\textsuperscript{136} 95/31/7-11
\textsuperscript{137} 93/199/18-200/2
\textsuperscript{138} 95/39/9-40/5
\textsuperscript{139} 93/180/5-16
his evidence, and Superintendent Gordon’s deference to it,\(^{140}\) that a taxi was not mentioned.

13.100 It was a significant oversight by Superintendent Gordon, accepted by him during his evidence, not to mention he was reliant on a taxi.\(^{141}\) That information was capable of influencing an important command decision by Chief Superintendent Gregory.\(^{142}\) The obvious disadvantages of travelling by taxi included: the wait time; the fact it could not travel on blue lights; the fact it did not have a police radio;\(^{143}\) and the fact it would be delayed at every checkpoint.\(^{144}\)

13.101 After the call with Chief Superintendent Gregory, Superintendent Gordon tried to arrange transportation in a police car. He was unsuccessful in this.\(^{145}\) He had to wait a further 15 minutes for the taxi to arrive.\(^{146}\)

13.102 Superintendent Gordon did not provide any update to anyone at BTP Control about the travel difficulties he was facing.\(^{147}\) He should have notified the Force Incident Manager, the Senior

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\(^{140}\) 95/39/15-40/5  
\(^{141}\) 95/40/6-19  
\(^{142}\) 95/40/6-19  
\(^{143}\) 95/44/10-16  
\(^{144}\) 93/200/17-22  
\(^{145}\) 95/38/2-13  
\(^{146}\) 95/41/21-42/5  
\(^{147}\) 95/42/6-43/13
Duty Officer or Chief Superintendent Gregory of the delay he was experiencing.

13.103 Superintendent Gordon did not have access to a radio in the course of the journey. Consequently, his situational awareness was derived from email and telephone calls. This was not a satisfactory way for a person who was to take up Bronze command at a Major Incident to prepare themselves. One of the things Superintendent Gordon was able to do in the course of the taxi journey was approve a press release. He was not in an appropriate position to do so, as he accepted.

13.104 At no point in the journey to Manchester did Superintendent Gordon speak to Chief Superintendent Gregory. He received an email from Chief Superintendent Gregory at 00:10 on 23rd May 2017 instructing him to “[t]ake command on scene initially”. In the same email, he was told that Chief Superintendent Gregory would “call GMP around command arrangements”.

13.105 At 00:19 on 23rd May 2017, Superintendent Gordon emailed in reply to ask if he could get a briefing from someone. He indicated he was in a taxi about 20 minutes from the scene, subject
to any diversions, and he wanted to arrive as “briefed as possible”. In fact, it was to take him another hour to reach the Victoria Exchange Complex. Chief Superintendent Gregory could not recall when he first read that email, but he did not reply until over an hour later. His reply, at 01:23, was that Superintendent Gordon should speak to CI Andrea Graham.

13.106 Superintendent Gordon spoke to CI Graham shortly after he sent his email at 00:19. He received “a very quick situational update” from her. At the conclusion of the conversation, Superintendent Gordon believed that CI Graham was acting as the Bronze Commander. As I shall set out at paragraphs 13.111 to 13.120, CI Graham did not think she was acting as Bronze Commander.

13.107 In the course of the journey, Superintendent Gordon’s BTP-issue BlackBerry device ran out of power. This caused him to lose access to a number of telephone numbers he had saved on it. This further compromised his ability to gain

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152 INQ041111/1
153 93/200/23-201/9
154 INQ041111/1
155 95/55/7-56/7
156 95/56/25-57/5, 95/59/12-60/1
157 95/76/6-77/12
situational awareness. He was still able to use his personal mobile phone.\textsuperscript{158}

13.108 Superintendent Gordon rightly accepted the Policing Experts’ opinion that: “\textit{There is little evidence that [he] was able to influence BTP actions or operational decisions during [his] journey.}”\textsuperscript{159}

13.109 The advantages of Superintendent Gordon’s undoubted experience and seniority were significantly outweighed by the practical difficulties that confronted him. These disadvantages should have been raised by him to help Chief Superintendent Gregory’s decision-making.

13.110 Superintendent Gordon did not ever take up the role of Bronze Commander in any meaningful sense. He arrived at the outer cordon at approximately 01:06 on 23\textsuperscript{rd} May 2017\textsuperscript{160} and at the Victoria Exchange Complex at approximately 01:20.\textsuperscript{161} CI Graham conducted a briefing shortly after he arrived.\textsuperscript{162} He considered that he assumed the role of Bronze Commander after this briefing.\textsuperscript{163} At 01:57, he supplied a briefing

\textsuperscript{158} 95/77/13-17
\textsuperscript{159} 95/80/17-23
\textsuperscript{160} 94/132/24-133/7
\textsuperscript{161} 95/65/9-66/4
\textsuperscript{162} 95/66/17-25
\textsuperscript{163} 95/67/13-18
to Chief Superintendent Gregory, who informed him that his role was to co-ordinate BTP assistance of GMP at the scene.

Chief Inspector Graham

13.111 In May 2017, CI Graham was in charge of the Manchester area for BTP. She was a qualified public order Bronze Commander.\textsuperscript{164} At the time the Attack took place, she was not on duty or on call.

13.112 CI Graham learned of the Attack shortly after 23:00, after her husband saw it on the news.\textsuperscript{165} At 23:08, she called BTP Control, who informed her that it was a Major Incident. CI Graham informed BTP Control she would “get [herself] in”.\textsuperscript{166} She got ready and drove to the Peninsula Building, arriving at 23:38.\textsuperscript{167} She collected some equipment and went from there to the Victoria Exchange Complex.\textsuperscript{168} At 23:56, she was captured on the CCTV on the raised walkway.\textsuperscript{169} Very shortly before that image was taken, CI Graham spoke to Sergeant Cawley, who gave her a situation report.\textsuperscript{170}

\begin{itemize}
\item \textsuperscript{164} 96/2/3-9
\item \textsuperscript{165} 96/19/7-14
\item \textsuperscript{166} 96/19/19-20/17
\item \textsuperscript{167} 96/20/18-22/4
\item \textsuperscript{168} 96/21/15-22/9
\item \textsuperscript{169} INQ035612/429
\item \textsuperscript{170} 96/24/13-25/15
\end{itemize}
13.113 CI Graham viewed herself as becoming on-scene commander at the point at which she arrived at the Victoria Exchange Complex.\textsuperscript{171} She stated that she did not view herself as relieving anyone of incident command.\textsuperscript{172}

13.114 Shortly after her arrival, CI Graham spoke to CI Malcolm McKinnon. CI McKinnon was not at the scene. He had been given the role of “bronze resources” by Chief Superintendent Gregory. The contemporaneous record in the BTP incident log by CI McKinnon states that he informed CI Graham of “her role as Bronze Scene”.\textsuperscript{173} CI Graham does not recall being informed that she was Bronze Commander.\textsuperscript{174}

13.115 Having heard CI Graham’s evidence on the point, I am satisfied that she did not finish that call understanding that she was the BTP Bronze Commander for the Victoria Exchange Complex.\textsuperscript{175} I am not able to say who, between CI Graham and CI McKinnon, is responsible for that communication breakdown.

13.116 The lack of clarity around whether or not CI Graham was the Bronze Commander for BTP was made worse by a telephone conversation

\textsuperscript{171} 96/16/5-7, 96/26/15-20
\textsuperscript{172} 96/26/18-20
\textsuperscript{173} INQ002000/71
\textsuperscript{174} 96/31/5-7
\textsuperscript{175} 96/31/23-32/12
between her and Chief Superintendent Gregory at 00:13 on 23rd May 2017.\textsuperscript{176} Chief Superintendent Gregory asked her to be his “eyes and ears” on the ground. He accepted he did not make clear in the conversation that he had appointed her the Bronze Commander pending Superintendent Gordon’s arrival.\textsuperscript{177}

\textbf{13.117} In the time between her arrival and Superintendent Gordon’s arrival, CI Graham spoke with GMP Inspector Smith, discussed cordons, discussed obtaining CCTV and offered resources to GMP.\textsuperscript{178} At 00:20 on 23rd May 2017, she liaised with the bomb disposal technicians from the Army.\textsuperscript{179} At 01:00, she spoke to the Ground Assigned Tactical Firearms Commander, GMP CI Mark Dexter.\textsuperscript{180} As set out above, she had also spoken to Sergeant Cawley, CI McKinnon, Superintendent Gordon, Chief Superintendent Gregory and other BTP officers at the scene.

\textbf{13.118} CI Graham stated that she never saw herself as “Bronze Commander” at the scene. As I understood her evidence, CI Graham took issue with the title of Bronze Commander applying to

\begin{itemize}
\item \textsuperscript{176} 96/38/13-39/3
\item \textsuperscript{177} 93/195/4-10, 93/196/5-8
\item \textsuperscript{178} 96/36/8-37/2
\item \textsuperscript{179} INQ035612/444
\item \textsuperscript{180} INQ035612/538
\end{itemize}
her role. She went on to say that if she had seen herself as Bronze Commander, it would have made “no difference” to her actions.\textsuperscript{181} She accepted that JESIP did not work without an FCP,\textsuperscript{182} that she should have set one up\textsuperscript{183} and that there were “learning points in relation to liaison with commanders”.\textsuperscript{184}

13.119 Through no fault of her own, having chosen to self-deploy from her home, CI Graham arrived after the critical period of the response. Her arrival mitigated Superintendent Gordon’s absence. While she worked well with her colleagues from GMP, she did not have JESIP at the forefront of her decision-making. Had she done so, she would have been more concerned about ensuring there was an FCP and speaking to the NWAS Operational Commander.

13.120 CI Graham focused her activity on the police response rather than the multi-agency response. A Bronze Commander at a Major Incident had communication obligations with all other responder agencies.\textsuperscript{185} She was an ideal candidate to act as Bronze Commander. She should have been clearly instructed to act in

\begin{itemize}
\item \textsuperscript{181} 96/66/22-67/9
\item \textsuperscript{182} 96/71/3-5
\item \textsuperscript{183} 96/64/3-23
\item \textsuperscript{184} 96/70/23-71/2
\item \textsuperscript{185} INQ025700/70
\end{itemize}
that role. It was for the Silver Commander, Chief Superintendent Gregory, to make this clear to her. He failed to ensure this occurred.

Gold command

13.121 ACC Smith was the on-call Chief Officer on the night of 22nd May 2017.\textsuperscript{186} He had joined BTP in September 2016 and was a qualified Gold Commander.\textsuperscript{187} Prior to the Attack, he had not read or received any training on BTP’s Major Incident Manual.\textsuperscript{188} This was an oversight on the part of BTP and ACC Smith.

13.122 At 22:56, ACC Smith received a telephone call from CI Lodge. He was at home in the south of England.\textsuperscript{189} At this point, ACC Smith became Gold Commander for BTP.\textsuperscript{190}

13.123 ACC Smith spent the next hour making telephone calls, including to the Chief Constable of BTP, Chief Superintendent Gregory and the Senior Duty Officer.\textsuperscript{191} At no stage did he ask whether a tactical plan had been developed.\textsuperscript{192} This was something ACC Smith should have done as it was his responsibility under the Major Incident

\textsuperscript{186} 94/102/7-9  
\textsuperscript{187} 94/73/14-16, 94/74/4-7  
\textsuperscript{188} 94/75/7-9  
\textsuperscript{189} 94/102/10, 94/103/1-6  
\textsuperscript{190} 94/107/11-14  
\textsuperscript{191} INQ041119/3  
\textsuperscript{192} 94/88/3-6
Manual as Gold Commander to “[r]atify and review” it. ¹⁹³

13.124 ACC Smith stated in evidence that he had assumed a tactical plan had been developed. ¹⁹⁴ He also stated, in contrast to Chief Superintendent Gregory’s evidence, that he would have expected it to have been developed within the first hour. ¹⁹⁵ ACC Smith’s failure to ratify the tactical plan meant that he did not discover that Chief Superintendent Gregory intended to leave its development until much later in the response.

13.125 ACC Smith was also informed that Superintendent Gordon would be attending in a command role. He was not told that it would take at least an hour for Superintendent Gordon to get to the Arena. Had he been, he would have asked if there were any alternatives. ACC Smith stated he did not believe it was essential that a person as senior as a Superintendent take the role at an early stage of the incident. ¹⁹⁶ I agree with ACC Smith’s view.

13.126 In the course of speaking to the Chief Constable of BTP at 23:17, ACC Smith was instructed to go to Manchester to attend the Strategic

13.127 At 00:37 on 23rd May 2017, ACC Smith was in a police vehicle being driven under blue lights to Manchester.

13.128 Between 01:16 and 01:22 on 23rd May 2017, ACC Smith spoke to the GMP Strategic/Gold Commander, ACC Deborah Ford. He was told that the station was a ‘warm zone’. He was not told that Operation Plato had been declared. In the course of the conversation, the two Strategic/Gold Commanders spoke about which agency was the lead agency. ACC Ford confirmed that GMP was taking the lead. ACC Smith agreed. Agreement at this stage was too late to make any meaningful difference to the response. The issue of which police service was the lead agency should have been resolved sooner than this.
13.129 ACC Smith arrived at GMP HQ shortly before 04:00 on 23rd May 2017. At 04:15, he attended the Strategic Co-ordinating Group.202

13.130 At no stage did ACC Smith try to contact the Strategic/Gold Commanders of NWAS or GMFRS before he arrived in Manchester. This, as ACC Smith rightly accepted, meant that he did not put himself in a position where he could tell those other responder agencies that there were many BTP officers working in the City Room.203

13.131 ACC Smith’s lack of communication with NWAS and GMFRS mirrored that of Inspector Dawson, CI Lodge, Chief Superintendent Gregory and, once she was on scene, CI Graham. The only external agency any of them sought to deal with at a command level during the critical period of response was GMP. In CI Graham’s case, her involvement came after this period, but what had gone before was consistent with her approach.

13.132 The fact that this was a consistent approach across all levels of command leads me to conclude that there was a major failure by BTP to train its commanders in the importance of joint working with all emergency service partners. This was a systemic issue. I do not criticise the individuals involved. The consequence of this

202 94/139/9-19
203 94/85/2-86/17
major failure by BTP was that NWAS and GMFRS were denied important situational awareness.

13.133 Finally, ACC Smith helpfully provided constructive remarks at the conclusion of his evidence. First, he suggested that contact details for on-duty and on-call commanders in an emergency responders’ app would speed up communication. This would require co-operation at a national level. Nevertheless, it seemed to me to be an idea worth exploring.

13.134 I recommend the Home Office, the National Ambulance Resilience Unit, the College of Policing and the Fire Service College consider together whether this may have value.

13.135 Second, as an officer who had come to BTP from a Home Office police service, he was initially “quizzical” of the Senior Duty Officer role. Having seen it in action, ACC Smith was strongly supportive of it.204 This accords with my view.

Conclusion

13.136 BTP officers made an important and positive contribution to the emergency response. The first officers to enter the City Room after the explosion showed particular courage. Better training would

204 94/145/5-149/1
have enhanced the contribution the frontline officers could have made.

13.137 The BTP command structure should have been better than it was. Having a Bronze Commander on scene as early as possible and playing an active role in accordance with JESIP is the best way to ensure BTP makes the most effective contribution it can to a multi-agency emergency response. It is important that BTP gives careful thought to how this can be improved in the future.
Greater Manchester Police response

Key findings

- The Greater Manchester Police (GMP) Force Duty Officer (FDO) correctly declared Operation Plato and did so at an appropriate time.

- It was vital that the FDO should communicate the declaration of Operation Plato to the emergency service partners of GMP. The FDO failed to do so. That failure fundamentally undermined the joint response to the Attack.

- The FDO failed in other important respects. The overall impact of his failures was serious and far-reaching.

- The FDO failed because he was overburdened on the night.

- GMP had known for years that there was a material risk that the FDO would become overburdened in the event of an Operation Plato declaration but had failed to put in place proper mechanisms of support for the FDO.
• GMP did not declare a Major Incident until 00:57 on 23rd May 2017, long after such a declaration was capable of making a difference to the emergency response during the critical period. A Major Incident should have been declared by GMP more than 140 minutes earlier. The failure to declare a Major Incident occurred across the GMP command structure.

• The FDO did make a prompt deployment of firearms officers to the Arena and provided those officers with the appropriate authority and instructions.

• The firearms officers arrived swiftly and in significant numbers and quickly secured the City Room. Had armed terrorists been present, they would have been neutralised. This is a part of the emergency response that worked well.

• The GMP Operational/Bronze Commander with responsibility for the unarmed officers in the City Room performed admirably under great pressure.

• The GMP Night Silver on the night made no contribution of substance to the emergency response.

• There was a lack of understanding within GMP that the scene or scenes of a Major Incident would require the physical presence of an officer to provide tactical command to the armed officers.
• GMP strategic/gold command on the night made no effective contribution to the emergency response although did make a significant contribution to managing the longer-term consequences of the Attack.

• Prior to the arrival at the scene of the Ground Assigned Tactical Firearms Commander at 23:23, no GMP officer gave any consideration to Operation Plato zoning.

• The importance of Operation Plato zoning was not adequately understood across the GMP command structure.

• The Ground Assigned Tactical Firearms Commander made a significant contribution to the emergency response.

• The unarmed officers of GMP had received first aid training that was inadequate to enable them to provide effective treatment to the injured in the City Room, although that was a situation common to many police services.

Introduction

13.138 In Part 12, I identified failures by GMP in planning, including in planning for the consequences of a declaration of Operation Plato. On the night of the Attack, those failures had consequences.
Force Duty Officer

First reports

13.139 Within a minute of the detonation of the bomb in the City Room, GMP was informed that there had been an explosion at the Arena. At 22:31:52, a member of the public named Ronald Blake made a 999 call. The very first thing he said was: “There’s been an explosion at Manchester Arena.” He went on to clarify that this had happened in “the foyer where the entrance is … near where MacDonald’s [sic] used to be.” He explained that there were “loads injured … 30 or 40 injured”.

13.140 When he made this call, Ronald Blake was with John Atkinson. He stayed with John Atkinson for nearly an hour, applying a makeshift tourniquet to his right leg and reassuring him, before then helping to carry John Atkinson down to the Casualty Clearing Station. Ronald Blake did all of this while himself injured. In the course of the evidence, John Atkinson’s family praised Ronald Blake for his humanity. I agree. Also, his 999
call was clear, prompt and helped the emergency response overall.

13.141 While Ronald Blake was still on the line, GMP began to receive many other 999 calls. Overwhelmingly, those calls reported an explosion. Often the callers accurately stated that a bomb had detonated. There were also, however, a small number of references in the calls to shooting or gunshots, including in the second 999 call that was received by GMP. That second call commenced at 22:32:40, and the caller said: “I’m at the MEN Arena in Manchester. There’s been gunshots and explosion … There’s loads of people bleeding. There’s been gunshots and explosion.”

13.142 Inspector Dale Sexton was the FDO for GMP on the night of the Attack. He was based in GMP Control along with the Force Duty Supervisor and other members of control room staff. The Force Duty Supervisor was Ian Randall, an experienced civilian employee with the title Police Support Staff Supervisor. His job was to support the FDO, supervising the rest of the staff in GMP Control and providing a link between the FDO and the rest of GMP and outside agencies.

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211 INQ023493T/23
212 Between 1998 and 2011, the Manchester Evening News (MEN) had the naming rights for the Arena and to this day some refer to it as ‘the MEN Arena’
213 INQ023493T/23
13.143 Inspector Sexton came on duty at 21:00 on 22\textsuperscript{nd} May 2017.\textsuperscript{214} As the FDO, it was his role to oversee and manage the response of GMP to incidents as they occurred across the service. To that end, he had authority to activate, deploy and command the different resources available to GMP. That included deploying GMP’s armed policing capability in his role as the Initial Tactical Firearms Commander.

13.144 As I explained in Part 12, Inspector Sexton had received the conventional FDO training in 2014 along with regular refresher training for his role as an Initial Tactical Firearms Commander. In the period between 2014 and 2017, he worked regularly as the FDO.\textsuperscript{215} I accept that by the night of the Attack, Inspector Sexton was experienced and competent in that role, although as I have already set out, FDOs require greater and more specific training in the response to an Operation Plato situation.

13.145 In the early stages after the detonation on 22\textsuperscript{nd} May 2017, each of the many 999 calls received by GMP was recorded on its own incident log. Each log was given a unique number known as a ‘Force Wide Incident Number’. At 22:34:00, a master incident log was created, and information was transferred to that from the individual

\textsuperscript{214} 97/132/17-19
\textsuperscript{215} 97/21/22-23/25
incident logs.\textsuperscript{216} That was a sensible step that enabled all relevant information to be seen in one place.

13.146 The master incident log records that, at 22:34:09, just over three minutes after the explosion, the call was “switched to FDO FDS [Force Duty Supervisor]”.\textsuperscript{217} Inspector Sexton explained that this means the call handler has sent the information via a ’switch system’ to the FDO’s screen. This was the point at which the FDO and the Force Duty Supervisor became aware of what had happened at the Arena.\textsuperscript{218} This was also the point at which Inspector Sexton took command of the incident,\textsuperscript{219} including command of the initial firearms response in his role as the Initial Tactical Firearms Commander.\textsuperscript{220} All this happened just three minutes after the explosion.

13.147 Inspector Sexton began to deploy firearms officers to the Arena immediately.\textsuperscript{221} He did so by radio. His instruction directed these officers to travel to the Arena, but the deployment itself did not permit the firearms officers to utilise their firearms. Firearms officers may only use their firearms when granted Firearms Authority by a

\textsuperscript{216} INQ007214/2, 97/153/9-154/9
\textsuperscript{217} INQ007214/8
\textsuperscript{218} 97/152/10-153/6
\textsuperscript{219} 97/150/11-15
\textsuperscript{220} 97/4/11-7/10
\textsuperscript{221} 97/151/9-12
firearms commander or where they judge there to be an imminent threat to life. 222

13.148 Inspector Sexton did not immediately grant Firearms Authority. He was ensuring that firearms officers were in position if needed, while giving himself time to assess the situation. This was a sensible approach. It meant that firearms officers arrived at the Arena very quickly and in numbers. Inspector Sexton’s approach ensured that, if there were a credible firearms threat at the Arena, there were officers there ready to engage with and neutralise the threat.

13.149 PC Edward Richardson was one of the firearms officers who heard the FDO’s instruction for all Armed Response Vehicles to go to the Arena. On hearing the instruction, PC Richardson travelled immediately to that location. He was to become the Operational Firearms Commander. I will consider his actions in the Operational Firearms Commander role in due course.

13.150 By 22:39, eight minutes after the explosion, PC Richardson had arrived on Trinity Way. 223 He had spoken to members of the public who reported that fireworks had gone off. He gained the impression that what was being reported was

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222 98/4/11-23
223 101/57/10-18
a false alarm.\textsuperscript{224} At 22:39:30, PC Richardson communicated that impression over the radio to the FDO.\textsuperscript{225} News of a 'false alarm’ was a relief for Inspector Sexton,\textsuperscript{226} but only momentarily so.

13.151 At 22:41, one of the other firearms officers who had arrived at the scene, PC Lee Moore, transmitted the following message to the FDO: “\textit{Boss. It’s become a different story now ... they’ve got major casualties.}”\textsuperscript{227} PC Moore also mentioned Operation Plato. From that information, Inspector Sexton understood that PC Moore thought officers at the scene were dealing with a Marauding Terrorist Firearms Attack.\textsuperscript{228}

13.152 As he transmitted this message, PC Moore was still outside the railway station. While there, having just arrived and seeking situational awareness, PC Moore spoke to PC Roach, a BTP officer. PC Roach had already been into the City Room before leaving in order to obtain medical supplies.\textsuperscript{229} PC Roach had firsthand knowledge of the position there. The information that PC Moore provided to Inspector Sexton was

\textsuperscript{224} 101/55/8-56/13  
\textsuperscript{225} 101/57/11-24  
\textsuperscript{226} 97/173/16-22  
\textsuperscript{227} 102/90/13-91/2  
\textsuperscript{228} 97/175/24-176/9  
\textsuperscript{229} 102/84/2-85/25
based on what he had been told by PC Roach, who, at the time, had situational awareness.

13.153 At 22:42:44, CCTV captured the first two GMP officers present within the Arena. They were two firearms officers, PC Troy Tyldesley and PC James Dalton. They had entered via the lower Trinity Way doors.\(^\text{230}\)

13.154 By this stage, Inspector Sexton had authorised an Emergency Search.\(^\text{231}\) A number of witnesses explained that an Emergency Search is a high-level, dynamic tactic. It would be inappropriate to explain that tactic in detail here. In simple terms, however, it involves firearms officers locating, confronting and neutralising a threat, typically a firearms threat. To that end, Inspector Sexton had also granted Firearms Authority two minutes earlier.\(^\text{232}\) These were the right decisions by Inspector Sexton and were made at the right time.

13.155 At 22:42:52, eight seconds after PC Tyldesley and PC Dalton were seen inside the Arena, PC Moore and his colleague PC James Simpkin entered Manchester Victoria Railway Station through the War Memorial entrance. They ran alongside PC Roach.\(^\text{233}\) The three ran up the
steps leading to the raised walkway. At 22:43:05, as they did so, PC Moore passed a message to the FDO over the radio, stating: “[T]hey’ve got major casualties in the MEN and they believe it’s a ball bearing device … Boss, I can confirm there’s definitely casualties … Operation Plato, Operation Plato.”

13.156 PC Moore performed his duties with distinction that night. In evidence, he was asked why he had referred to Operation Plato in the radio messages he transmitted to the FDO. He confirmed that he had received information that shootings had taken place. PC Moore considered that the situation was one in which Operation Plato ought to be declared. This was what he sought to pass on to the FDO. He was successful in that aim because that is what Inspector Sexton understood PC Moore to be communicating.

13.157 At 22:44, the Force Duty Supervisor, Ian Randall, made contact with Temporary CI Rachel Buckle, the duty cadre Tactical Firearms Commander. He told her that the FDO, whom he described as “mad busy”, had asked him to contact her. Temporary CI Buckle said that she would make
her way “in”.\textsuperscript{238} I will consider her role in due course.

13.158 Firearms officers continued to arrive at the Victoria Exchange Complex in numbers throughout this period. That is what Inspector Sexton wanted to achieve. This was a part of the emergency response that worked well. Had there been an armed terrorist present at the Victoria Exchange Complex, I have little doubt that person would have been swiftly located and neutralised.

13.159 At 22:44, GMP Inspector Michael Smith arrived in a patrol vehicle on Station Approach.\textsuperscript{239} He was to become the Operational/Bronze Commander in respect of the unarmed officers in the City Room. A striking feature of the events that night was that Inspector Sexton did not speak to Inspector Smith at any point.\textsuperscript{240} That the FDO never spoke to the Operational/Bronze Commander is a clear indication that not only did multi-agency communication fail on the night of the Attack, but communication within GMP was also inadequate.

13.160 As I set out in Part 12, the refreshed CTPHQ Operation Plato guidance of March 2017

\textsuperscript{238} 97/185/5-186/13
\textsuperscript{239} INQ035612/89
\textsuperscript{240} 99/14/1-4
acknowledged that the dynamic and demanding nature of an Operation Plato incident would make it difficult to keep a written command log. It was recommended that police services therefore consider the introduction of audio-recording devices for commanders, particularly the Initial Tactical Firearms Commander, in the police control room.241 This was a sensible recommendation that I will consider further in Part 19 in Volume 2-II.

13.161 There were Dictaphone recordings available to the Inquiry from two GMP commanders that night: Inspector Sexton and CI Dexter. Those recordings made a significant contribution to the Inquiry’s understanding of the emergency response to the Attack. In a Major Incident, emergency service commanders should use audio-recording, or where appropriate video-recording, devices to record their decisions and their rationales. On the face of it, this should be universal at any Major Incident. I recommend the Home Office, the College of Policing, the National Ambulance Resilience Unit and the Fire Service College take steps to achieve this.

13.162 About four weeks before the Attack, no doubt in response to the CTPHQ advice, GMP had provided a Dictaphone for use by its FDOs.
At 22:46, Inspector Sexton switched on that device.  

13.163 I have listened to the whole of the recording from Inspector Sexton’s Dictaphone. It lasts for just under 2 hours and 50 minutes in total. During Inspector Sexton’s evidence, the first 1 hour and 32 minutes of the recording was played. This covered the period from the declaration of Operation Plato up until Superintendent Craig Thompson took over from Inspector Sexton as Tactical Firearms Commander.

13.164 In the recording, Inspector Sexton gave the time at which he was relieved of the Initial Tactical Firearms Commander role as 00:15 on 23rd May 2017, when in fact this occurred at 00:18. By then, Inspector Sexton had been Initial Tactical Firearms Commander for a period of 1 hour and 44 minutes: 22:34 to 00:18. I consider that to have been far too long. This is an issue to which I will return in paragraph 13.239.

Declaration of Operation Plato

13.165 Inspector Sexton declared Operation Plato at 22:47. This was almost the first thing that was recorded on the Dictaphone:

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242 97/187/6-16
243 97/192/18-20, 98/1/23-25
244 98/1/24-2/8
“Yeah in view of that obviously er my first call was for OP Plato, that’s what we’ve got declaring OP Plato in relation to a report that we now have confirmation of a male who would appear to have strapped a device to his er body and er detonated it inside the arena causing multiple victims and injuries. Erm update when you’re (background noise) when you’re able to get inside to give me any er fatalities etc. Err but obviously we’re not we err expect that there’s anyone else involved. At this moment in time I can’t negate that it erm that it was a lone actor on this one.”

13.166 Operation Plato has been the agreed national identifier for the multi-agency response to a Marauding Terrorist Firearms Attack since 2012. The original Association of Chief Police Officers (Terrorism and Allied Matters) (ACPO (TAM)) guidance and the CTPHQ March 2017 refreshed guidance made clear that the focus of Operation Plato was on a firearms attack.

13.167 It is now well known that the Attack did not involve the use of firearms. In fact, the FDO was not confronted with a Mumbai-style attack, but he was not to know that at the time of his declaration. I have explained what a Mumbai-style attack is in Part 12.
13.168 I am not critical of Inspector Sexton for his declaration of Operation Plato or for the timing of that declaration.

13.169 Many FDOs in May 2017 would have been concerned that the detonation in the City Room might mark the start of a multi-site, multi-method terrorist attack. For several years, the strong focus within counter-terrorism policing had been on countering a Mumbai-style attack. Furthermore, the attack in Paris in November 2015 inevitably reinforced that focus. Inspector Sexton said in evidence that, when he declared Operation Plato, he had in mind the Paris attacks.247

13.170 In the Paris attacks, there had been explosions outside the Stade de France followed by gun attacks in busy restaurant and café areas and then a mass shooting at the Bataclan Theatre.248 I accept that Inspector Sexton had these events in mind when he declared Operation Plato and that it was sensible for him to do so.

13.171 In the period after the explosion in the City Room, some reports of gunshots and shooting were received by GMP. I referred to the 999 calls at paragraphs 13.139 to 13.141. At 22:43, the incident log records that there was a person with

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247 97/13/2-11
248 I deal with the circumstances of the Paris attack in further detail in Part 20 in Volume 2-II
a “gunshot wound to the leg” at the entrance to the railway station.\textsuperscript{249} Inspector Sexton understood that this report had been made by an experienced firearms officer and it therefore carried weight with him.\textsuperscript{250}

13.172 While these references to gunshots and shooting were not frequent in the reports that were being made, it is understandable that they provided support for the FDO’s view that a Mumbai-style attack might be under way.

13.173 I am supported in my view that the decision to declare Operation Plato at 22:47 was a reasonable one by the opinion of the Policing Experts. They consider the declaration was appropriate in the circumstances that then existed.\textsuperscript{251}

13.174 Other experienced and knowledgeable witnesses held the same view. In particular, CI Richard Thomas, the Head of Specialist and Counter-Terrorism Armed Policing at CTPHQ, made clear that the approach of CTPHQ was that if there was any doubt about whether a Marauding Terrorist Firearms Attack was under way, Operation Plato should be declared.\textsuperscript{252} In my view, that is a sensible approach. It is clear,
however, that any declaration must be kept under close review.

13.175 As for the timing of the declaration of Operation Plato by Inspector Sexton, it is possible to argue that the declaration could have been given earlier in view of the stage at which gunshots were first mentioned in a 999 call. It is also possible to argue that the declaration could have been delayed until firearms officers had provided a detailed situation report.

13.176 Both arguments were explored in the course of the evidence, and both arguments are credible. However, in my view, Inspector Sexton took an appropriate amount of time to assess the situation, having deployed firearms officers to the scene immediately. The timing of his declaration was reasonable in the circumstances, even if some FDOs might have declared it earlier and some later, and perhaps some not at all.

Declaration of a Major Incident

13.177 GMP’s Major Incident Plan had been in place for several years and had been updated in March 2017.\textsuperscript{253} It defined a Major Incident as “\textit{an event or situation, with a range of serious consequences, which requires special }
arrangements to be implemented by one or more emergency responder agencies.”

13.178 At no stage that night did Inspector Sexton declare a Major Incident. In evidence, he said that he did not consider it necessary to do so because he thought, “It was obvious what people were dealing with.” In reality, I consider it likely that Inspector Sexton, in the highly pressured situation in which he found himself, simply overlooked the need to declare a Major Incident. I will consider the issue of the burden on the FDO in greater detail at paragraphs 13.236 to 13.255.

13.179 Whatever the reason for Inspector Sexton’s failure to declare a Major Incident, I regard it as a serious omission.

13.180 There is no doubt that the Attack constituted a Major Incident as defined by the GMP Major Incident Plan. Inspector Sexton even referred to it as a Major Incident in a call he made to a Derbyshire Police officer at 23:04. He stated: “Yeah we have got a major incident. It’s been confirmed it’s a terrorist attack.”

13.181 The Policing Experts explained that a Major Incident should have been declared as soon as
the scale of the casualties was known and therefore before the declaration of Operation Plato.\textsuperscript{257} It is clear that other senior officers who came into the command structure at a later stage share that view.

13.182 Superintendent Thompson, who became the Tactical Firearms Commander, said that the delay in the declaration of a Major Incident was a mistake.\textsuperscript{258} Temporary Superintendent Christopher Hill, to whom silver command was transferred from Temporary Superintendent Arif Nawaz shortly after 00:00 on 23\textsuperscript{rd} May 2017, agreed. Shortly before 01:00, Temporary Superintendent Hill realised that a Major Incident had not been declared: “I just literally thought crikey no one’s declared a Major Incident yet, so I’m going to declare a Major Incident.”\textsuperscript{259} It was clear from the evidence that both of these senior officers considered that a Major Incident should have been declared very much earlier.

13.183 I have no doubt that Inspector Sexton should have declared a Major Incident within a few minutes at most of first becoming aware of the events at the Arena at 22:34.

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\begin{tabular}{ll}
\textbf{257} & 146/136/17-137/16 \\
\textbf{258} & 108/53/19-54/9 \\
\textbf{259} & 104/191/16-23 \\
\end{tabular}
\end{center}
13.184 I disagree with Inspector Sexton’s expressed view that such a declaration at an early stage would not have been meaningful. 260 I consider that an early declaration should have resulted in the implementation of the GMP Major Incident Plan. The Policing Experts note that this would have brought an automatic FCP and RVP structure into effect; it would have mobilised specialist assets and equipment. As the Policing Experts explained: “[I]t would have mobilised the force around consequence management rather than focussing exclusively on the believed continued threat.” 261 Both Temporary Superintendent Hill 262 and Superintendent Thompson 263 considered that an early declaration of a Major Incident by GMP would have made a real difference.

13.185 An early declaration of a Major Incident and the implementation of the GMP Major Incident Plan would have encouraged and enhanced a JESIP approach. Such an approach was lacking on the night. It would also have given greater clarity in relation to roles within the command structure. It would therefore have had real value.

260 98/96/11-24
261 146/139/22-140/4
262 104/191/24-192/14, 104/193/16-18
263 108/54/2-11
13.186 It was not until 00:57, nearly two and a half hours after the explosion, that GMP declared a Major Incident. As I have explained, that declaration was made by Temporary Superintendent Hill. He did the right thing and took action as soon as he was aware that a declaration had not already been made. However, by then, the opportunity for that declaration to make a difference to the emergency response was long gone.

13.187 While the failure to declare a Major Incident was principally Inspector Sexton’s, others also bear some responsibility. In particular, neither Temporary Superintendent Nawaz in his role as Tactical/Silver Commander nor ACC Ford in her role as Strategic/Gold Commander declared a Major Incident. Each of them should have done so.

Communication of Operation Plato declaration

13.188 As I have explained, in May 2017, Operation Plato was the national identifier for the multi-agency response to a Marauding Terrorist Firearms Attack. The term ‘Operation Plato’ had been adopted not only by the police, but also the ambulance service, the fire and rescue service, the military whose assets might be deployed in support of the response, the NHS, and local and
central government departments.\textsuperscript{265} The expectation was that these bodies would all work together to achieve the best response possible in the event of a Marauding Terrorist Firearms Attack. This is at the heart of JESIP.

13.189 For Operation Plato to work, it is vital that all emergency services are informed promptly that an Operation Plato declaration has been made. Otherwise, no joint approach is possible, and JESIP will be compromised and may fail altogether. The imperative for sharing information is reflected in the national guidance.

13.190 The ACPO (TAM) guidance stated: \textit{“It is important that the FCR Inspector ensures that the other emergency response agencies are informed immediately once a declaration has been made, as this will also trigger a pre-defined response by those organisations.”}\textsuperscript{266} Within GMP, the “FCR” (Force Control Room) Inspector was the FDO.

13.191 The CTPHQ guidance of March 2017 stated:

\begin{quote}
\textit{“The declaration of an Operation PLATO incident triggers a multi-agency response designed to rapidly inform, mobilise and operationally deploy the most appropriate resources in order to identify, locate, confront and neutralise the threat and save life. In}
\end{quote}
order to support an effective response, it is important that the relevant partner agencies and specialist national assets are informed as a priority.”

13.192 This guidance made clear that the responsibility for sharing this critical information rested with the FDO in their role as Initial Tactical Firearms Commander:

“When the Initial TFC identifies and declares an Operation PLATO incident they will be responsible for notifying their local Ambulance and FRS [fire and rescue service] control rooms as soon as possible. This will assist with the activation of contingency plans and also assist in minimising the risk to emergency service responders who may not be aware that an MTFA [Marauding Terrorist Firearms Attack] is occurring in their area.”

13.193 I recognise that the 2017 guidance was introduced only shortly before the Attack, and training had not been given on it within GMP by 22nd May 2017. This makes no difference, however, to the point under consideration, as no matter which national guidance was applied, it remained the job of the FDO to notify emergency service partners of the Operation Plato
declaration. Under each plan, only the police could declare Operation Plato, so only they could communicate its declaration.

13.194 As for the GMP Operation Plato plans, there was confusion about which policy was applicable on 22nd May 2017. That is a situation I criticised in Part 12. That confusion should not have happened and should never be allowed to happen again. The various policies were, however, consistent about the need for the FDO to alert emergency service colleagues to a declaration of Operation Plato.

13.195 Standard Operating Procedure (SOP) 47 v.5 provided that the duties of the FDO included to “inform emergency service partners once ‘Operation PLATO’ has been declared to enable Emergency Service contingency plans to be put into effect”.269

13.196 As I explained in Part 12, the Whittle Plan stated that the duties of the FDO included contacting the control rooms of GMFRS and NWAS and declaring Operation Plato, then establishing three-way communications and providing a METHANE message.270

13.197 Whether the national plan or the GMP plan was applied, the burden remained with the FDO to
notify NWAS and GMFRS of the declaration of Operation Plato and to do so promptly. This was a fundamental responsibility of the FDO.

13.198 Inspector Sexton described a situation in which 1,500 GMP policies and plans were applicable, or potentially applicable, to the work of the FDO. It was impossible, he explained, for an FDO to gain ready access to any particular plan at short notice. That included the Operation Plato plan.\(^\text{271}\)

I dealt with this and set out my criticisms of GMP’s approach to planning in the years leading up to the Attack in Part 12.

13.199 Recognising this proliferation of plans and the particular demands that a declaration of Operation Plato would place upon the FDO, Inspector Sexton had prepared what he described as an “aide-memoire”\(^\text{272}\) for a Marauding Terrorist Firearms Attack.\(^\text{273}\) He had first prepared this in January 2016.\(^\text{274}\) On 6\(^{th}\) June 2016, Inspector Sexton updated his aide-memoire in light of learning from Exercise Winchester Accord and circulated it to his FDO colleagues.\(^\text{275}\)

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\(^{271}\) 97/54/24-56/1  
\(^{272}\) INQ040955  
\(^{273}\) 97/57/3-22  
\(^{274}\) 97/135/20-21  
\(^{275}\) 97/136/10-23
13.200 Inspector Sexton’s aide-memoire recognised the need to ensure that the emergency service partners of GMP were informed in the event that Operation Plato was declared. 276

13.201 In evidence, Inspector Sexton acknowledged that his aide-memoire included early communication, by the FDO, of the Operation Plato declaration, followed by co-location of the emergency service commanders at an FCP, to enable effective co-ordination of the multi-agency response in accordance with JESIP. 277

13.202 Inspector Sexton was undoubtedly under a duty that night to notify the ambulance service and the fire and rescue service that he had declared Operation Plato, and he was under a duty to do so promptly. Both the national and GMP materials made that clear. Inspector Sexton’s aide-memoire document also acknowledged that. Prior to the Attack, he was well aware of what his responsibility was. An indication of the pressure he was under that night is that it did not come to his mind during the response.

13.203 Shortly after 22:47, when he had declared Operation Plato, Inspector Sexton should have informed NWAS and GMFRS that he had done so.

276 INQ040955/1
277 97/138/6-23, 99/28/16-21
13.204 On 22\textsuperscript{nd} May 2017, Inspector Sexton did not communicate his declaration of Operation Plato to NWAS or GMFRS either promptly or at all. That was a significant failure by him that had major consequences to which I shall turn.

13.205 This failure by Inspector Sexton gives rise to the question of why he failed to do something so fundamental to the response to a perceived Marauding Terrorist Firearms Attack and which was required by the national and regional Operation Plato plans and recognised in his own aide-memoire document.

Inspector Sexton’s failure to communicate the Operation Plato declaration

13.206 Inspector Sexton gave evidence for two and a half days.\textsuperscript{278} From start to finish, he maintained that he had made a decision, on the night of the Attack, not to communicate his declaration of Operation Plato to the ambulance service and the fire and rescue service. He explained that he regarded the City Room as a ‘hot zone’ and he feared that, if he communicated the declaration, those who were in that location and tending to the injured would be withdrawn.\textsuperscript{279}

\textsuperscript{278} Days 97 to 99
\textsuperscript{279} 97/111/8-114/19
13.207 In his first witness statement dated 6th December 2019, provided before he gave evidence, Inspector Sexton said:

“I knew I had a number of armed officers at the scene. I believed they would be in a position to afford a level of protection against any possible firearms attack, therefore, I took a calculated risk to leave vulnerable unarmed people at the scene to treat and evacuate the casualties.”

13.208 In evidence to me, Inspector Sexton confirmed that this represented his reasoning at the time. He maintained that he had a recollection of having these thoughts as the situation unfolded on the night. He was asked on a number of occasions by Counsel to the Inquiry and various other advocates to consider whether the burden of the role and/or the burden of the occasion meant that, in fact, he had simply overlooked the need to communicate his declaration of Operation Plato. He insisted this was not so and that, instead, he had made a positive decision to conceal the declaration from GMP’s emergency service partners.
13.209 In my view, a series of factors point away from the conclusion that Inspector Sexton made a deliberate decision to conceal his declaration of Operation Plato in this way.

13.210 First, many people within GMP knew that Inspector Sexton had declared Operation Plato. He did not tell anyone to keep that information to themselves.\(^\text{283}\) So, any one of them might, for all he knew, have disclosed the declaration to a representative of the ambulance service or the fire and rescue service.

13.211 Inspector Sexton broadcast a message on the firearms radio channel at 22:47 making clear that he had declared Operation Plato. It follows that all firearms officers will have known this had been done. Many of those firearms officers were at the Arena and could have told the paramedics there that Operation Plato had been declared.

13.212 Some of those working within GMP Control heard Inspector Sexton’s broadcast over the firearms channel. Certainly, the Force Duty Supervisor knew that Operation Plato had been declared. At 22:49, Inspector Sexton’s Dictaphone recording captures Ian Randall on the telephone referring to Operation Plato.\(^\text{284}\) In fact, this call was to the

\(^{283}\) 98/142/24-143/2, 99/118/10-17

\(^{284}\) INQ024325/3
GMP Force Press Officer, Ben Ashworth.\(^{285}\) David Myerscough, who was in due course given the responsibility of answering the FDO telephone, also knew. He was also captured on the Dictaphone recording making reference to Operation Plato.\(^{286}\)

13.213 The fact that Operation Plato had been declared was also recorded on the GMP master incident log at 22:47. That meant that anyone within GMP Control, or GMP more widely, who accessed the log would have known that Operation Plato had been declared, even if they did not hear the radio message.\(^{287}\) For all Inspector Sexton knew, the Force Duty Supervisor or any GMP Control Room Operator could have disclosed the declaration of Operation Plato to anyone from the ambulance service, the fire and rescue service or NWFC.

13.214 At 22:51, Inspector Sexton informed Temporary Superintendent Nawaz, the Night Silver, of the declaration of Operation Plato.\(^{288}\) At about 23:08, Inspector Sexton spoke to Inspector Darren Meeks of the North West Counter Terrorist Unit about the declaration, after leaving him a voicemail message to the same effect a few days earlier.
moments earlier.\textsuperscript{289} The Dictaphone recording shows that Inspector Sexton also told others within GMP that he had declared Operation Plato and did not ask or direct them not to disclose it further.\textsuperscript{290} Any of these people could have passed this information on to a colleague within the other emergency services.

13.215 If Inspector Sexton really intended to keep the fact of the declaration of Operation Plato a secret, it is incomprehensible that he did not, at any stage, even hint to those whom he had told that they should keep the declaration to themselves. That he did not do so points away from Inspector Sexton having made a positive decision at the time to conceal his declaration of Operation Plato from emergency service partners.

13.216 Second, the word “\textit{Plato}” is heard 23 times in the Dictaphone recording. On 17 of those occasions, the speaker is Inspector Sexton.\textsuperscript{291} There is not the slightest hint in any of those references that Inspector Sexton wished, at the time, to conceal the Operation Plato declaration from the wider emergency service community.

\begin{itemize}
\item[289] INQ024325/12-13
\item[290] INQ024325/1-5, INQ024325/15, 97/111/8-115/22
\item[291] INQ024325/1-48
\end{itemize}
13.217 Third, Inspector Sexton knew that the purpose of the Dictaphone was to record his decision-making.\(^{292}\) He did not record on the Dictaphone or anywhere else at the time that he had made a decision to conceal the fact that he had declared Operation Plato.\(^{293}\)

13.218 Fourth, the job of the Force Duty Supervisor is to provide support to the FDO. Inspector Sexton explained of the Force Duty Supervisor: “They are a very good source of support and they’re very knowledgeable about the mechanics of the room.”\(^{294}\) He said that he had worked with Ian Randall many times and regarded him as “very capable”\(^{295}\)

13.219 I am satisfied, having heard from both Inspector Sexton and Ian Randall, that if Inspector Sexton had really been considering concealing his Operation Plato declaration, he would have discussed that with the Force Duty Supervisor. He did not do so. It is striking that at no stage that night did Inspector Sexton discuss or even mention to anyone the crucially important decision he claims to have made. That is a feature that speaks powerfully against his account to the Inquiry.

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292 97/110/17-24
293 97/111/13-20, 98/143/10-15, 99/117/14-118/17
294 97/78/4-6
295 97/78/11-13
13.220 Fifth, the Dictaphone recording captures a short conversation between Inspector Sexton and Ian Randall at about 23:09. Inspector Sexton asked the Force Duty Supervisor “who have we spoken to now, everyone pretty much?” The recording indicates that this is the genuine query of an FDO who wishes to make sure he has alerted those who need to be aware of what is going on. As I have made clear, the Force Duty Supervisor had not been told that the declaration of Operation Plato was a secret. Asking him whether anyone else needed to be contacted carried the obvious risk that he would refer to the need to communicate the declaration of Operation Plato to emergency service partners. That Inspector Sexton asked the question provides an indication that he was not seeking to conceal the declaration from NWAS or GMFRS. In fact, the Force Duty Supervisor did not refer to the need to communicate on the declaration. That was pure chance and does not undermine this reasoning.

13.221 Sixth, subsequent to 22nd May 2017, Inspector Sexton gave accounts of the events that night that are inconsistent with his account to the Inquiry.
13.222 On 26th July 2017, Inspector Sexton took part in a structured debrief on behalf of GMP.\textsuperscript{297} He was Participant 6.\textsuperscript{298} He recorded:

\begin{quote}
There was an inordinate amount of work for the Force Duty Officer to complete including a large number of people to contact. This proved almost impossible to do while completing all other tasks around the incident … It was difficult to speak to other Emergency Services due to the multi Airwave channel not working.”\textsuperscript{299}
\end{quote}

13.223 During the debrief process, Inspector Sexton did not suggest that he had made a deliberate decision to conceal the fact of the declaration of Operation Plato. On the contrary, he sought to justify the failure to communicate the declaration to GMP’s emergency service partners by reference to other factors, including the burden upon him as FDO.\textsuperscript{300}

13.224 Operation Manteline was the Counter Terrorism Policing investigation into the Attack. In common with other officers and police staff, Inspector Sexton completed a questionnaire on 27th July
2017, as part of that investigation. In that questionnaire, he stated:

“I declared Op Plato some 20 mins from being made aware of the incident. However, due to demand on the FDO role and limited experienced Comms Operators I was unable to make contact with North West Ambulance and Greater Manchester Fire and Rescue Service.”

Inspector Sexton did not state that he had made a deliberate decision to conceal the declaration of Operation Plato. On the contrary, once more, he sought to justify the failure to communicate the declaration to GMP’s emergency service partners by reference to other factors, including the burden upon him as FDO.

Inspector Sexton was interviewed on 10th January 2018 as part of Lord Kerslake’s independent review of the preparedness for and emergency response to the Attack. Inspector Sexton explained what he had done on becoming aware of the Attack. He went on to say:

“I was satisfied that because I knew what services were at the scene, that certainly the key ones for NWAS, being the medical side,
they knew exactly what was going on. I was satisfied with that. They knew it was an Op Plato. They were still happy to leave their staff in that zone. The police on the ground knew exactly what was going on. The fire service will have known from their communication, because obviously our divisional staff kept on making contact with the fire service, certainly in the early stages to let them know what was developing. And then, if I’m honest, as things developed, I totally forgot about the other services. I knew that actually Silver would put a foot on the ball and start, you know, really giving that clear picture, and certainly the forward command post, once [CI] Mark Dexter was on the ground, would have been able to do that. So, I wasn’t really that concerned about it, while I’m still dealing with this ongoing threat.”

Accordingly, Inspector Sexton was saying that NWAS knew that Operation Plato had been declared. That is incorrect. He was also saying that he had forgotten about the other emergency services. There is not the slightest suggestion that he had made a deliberate decision to conceal the declaration. Indeed, he was saying something quite different in the Kerslake process.

304 INQ023523T/37, INQ023523T/38 (emphasis added)
from what he said when he gave evidence to the Inquiry.

13.228 When pressed in evidence, Inspector Sexton had no convincing explanation for why he had given these accounts if in truth he had made a deliberate decision at the time to conceal the declaration, as opposed to simply overlooking the duty upon him to communicate. 305

13.229 In all of these circumstances, I am satisfied that Inspector Sexton did not make a decision on the night to conceal the fact that he had declared Operation Plato from GMP’s emergency service partners.

13.230 That conclusion gives rise to two questions: first, what is the true explanation for the failure of Inspector Sexton to communicate the declaration to GMP’s emergency service partners; and second, how has Inspector Sexton come to give seriously inaccurate evidence to the Inquiry on an issue of the utmost importance?

13.231 As for the first of these questions, I consider that Inspector Sexton was overburdened on the night. He simply had too much to do. He overlooked the requirement to contact NWAS and GMFRS, just as he overlooked the need to declare a Major Incident. No one reminded him that he should do

305 99/116/25-125/18
so. No one else within GMP Control had the responsibility allocated to them for making the necessary communication or for reminding the FDO to do so. Inspector Sexton was the single point of failure and, under severe individual pressure, he failed that night.

13.232 As for the second of these questions, towards the very end of his evidence, Inspector Sexton said:

“… it would have been easier for me to come here and say the demands and pressures that were placed on me by GMP and the role meant that, yes, I forgot about it. And my evidence, I'm sure, would have been a lot shorter if that was the case, but that’s not how it happened.”

13.233 There is some force in Inspector Sexton’s claim that it would have been easier for him to blame the burden he was undoubtedly under for his failure to communicate on the Operation Plato declaration. In one sense, therefore, the position he adopted with the Inquiry was contrary to his interests.

13.234 Inspector Sexton gave evidence over the course of about 17 hours. Ultimately, I was left with the impression of a man who believed what he was saying. I consider it a realistic possibility that over
time he has persuaded himself that he cannot have overlooked something as fundamental as communicating on his declaration of Operation Plato, but must instead have made a decision to conceal that fact.

13.235 I do not consider that I can safely conclude that Inspector Sexton set out to lie to the Inquiry. However, as I have made plain, I am satisfied that his evidence about the reason for his failure to communicate the declaration of Operation Plato to GMP’s emergency service partners was incorrect.

Burden on Force Duty Officer

13.236 The Policing Experts expressed the following view, with which I agree:

“The activation of a regional Operation Plato response required the immediate completion of multiple different actions; the FDO completed many of them personally. He was quickly overwhelmed by the volume of Operation Plato related operational notifications, which was in addition to his command of the terrorist attack, of the Operation Plato armed response and to his remaining responsibilities as the force’s FDO. His role became untenable. To be clear this was not, in our view, a case of an inexperienced or incapable officer being faced
with a situation beyond his capability. Insp Sexton was very capable, experienced, well trained and knowledgeable.”

13.237 I will not attempt to describe every aspect of the burden that was placed upon Inspector Sexton that night, but it is relevant to note the following six factors.

13.238 First, firearms officers from GMP, and a number of officers from other police services, deployed into Greater Manchester on the night of the Attack. Many went to the Arena, but others went to different locations, such as Manchester Piccadilly Railway Station and the Royal Oldham Hospital. The firearms operation was a substantial one.

13.239 Inspector Sexton became responsible for that operation as Initial Tactical Firearms Commander at 22:34. He retained that responsibility until relieved by Superintendent Thompson at 00:18. Later in this Part, at paragraphs 13.518 to 13.519, I will consider the decision-making that led to that situation. The result was that Inspector Sexton had the responsibility for tactical firearms command for far too long. In my view, this played a material
part in the unacceptable burden that was imposed upon him that night.

13.240 Second, the role of the Force Duty Supervisor is vital in an Operation Plato situation. Inspector Sexton had an expert and experienced Force Duty Supervisor in Ian Randall. Inspector Sexton made a decision that Ian Randall should leave GMP Control at about 23:20 to travel to GMP HQ to set up the Silver Control Room.\textsuperscript{310} That was a mistake.

13.241 The officer who replaced Ian Randall, Sergeant Andrew Core, lacked Ian Randall’s experience.\textsuperscript{311} Inspector Sexton should have recognised that Ian Randall was better deployed in GMP Control. His departure significantly depleted the experience available to the FDO and added to the already substantial demands on Inspector Sexton. There should have been someone else who was capable of setting up the Silver Control Room and available to do it.

13.242 Third, answering the FDO telephone line quickly became a drain on resources. At 22:57, Inspector Sexton demanded support from within the control room he was in. He asked for someone to step up and answer the FDO telephone on his
behalf. David Myerscough, who had been a GMP radio operator since 2014, assumed that responsibility.

13.243 I am not critical of David Myerscough. He did all that could reasonably have been expected of him and more. He sought to step up and that is to his credit. However, he was placed into a position that he was not trained for and for which he lacked experience. He was out of his depth. In evidence, he said:

“I’d never had the right sort of training for that role, I’m not familiar with the workings of the FDO, I have never been an FDS [Force Duty Supervisor] or a supervisor, so it’s not something I have been involved in a lot. I have a brief understanding of what they do but not an in-depth knowledge, so I didn’t feel prepared or qualified or experienced enough … I felt totally overwhelmed and completely stressed out by the task of answering the FDO line but I just wanted to help and assist as best I could.”

13.244 Inspector Sexton’s Dictaphone records several occasions when David Myerscough lacked the knowledge and understanding necessary to
perform the role he had been given. He regularly had to seek clarification from the FDO, which distracted Inspector Sexton from his other work of directing the emergency response.316

13.245 Fourth, it is striking how often the FDO telephone line became engaged by calls from the media. The Dictaphone recording shows that Inspector Sexton found this frustrating in the extreme. The following exchange between Inspector Sexton and David Myerscough at 23:02 illustrates that:

“[David Myerscough] Boss, do you want media enquiries cancelling or do you want me to answer them?

[Inspector Sexton] No, I don’t want you to speak to them at all I want you to tell them that we’re too busy, they’re going to have to wait. We have just turned out the media officer who should be able to start fielding those questions.”317

13.246 The enquiries from the media nonetheless kept coming, including calls from the international media.318

316 INQ024325/30, INQ024325/48
317 INQ024325/10
318 INQ018834T/1-2
13.247 Inspector Sexton explained that the media enquiries had two effects on the FDO line. Time was taken up with answering calls from the media, and other calls received an engaged tone and were unable to get through.\footnote{319} This had real consequences.

13.248 In drawing attention to this issue, I am not criticising the media. The media were calling the FDO number because that was the number they had. There was an obvious public interest in accurate early reporting of what had happened at the Arena, and the media needed information to that end. The media also had an important role in encouraging members of the public not to enter the centre of Manchester and needed information for that purpose also.

13.249 However, the media enquiries on the FDO telephone line meant that time and resources were taken away from the work of the emergency response. It is clear to me from listening to the Dictaphone recording that the constant media enquiries added to the pressure that Inspector Sexton was experiencing. This should never happen again.

13.250 Steps need to be taken by all police services to ensure that, in the event of a Major Incident: the burden of dealing with media enquiries does not
fall to the FDO; and the FDO telephone line does not become bogged down with such enquiries. Some separate provision needs to be made to ensure that the media gets the information it needs, while not interfering with the FDO response to the incident. This is an issue that the College of Policing should address.

13.251 Fifth, I have made clear the importance of action cards within GMP Control and the serious failure of GMP to introduce such prompts. David Myerscough stated that he had never seen CI Michael Booth’s action cards, and that no action cards were in use in GMP Control on the night of the Attack.\textsuperscript{320} Inspector Sexton said the same.\textsuperscript{321}

13.252 It would have helped to a significant degree on the night if action cards had been available in the control room and if the control room staff had been properly trained in their use. Particular tasks would have been automatically delegated from the FDO to others within GMP Control. That would have included, for example, the notification of emergency service partners that Operation Plato had been declared and the notification to other emergency services of the channel to be used for multi-agency control room communication. This would have reduced the
burden on the FDO and improved the emergency response.

13.253 David Myerscough confirmed that action cards are now available within GMP Control but said that he had received no training in them. He considered that if another event such as the Attack were to occur, he would not be able to cope.\textsuperscript{322} That evidence was concerning. I do not know whether that state of affairs exists elsewhere in the country. I recommend the College of Policing and His Majesty’s Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) urgently take steps to ensure that all police control rooms have action cards in place, and that all control room staff have been properly trained in their use. The importance of action cards to an effective emergency response cannot be under estimated across the emergency services. I will return to this topic in the recommendations in Part 21 in Volume 2-II.

13.254 Sixth, Inspector Sexton was given no material assistance in directing the emergency response by either the Strategic/Gold or Tactical/Silver Commander during the period that he needed it.\textsuperscript{323} I will consider their roles later in this Part, at paragraphs 13.478 and 13.444.
In that regard, I acknowledge that when CI Dexter assumed the role of Ground Assigned Tactical Firearms Commander, he did relieve some of the burden upon Inspector Sexton, but he did not arrive at the scene until 23:23.

Consequences of the Force Duty Officer’s failures

Inspector Sexton’s principal failures were his failing to communicate the declaration of Operation Plato to the ambulance service and the fire and rescue service and his failure to declare a Major Incident.

Other failures flowed from those omissions.

First, Inspector Sexton’s aide-memoire identified that it was his job to ensure, in line with JESIP, that multi-agency communications were put in place. As his own document acknowledged, that required Inspector Sexton to nominate one of the operational multi-agency talk groups. He failed to do so.

Multi-agency communication is vital to an effective joint response. On the night of the Attack, multi-agency communication between the three emergency services was non-existent.

324 99/153/9-154/24
325 106/156/3-6
326 INQ040955/1
327 98/148/20-149/21
That failure played a major part in what went wrong. While I recognise that other means for multi-agency communication were a possibility, Inspector Sexton’s failure in this regard made a significant contribution to the overall failure of JESIP on 22nd May 2017.

13.260 Second, as Inspector Sexton recognised in evidence, establishing an FCP is critical to the emergency response. This should be the location at which, in accordance with JESIP, the commanders from each emergency service co-locate so as to enable them to communicate, co-ordinate, jointly understand the risk and share situational awareness. Inspector Sexton failed to ensure there was an FCP. Nor did he do anything to manage the confusion that developed in relation to a nominated RVP. These failures represent an important part of the explanation for why joint working never happened, but instead the three emergency services ended up operating largely in silos.

13.261 Third, the Policing Experts confirmed that the concept of zoning is critical to Operation Plato. At the time of the Attack, the third edition of the

328 98/100/15-101/12
329 INQ040955/1
330 INQ018900/9-10
331 99/44/12-19
332 146/176/14-21
Joint Operating Principles (JOPs 3) was applicable and defined Operation Plato zones as cold, warm and hot. I will address the meaning of these terms in further detail in paragraphs 13.336 to 13.355.

13.262 No emergency responder was ordinarily expected to operate in an Operation Plato hot zone save for police firearms officers. No emergency responder was ordinarily expected to operate in an Operation Plato warm zone except for specialist assets, such as: the Hazardous Area Response Team (HART); the Ambulance Intervention Team; and the Specialist Response Team of the fire and rescue service.

13.263 Having declared Operation Plato, it was vital that Inspector Sexton should have decided how areas were to be zoned as soon as he had the information to enable him to do so. It was also vital that he should then have communicated that decision to the police officers involved in the response along with the emergency service partners of the police. That is for the obvious reason that such decisions have, as JOPs 3 made clear, a major impact on the deployment forward of unarmed and/or non-specialist emergency responders. In turn, that is likely
to determine how quickly casualties receive the treatment they require and/or are evacuated.

13.264 Inspector Sexton repeatedly said in evidence that he considered the City Room, and indeed a larger area, to have been an Operation Plato hot zone for a prolonged period.\footnote{97/39/23-40/21} I conclude that he made no such decision and that, on the contrary, he gave no thought to zoning that night. Support for that conclusion is provided by the fact that, as the Dictaphone recording reveals, Inspector Sexton did not use the words ‘zone’ or ‘zoning’ or ‘hot’, ‘warm’ or ‘cold’ at any stage during the period that he was Initial Tactical Firearms Commander, or indeed at any stage.\footnote{INQ024325} That Inspector Sexton gave evidence that was factually inaccurate about his thinking at the time is a further example of the situation I described in paragraphs 13.227 and 13.228.

13.265 Not only did Inspector Sexton not use these terms, no one else did in discussion with him. As Inspector Sexton accepted in evidence, at no stage did any firearms officer, or indeed any officer at the scene or elsewhere, ask him how he had zoned the Arena and surrounding area.\footnote{98/13/6-15} That the failure to engage with this vital issue was so widespread indicates strongly that there

\footnotetext{334}{97/39/23-40/21} \footnotetext{335}{INQ024325} \footnotetext{336}{98/13/6-15}
was a lack of understanding generally within GMP of the importance of zoning. That lack of understanding may well be present elsewhere in the country. It must be addressed. That is a job for CTPHQ.

13.266 I am satisfied that, had he engaged in a careful and informed assessment of risk, Inspector Sexton should have concluded by no later than 22:50 that the City Room was an Operation Plato cold zone. I consider that such a clear decision at that stage would have made a difference on the night.

13.267 What in fact happened was that different emergency responders and their commanders made their own decisions about zoning and/or risk. This had consequences. For example, it led the NWAS Operational Commander, Daniel Smith, to make unduly cautious decisions about deployment as I will explain in Part 14. If Inspector Sexton had made and communicated the right decision as to Operation Plato zoning, that should have given Daniel Smith the confidence to commit additional specialist and non-specialist resources forward.

13.268 Fourth, the fact that Inspector Sexton failed to give any thought to zoning meant that, not only did he make no decision in that regard, he was
not in a position to reconsider that decision.\textsuperscript{337} Such reviews of zoning decisions are critical, given their impact on deployment. JOPs 3 made that clear,\textsuperscript{338} although in my view it was a matter of common sense. There were a number of points in time at which Inspector Sexton should have reviewed his position on zoning.

13.269 Overall, the failures of Inspector Sexton were serious and far-reaching in effect.

13.270 A number of senior GMP witnesses expressed the view that the things Inspector Sexton failed to do were straightforward.\textsuperscript{339} That was also the position of GMP in its closing statement to me.\textsuperscript{340} I regard that as an over-simplification, and unfair to Inspector Sexton. In a situation where someone becomes overburdened, they may be just as likely to overlook something straightforward as something complicated.

13.271 I am satisfied that the burden placed on Inspector Sexton on the night of the Attack was too great. It overwhelmed Inspector Sexton. While this does not excuse Inspector Sexton’s failures, it does mitigate his culpability.

\begin{footnotes}
\item[337] 99/45/2-46/6
\item[338] INQ008372/15
\item[339] 130/178/7-179/3, 137/235/4-236/15
\item[340] 186/52/14-22
\end{footnotes}
13.272 As I set out in Part 12, GMP had known, for several years, of the risk that the FDO would be overwhelmed in an Operation Plato situation. GMP should have put in place proper mechanisms of support for the FDO, such as ensuring that action cards were implemented, were well understood and utilised to achieve systems of delegation. GMP failed to do so. I regard that failure as very serious.

13.273 Looking as a whole at what went wrong in GMP Control on 22nd May 2017, GMP’s culpability is substantial.

Firearms officers and Operation Plato zoning

Containing the scene

13.274 In the UK, police officers do not generally carry firearms. Instead, substantial investment has been made by policing in a network of Authorised Firearms Officers. They provide the primary armed response to no-notice incidents such as terrorist attacks. They operate in Armed Response Vehicles. I will refer to Authorised Firearms Officers as ‘firearms officers’.

13.275 At 22:41:27, the first GMP Armed Response Vehicle arrived in the area of the Victoria Exchange Complex. The vehicle drove along Station Approach before travelling down Hunts
Bank and onto Victoria Street. Less than half a minute later, a second Armed Response Vehicle arrived. 341

13.276 By 22:42:44, PC Tyldesley and PC Dalton, both firearms officers, had entered the Arena via the Trinity Roller entrance, 342 having arrived on Trinity Way in a further Armed Response Vehicle. They then proceeded up the internal staircase and towards the City Room. 343

13.277 Seconds later, at 22:42:52, two more firearms officers, PC Moore and PC Simpkin, ran into Manchester Victoria Railway Station from Station Approach. They ran straight up the staircase leading to the raised walkway and on towards the City Room. They were accompanied by PC Roach of BTP, who had already been into the City Room. 344 PC Moore had visited the Arena before the night of the Attack, so was familiar with its layout. 345

13.278 In broad terms, PC Tyldesley and PC Dalton were approaching the scene of the bombing from the north and PC Moore and PC Simpkin were approaching from the south. This was an

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341 53/14/4-18
342 53/16/25-17/10, INQ035612/75
343 136/85/23-86/19
344 53/17/16-18/11, INQ035612/78-79
345 102/111/24-12/15
obviously sensible tactic in seeking to locate and neutralise any terrorist armed with a firearm.

13.279 By 22:43:21, two more firearms officers were within the Victoria Exchange Complex. Those officers were PC Richardson and PC Lewis Adams. Like PC Tyldesley and PC Dalton, they had entered the building via the Trinity Roller entrance. They, too, began to make their way towards the City Room.  

13.280 By 22:43:35, PC Moore and PC Simpkin had almost reached the doors to the City Room. Seconds later, they entered. They emerged at 22:44:37, having spent almost exactly a minute at the seat of the explosion. When he gave evidence, PC Moore explained what he and PC Simpkin spent that minute doing. I will reach that important part of his account in paragraphs 13.289 to 13.292.

13.281 PC Moore had joined GMP in 2004, following service in the British Army. His previous career meant that he had some familiarity with explosives. He had been a firearms officer for six years and qualified as an Operational Firearms

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346 101/70/8-71/3 [Note: PC Lewis Adams is mistakenly referred to as PC Adam Lewis on Day 101; this is corrected on Day 102]
347 INQ035612/85
348 INQ035612/91
Commander in late 2016. By 22\textsuperscript{nd} May 2017, PC Moore was an experienced firearms officer.\textsuperscript{349}

13.282 On the night of the Attack, PC Moore and PC Simpkin were monitoring the GMP firearms radio channel when, shortly after 22:30, they heard reports of an explosion and possible gunshots at the Arena. They immediately made their way, in an Armed Response Vehicle, to the scene. On the way there, they learned that PC Richardson had been made the Operational Firearms Commander and that the FDO had granted Firearms Authority.\textsuperscript{350}

13.283 PC Moore and PC Simpkin parked on Station Approach. In his evidence, PC Moore described seeing injured people. It was immediately obvious to him that something significant had happened.\textsuperscript{351} Recognising the urgency involved in the situation, PC Moore and PC Simpkin deployed to the scene straight away, without putting on their extra personal protective equipment (PPE).\textsuperscript{352} They put the protection of the public above their own personal safety.

13.284 As I explained earlier in this Part at paragraph 13.152, at about the time he entered the station, PC Moore spoke to PC Roach of BTP. PC Roach

\textsuperscript{349} 102/75/5-25
\textsuperscript{350} 102/76/19-78/24
\textsuperscript{351} 102/79/14-81/2
\textsuperscript{352} 102/132/25-133/12
had already been into the City Room and told PC Moore that there were many casualties in that location. That enabled PC Moore to pass a clear message to the FDO. At 22:43:05, as he ran up the stairs leading to the raised walkway, PC Moore broadcast a message to the FDO making clear that a bomb had detonated, causing major casualties.\textsuperscript{353} He added, “… \textit{Operation Plato, Operation Plato}”.\textsuperscript{354} In evidence, PC Moore explained that on the basis that there existed the material possibility of an active shooter, he considered that he and his colleagues were dealing with an Operation Plato situation. In such circumstances, as PC Moore observed: “[\textit{E}very second counts].”\textsuperscript{355} Therefore, he sought to communicate his message to the FDO quickly by using the shorthand operational name for a Marauding Terrorist Firearms Attack.\textsuperscript{356}

13.285 PC Moore’s thinking was clear and appropriate. He communicated his assessment to the FDO promptly and effectively.

‘Raw check’ of the City Room

13.286 PC Moore and PC Simpkin ran into the City Room. They were the first firearms officers to
enter. While I recognise that this is what they were trained to do, their actions were undoubtedly brave.

13.287 In evidence, PC Moore described what confronted the two of them. It was immediately apparent to PC Moore that there were many dead and injured in the room. He also saw BTP officers, Arena staff and members of the public. Nothing, he explained, could have prepared him for what he saw and had to deal with. He wanted to stop and help the casualties, but believed that his sole responsibility was to locate and eliminate any threat.

13.288 This highlights a shortcoming in the training of firearms officers. As I shall explain in Part 20 in Volume 2-II, the evidence reveals that this shortcoming applies beyond GMP. Firearms officers should have been trained to understand that, while their primary responsibility in an Operation Plato situation is to locate and eliminate the terrorist threat, they may also have a role in providing emergency treatment to the injured. The opportunity to provide urgent treatment, even while seeking out any armed terrorist, may arise. I heard evidence that, in active combat, it is sometimes possible for soldiers to stop for seconds to treat a wounded
colleague. Furthermore, once the firearms officers have secured the area concerned, such treatment should generally be provided. I emphasise that, in making this observation, I am not raising a criticism of any officer on the night. They did precisely what they understood their training required of them.

13.289 With a view to locating and eliminating any threat, PC Moore and PC Simpkin carried out what PC Moore described as a “raw check” of the City Room. The CCTV footage shows that this took almost one minute. The raw check involved the officers carrying out a sweep to establish whether there was a gunman or secondary device in the area. PC Moore explained that excluding the possibility of a gunman was more straightforward than excluding the possibility of a secondary device.

13.290 At the conclusion of the raw check, PC Moore was satisfied that there was no “imminent threat of an active shooter”. As for secondary devices, there was a rucksack on the concourse between the City Room and the Arena bowl which seemed to PC Moore to be out of place.

359 191/101/6-102/10
360 102/100/2-13
361 INQ035612/85, INQ035612/91
362 102/100/14-101/4
363 102/102/19
364 PC Moore sensibly drew attention to this and, ultimately, the rucksack was not suspicious
but nothing of concern within the City Room itself.\textsuperscript{365}

13.291 PC Moore considered that it was the FDO’s responsibility to zone the City Room and surrounding area on the advice from the Operational Firearms Commander on the ground who would be expected to have situational awareness.\textsuperscript{366} That seems to me to be correct as a matter of hierarchy, but it did not stop PC Moore forming his own view. Given his experience, it would have been desirable for him to have communicated his view to the FDO or Operational Firearms Commander. PC Moore did not do so.\textsuperscript{367} I regard this as a training issue rather than as a criticism of PC Moore.

13.292 PC Moore considered that on arrival, prior to the raw check, the City Room was an Operation Plato hot zone. After he and PC Simpkin had “cleared through”,\textsuperscript{368} PC Moore regarded that area as an Operation Plato warm zone. He explained that he was accustomed as a firearms officer to carrying out dynamic risk assessments\textsuperscript{369} and said: “[M]y dynamic risk assessment of the foyer of that area [the City
Room] at that time was it was a warm zone and we’d be able to bring in medics.”

13.293 The radio messages show that PC Moore’s assessment that “medics” should enter was not an after-the-event rationalisation, but instead represents what he thought at the time. At 22:45, the following exchange took place over the firearms channel:

“[PC Moore] Boss, we’ve got multiple casualties top of the Victoria Train Station Entrance. I can confirm it looks like the scene of the explosion is above the train station. All available assets to that area please, medics, trauma kits etc.

[Inspector Sexton] To the Victoria entrance to the Arena?

[PC Moore] That’s correct boss. We’re talking upwards of 30 or 40 casualties.
[PC Deponeo] Angelo to the team at Victoria Station. Just by the front stairs. Got a couple of casualties. We need to go inside. Is anybody with me?

[PC Moore] Can we have all available trauma kit to the top of Victoria Station?"\(^{371}\)

13.294 I will return to these events concerning PC Moore, which all occurred within the first 15 minutes following the detonation, when I consider the issue of zoning in further detail.

13.295 PC Angelo Deponeo was another firearms officer.\(^{372}\) It is clear from what he said in this exchange that he was not far from the City Room at the time. That reflects the fact that, throughout this period, other firearms officers were arriving at the railway station.\(^{373}\) Very quickly, firearms officers were present at and around the Victoria Exchange Complex in numbers. That included the prompt attendance of a number of Counter Terrorist Specialist Firearms Officers (CTSFOs). They arrived at the Victoria Exchange Complex

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371 102/126/14-128/1, INQ024445T; some earlier versions of the transcript attributed the statements of PC Moore to PC Simpkin, but in evidence PC Moore confirmed that he was the person speaking, using PC Simpkin’s radio: 102/140/6-19

372 102/108/17-109/5

373 INQ035612/90, INQ035612/100
at 22:54. CCTV captured those officers in the building at 22:57.\textsuperscript{374} I will consider the role of such officers in further detail in Part 20 in Volume 2-II.

13.296 While PC Moore and PC Simpkin were carrying out their raw check in the City Room, PC Richardson and PC Adams,\textsuperscript{375} and PC Tyldesley and PC Dalton,\textsuperscript{376} were making their way to that location. By 22:46:30, they had arrived at the doors leading from the station concourse to the City Room.\textsuperscript{377} PC Richardson approached PC Moore. PC Moore informed him that he had carried out a “quick raw check” but that a secondary search would be necessary.\textsuperscript{378}

**Operational Firearms Commander**

13.297 PC Richardson became a police officer with Merseyside Police in 2003, following eight years in the British Army. He qualified as a firearms officer in 2007 and became an Operational Firearms Commander in 2008.\textsuperscript{379} In November 2016, he transferred to GMP for career development reasons.\textsuperscript{380} At the time of the Attack, PC Richardson was an experienced firearms officer.
13.298 I have concerns about PC Richardson’s knowledge of the police response to a declaration of Operation Plato. His understanding in 2017 was that Operation Plato was the response to a terrorist attack, as opposed to being the response to a specific type of terrorist attack, namely a Marauding Terrorist Firearms Attack.\(^{381}\) His understanding of zoning did not fit precisely with the definition in JOPs 3. He said that his idea of zoning was a “general” one.\(^{382}\) He was not fully aware of the Marauding Terrorist Firearms Attack response capability of GMFRS.\(^{383}\)

13.299 PC Richardson was the Operational Firearms Commander that night.\(^{384}\) It is important that an officer performing that role should have accurate and detailed knowledge of each of these things. PC Richardson did not. This does not represent a criticism of PC Richardson personally. It represents a criticism of the training he received. That PC Richardson’s training and experience spanned both Merseyside Police and GMP\(^{385}\) generates a concern that the training of firearms officers had not sufficiently embedded these important principles not only in GMP, but more widely. As I explained in Part 12, this is an

\(^{381}\) 101/41/20-42/8, 101/62/14-18  
\(^{382}\) 101/31-36/9-19  
\(^{383}\) 101/30/21-23  
\(^{384}\) 101/2/24-3/6  
\(^{385}\) 101/3/10-15, 101/24/13-23
issue that CTPHQ and the College of Policing should address.

13.300 On the night of the Attack, PC Richardson was partnered with PC Adams. They were on patrol when they became aware of the incident at the Arena. They responded immediately to the FDO’s instruction to attend. On the way, PC Richardson declared himself the Operational Firearms Commander.\(^{386}\) Given his experience and the expectation that he would arrive at the scene at an early stage, this was an appropriate decision.

13.301 PC Richardson and PC Adams parked on Trinity Way. On arrival at the railway station, PC Richardson spoke to people there. As a result of those discussions, he initially thought he was dealing with a false alarm, so he passed a message to the FDO at 22:39 to that effect.\(^{387}\) PC Moore had arrived at the scene a little earlier on the opposite side of the complex. He had gained situational awareness from PC Roach and put the FDO right.\(^{388}\)

13.302 PC Richardson and PC Adams then headed straight to the City Room, with PC Tyldesley and PC Dalton.\(^{389}\) As they made their way there, the

\(^{386}\) 101/44/2-49/20
\(^{387}\) 101/57-60/10-15
\(^{388}\) INQ024445T/1
\(^{389}\) 101/71/1-8
sights and smells they encountered made clear to PC Richardson that they were dealing with something very significant. PC Richardson gave an instruction to the officers he was with to enter “advance mode”, in other words to speed up towards the scene of the Attack. Shortly after PC Moore and PC Simpkin had concluded their raw check, at 22:46:30, the four officers arrived at the doors dividing the concourse from the City Room.

13.303 Having been briefed by PC Moore on the concourse, PC Richardson entered the City Room, with his partner PC Adams. As he did so, he gave instructions to the other firearms officers. He positioned firearms officers on the concourse in a position to neutralise any potential armed threat coming from the Arena bowl. PC Richardson and PC Adams then performed a second sweep of the City Room. Like PC Moore and PC Simpkin, they were clear that there was no armed terrorist and no obvious secondary device within the City Room, but there could be no certainty about the absence of the latter.

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390 101/74/1-22
391 INQ035612/103
392 101/75/23-76/25
393 101/76/1-77/12
Briefing the Force Duty Officer

13.304 There is no doubt that, on leaving the City Room at about 22:48, PC Richardson made contact with the FDO. 394 The content of the exchange is, however, the subject of some controversy.

13.305 In a witness statement provided to the Inquiry dated 1st February 2020, 395 PC Richardson explained that in making contact he was seeking to respond to a request by the FDO for an update on casualties. Inspector Sexton had made that request in the course of declaring Operation Plato at 22:47. 396

13.306 PC Richardson’s recollection, as set out in his witness statement, was that in responding at 22:48, he informed the FDO that although he regarded the City Room as a “hot zone”, he considered it should be treated as a “warm zone” so that casualties could be treated and evacuated by emergency responders. 397

13.307 In evidence, PC Richardson confirmed that this was an accurate reflection of his recollection. 398 By the date of his evidence, PC Richardson had plainly become aware that the recording of the radio messages does not support his recollection

394 101/79/1-80/2
395 INQ032362/14
396 INQ024325/1-2
397 INQ032362/14
398 101/85/4-89/17
of what he said. He advanced a number of potential explanations for this. First, that he had not in fact said what he recalled having said but had experienced what he described as “perceptual distortion”. Second, that he had not pressed the talk button on the radio when he sought to transmit the message. Third, that his message was blocked by someone else transmitting on the radio at the same time.

In my view, explanations two and three can be discounted. That is because the message that PC Richardson did transmit following his sweep, and in which he believes he made mention of the issue of zoning, was captured both on the radio recording and on the recording from Inspector Sexton’s Dictaphone. The exchange of messages started at 22:48:05:

“[PC Richardson] OFC [Operational Firearms Commander] to FDO.”

“[Inspector Sexton] Go ahead.”
“[PC Richardson] At the moment we we’ve got a large number of casualties inside the entrance to the arena some are not in a good way, we’ve got er paramedics and people administering First Aid, we’ve got to consider also a secondary device err we’ve got no one else coming forward in relation to anyone else that who’s been involved with this, but we need to start getting the public out the way from the front. We’ve got 3 ARV’s [Armed Response Vehicles] inside at the moment two are armed contingency and we got a number Paramedics who are administering First Aid.”
“[Inspector Sexton] Yeah received er we’ll get the er people moved from outside the location erm to clear er a sterile area as soon as we can, and try to get more erm resources down there to clear.”

“[PC Richardson] Any Whiskey patrols who have err explosive dogs on board please.”

13.309 PC Richardson’s reference to paramedics was incorrect. The people he thought were paramedics were staff of Emergency Training UK.  

13.310 This exchange reveals that PC Richardson asked to speak to the FDO and the FDO expressly and immediately acknowledged that request. PC Richardson then spoke uninterrupted for almost 40 seconds, providing much information about his sweep but saying nothing about zoning. There is no hint of anyone else cutting in. The FDO then acknowledged what PC Richardson had said. PC Richardson is then heard, almost immediately, broadcasting a more general request for the attendance of explosives
detection dogs. He had moved on from providing a situation report. I have listened to this exchange many times. I am satisfied that this is the exchange in which PC Richardson believes he referred to zoning. He did not do so or attempt to do so.

13.311 In my view, PC Richardson was an honest but mistaken witness. He made his first statement on 31st January 2019.\textsuperscript{404} In it, he made no mention of this exchange with Inspector Sexton. The first reference to the exchange came in his witness statement of 1st February 2020,\textsuperscript{405} 31 months after the events at the Arena. The likely explanation for PC Richardson’s error is that the delay in providing his detailed account has affected his memory of events that were over quickly and obviously fraught. That delay is unfortunate for reasons that are obvious and which I will address in Part 19 in Volume 2-II.

13.312 It has been necessary for me to spend time addressing the inconsistency between PC Richardson’s recollection and the objective evidence only because it enables me to find that he made no reference to zoning over the radio that night. He has that in common with the other firearms officers and others, an issue to which I shall turn.

\textsuperscript{404} INQ025000
\textsuperscript{405} INQ032362/14
Recording events

13.313 Before I return to the chronology of events, I will deal with a related topic.

13.314 Several of the unarmed GMP officers who attended the City Room were wearing body-worn video cameras. The footage from those cameras, much of which I have watched, was harrowing, but it did provide important evidence on a number of issues. Rightly, no one suggested at any stage of the oral evidence hearings that any of that footage should be played publicly.

13.315 PC Richardson explained that the firearms officers within GMP were not, at that time, equipped with body-worn video cameras. PC Richardson considered that it would “definitely” be beneficial for all firearms officers to be deployed with body-worn video cameras in future. It is easy to see the advantages in that. In this Inquiry, it would have removed any debate about whether PC Richardson ever made a reference to zoning. It would have revealed what passed between the firearms officers at the crucial stages. It would have enabled me to see what they saw as they carried out their sweeps of the City Room. Such advantages are likely to

406 101/99/24-100/11
407 101/99/24-100/11
accrue in any serious incident in which firearms officers are deployed.

13.316 I did not hear detailed evidence on this topic, and it may be that there are reasons why firearms officers should not wear body-worn video cameras. Nevertheless, I consider it appropriate that CTPHQ and the College of Policing consider whether all firearms officers should be so equipped.

City Room secured

13.317 To return to the chronology, CCTV footage shows that, having spoken to Inspector Sexton at 22:48, PC Richardson then returned to the City Room. He remained there until he left with CI Dexter at 23:30. CI Dexter had arrived and assumed the role of Ground Assigned Tactical Firearms Commander seven minutes earlier. I will consider his role in due course, at paragraph 13.529.

13.318 On the evidence overall, it was clear to me that the City Room was entirely contained by firearms officers throughout the period from 22:48. PC Richardson described it as a “spiky bubble”.

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408 101/71/1-25
409 INQ035612/336, 101/71/9-21
410 INQ035612/302
411 101/76/11-19, 101/126/4-12
13.319 The firearms officers arrived at the Arena promptly and in substantial numbers. They bravely entered the City Room, quickly establishing that there was no active shooter and did what they could to establish that there was no secondary device in that location. They then locked down the City Room, creating an armed cordon to protect those within that area. Had a terrorist armed with a firearm sought to gain access, that person would have been killed almost immediately. While the firearms officers should have been trained to understand the need for them to provide ‘Care Under Fire’, a term I will explain in Part 20 in Volume 2-II, they were entirely successful in discharging their primary responsibility under Operation Plato.

Role of the Operational Firearms Commander

13.320 Prior to the Attack, the College of Policing had issued a document addressing the roles and responsibilities of firearms command.\(^{412}\) This was a document of general application and not specific to Operation Plato situations.

13.321 The document described the Operational Firearms Commander as responsible for the command of “a group of officers carrying out functional or territorial responsibilities related to
A tactical plan". This emphasised the importance to the Operational Firearms Commander of a tactical plan. In the context of a firearms operation, the Tactical Firearms Commander will be responsible for the provision of the tactical plan. Between 22:34 and 00:18, Inspector Sexton was the Tactical Firearms Commander.

The College of Policing document set out the role of the Operational Firearms Commander under a number of bullet points. The document emphasised the importance of the tactical plan, and the role of the Operational Firearms Commander in ensuring “the implementation of the tactical firearms commander’s tactical plan within their territorial or functional area of responsibility”.

An Operational Firearms Commander can only implement the tactical plan if given one. On the night of the Attack, Inspector Sexton provided no tactical plan to PC Richardson. He should have done. This represents a further respect in which the FDO failed that night. Throughout the critical period of the response, the FDO was too
reactive. He did not take the necessary step back in order to assess, in a structured and proactive way, what was needed to ensure that the firearms response, the broader police response and the emergency response worked. I am satisfied, for the reasons I have given, that the burden imposed upon Inspector Sexton largely explains this failure.

Operational Firearms Commander’s situation reports

13.324 A further requirement of the Operational Firearms Commander role, as described within the College of Policing document, was to “update the Tactical Firearms Commander, as appropriate, on current developments”. 418

13.325 During the time he spent in the City Room prior to 23:30, PC Richardson discharged this responsibility by passing a number of situation reports to the FDO over the firearms channel. I am satisfied that he provided relevant and up-to-date information. I am also satisfied that PC Richardson gave clear indications of what was needed to enable the emergency response to make progress. In particular, PC Richardson made clear that more NWAS staff were needed in the City Room.

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418 INQ004140/5-6
13.326 In a radio transmission at 22:53, PC Richardson stated: “[W]e just need more ambo staff, paramedics, anyone that they can get hold of please.” In evidence, he clarified that he was referring to a need for medically trained staff in the City Room. Inspector Sexton replied: “Yes, I’ve obviously declared Operation Plato and I’m trying to get as many NWAS down there as possible.”

13.327 This exchange took place after PC Richardson had been into the City Room and seen the devastation there. It was obvious to him that emergency responders, able to provide treatment and evacuate casualties, were needed urgently and in numbers. In evidence, PC Richardson confirmed that the FDO’s response at 22:53 reassured him that steps were under way to get additional paramedics into the City Room.

13.328 A short time earlier, PC Richardson’s partner, PC Adams, transmitted a message to the FDO in similar terms. That exchange took place at 22:50:
“[PC Adams] Yeah boss so far I probably estimated we’ve got about 10 fatalities and probably 50-60 wounded and being worked on erm we do need a lot more trauma kits and staff etc.”

“[Inspector Sexton] … obviously I’ll feed this back to er NWAS to try and get as many resources they have got as we can, erm obviously you’re getting 3 ARV’s [Armed Response Vehicles] from the Airport to come and assist and we are trying to clear the personnel from outside in case there is a secondary device or a er another offender.”

PC Adams had been in the City Room with PC Richardson. It is obvious that, like PC Richardson, he would have been reassured by what he was told by the FDO that real attempts were being made to get paramedics to the City Room.
13.330 Inspector Sexton took no steps to secure that outcome.\textsuperscript{426}

13.331 In evidence, Inspector Sexton did not accept that it was ‘unfortunate’ that he told the firearms officers that he was going to seek the attendance of NWAS resources and then did nothing about it.\textsuperscript{427} He said that he assumed that NWAS would be arranging their own resources. Inspector Sexton recognised that JESIP was designed to avoid the making of such assumptions, which might or might not be correct.\textsuperscript{428}

13.332 Inspector Sexton’s failures were, as I have explained, one of the main reasons why JESIP failed.

13.333 I cannot say what would have happened if PC Richardson had not been misled into believing that the FDO was working hard to get paramedics into the City Room. I recognise that unarmed officers were asking for that to happen in any event and that this made no material difference to the response of NWAS.

13.334 However, if the Operational Firearms Commander had known that the FDO was not doing anything to secure the attendance of paramedics in numbers, there is a realistic

\begin{flushright}
\textsuperscript{426} 98/46/14-47/15  \\
\textsuperscript{427} 98/48/1-5  \\
\textsuperscript{428} 98/48/1-20
\end{flushright}
possibility that PC Richardson would have done more himself. There are a number of obvious steps he might have taken: chasing the FDO; seeking the guidance of Inspector Smith, the Operational/Bronze Commander who was in the City Room; trying to communicate with the NWAS Operational Commander; and directing firearms officers to provide initial trauma care.

13.335 Inspector Sexton’s failure to act on the requests of the Operational Firearms Commander and PC Adams, for paramedics to attend, was a serious failure.429

Operation Plato zoning

13.336 The concept of zoning is critical to Operation Plato.430 That is because the designation given to a particular area determines, subject to operational discretion, which emergency responders are able to enter that area.

13.337 In the aftermath of the Attack, the most seriously injured casualties were in the City Room. Immediately after the declaration of Operation Plato, it was essential that consideration was given to the appropriate zoning of that area. That consideration did not happen.431

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429 98/45/16-48/20
430 146/176/14-177/5
431 98/45/16-48/20
13.338 At 22:45, immediately before the declaration, Inspector Sexton spoke to PC Moore over the firearms channel. By this time, PC Moore had been into the City Room. From that exchange, Inspector Sexton discovered that there were upwards of 30 or 40 casualties, and as many medics and as much medical equipment as possible were needed.\(^432\)

13.339 At 22:48,\(^433\) immediately after the declaration, Inspector Sexton spoke to PC Richardson over the firearms radio channel. In that exchange, it was emphasised by PC Richardson that there were many badly injured casualties, that they were being treated by unarmed responders who were present and providing treatment, and that no one was suggesting that anyone other than the bomber was involved, but consideration needed to be given to the possible presence of a secondary device.\(^434\) PC Richardson had been into the City Room at the time of this exchange, as was apparent from what he said.\(^435\)

13.340 Accordingly, by 22:50, Inspector Sexton was well aware that there were multiple casualties in the City Room. He knew that some unarmed responders were present and providing

\(^{432}\) 102/126/23-127/24
\(^{433}\) INQ024325/2
\(^{434}\) INQ024325/2
\(^{435}\) INQ024325/2
treatment. He also knew that many more emergency service responders were required in order to care for and/or evacuate the casualties. It was his responsibility as the FDO to take reasonable steps to ensure that treatment and evacuation could be achieved. Making the right Operation Plato zoning decision in relation to the City Room was critical to that aim.

Had Inspector Sexton discharged his duties adequately, he would have ascertained from PC Richardson at 22:48 that the City Room had been swept on two separate occasions by two separate teams of experienced firearms officers. He would have ascertained that the firearms officers were confident that there was no active shooter in the City Room. Inspector Sexton would have ascertained that the area was contained and that no armed terrorist could gain access to the City Room. Inspector Sexton would have ascertained that, while the firearms officers could not exclude the possibility of a secondary device in the City Room, they had seen nothing to indicate that such a device was present.

In fact, Inspector Sexton ascertained none of that information at that time, or even soon afterwards, beyond his understanding that a secondary device was a possibility.

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436 INQ039970/6-7, INQ000781/1-2
437 101/156/23-158/7
13.343 Had Inspector Sexton discharged his duties adequately, by 22:50, he would have been in a position to make an informed decision about the Operation Plato zoning of the City Room.

13.344 At the time of the Attack, JOPs 3 defined the Operation Plato zones as follows:

**Cold zone**
An area where it has been assessed that there is no immediate threat to life.

**Warm zone**
An area where the attackers are believed to have passed through but could enter/re-enter imminently. These areas cannot be guaranteed as safe.

**Hot zone**
An area where the attackers are present and/or there is an immediate threat to life.\(^{438}\)

13.345 In May 2017, unlike now, Operation Plato focused solely on a Marauding Terrorist Firearms Attack.\(^{439}\) That gives rise to the question of whether the immediate threat to life raised in the definitions of Operation Plato cold zone and hot zone must be a threat from a firearms attack or may arise from a different threat, such as a secondary explosive device. Similarly, the

\(^{438}\) INQ008372/4-5

\(^{439}\) 60/6/10-7/17
question of safety arises in the definition of an Operation Plato warm zone: does safety mean safe from a firearms attack or safe from all forms of attack, including by a secondary explosive device?

13.346 The Operation Plato definitions could have been clearer, particularly in the definition of a cold zone. However, in my view, the definitions, including the references to immediate threat to life and safety, should have been read as referring solely to a firearms threat. 440 I have reached that conclusion for the following three reasons.

13.347 First, in May 2017, a declaration of Operation Plato was one that should only have been made if there was a proper basis for believing that a firearms threat existed. If there was no such basis, Operation Plato would not be an appropriate declaration. 441 Absent a declaration of Operation Plato, no issue of JOPs 3 zoning arises.

13.348 Second, specialist responders from the ambulance service and fire and rescue service are able to operate in a warm zone because they have PPE providing ballistic protection. 442

440 INQ008372/4-5
441 INQ016688/7-8
442 105/67/1-25, 114/181/21-182/13, 119/104/17-105/14
In 2017, that PPE provided no reliable protection from an explosion. As a result, the issue of safety in the definition of a warm zone must be understood by reference to a firearms threat: responders and those present in the zone were not safe from the threat of an explosion. It would be surprising if the Operation Plato warm zone had that narrow focus of only firearms and the other two zones a broader focus of firearms and explosions.

13.349 Third, my interpretation accords with that of CTPHQ. That was the effect of the evidence of CI Thomas, to whom I have referred earlier, at paragraph 13.174. The relevant exchange with Counsel to the Inquiry during his evidence on 7th September 2021 was as follows:

“Q. If a point is reached at which there is no armed attacker within a particular area and where the police, by which I mean armed police, have control of the area, so they have armed officers within the area covering all points of potential entry by armed terrorists, does it follow that that area cannot be a hot zone in accordance with JOPs 3 and the refreshed guidance?"
A. In line with the guidance, yes.

Q. Does it follow, moreover, if the police have control of that scene, in circumstances in which there might be an IED [Improvised Explosive Device] somewhere but there is no obvious sign of one, that that area is also not a warm zone?

A. So if there is control of the area – so to go back to the definitions of the zones, so if the attackers are believed to have passed through that area but they can’t re-enter by whatever control measures have been put in place, and you’ve secured that area, then by definition I would suggest that that then becomes a cold zone because, by the control measures you’ve placed around that area, you are making that area safe, you’re preventing the attackers coming back in there, and you don’t believe the attackers are already within it, so you are therefore creating a safe environment to deploy your responders.”  

13.350 Given that the Operation Plato risk assessment related only to the threat from firearms, it would have been better if JOPs 3 had made clear that a second risk assessment was also required. This

445 141/70/23-71/11-21
second risk assessment would cover not only the potential threat from a secondary device, but also from risks that should routinely be assessed during a Major Incident, such as structural collapse, gas leak and fire.

13.351 It follows, from my conclusion that the Operation Plato risk assessment related only to the threat from firearms, that in the circumstances of 22nd May 2017 the decision that Inspector Sexton ought to have made at 22:50, had he adequately informed himself, was that the City Room was an Operation Plato cold zone.

13.352 That decision, if communicated to GMP’s emergency service partners promptly after 22:50, along with or shortly after communication of the declaration of Operation Plato and a further assessment of the risks, should have resulted in both the specialist and non-specialist resources of NWAS and GMFRS deploying into the City Room on arrival. That would have resulted in much swifter treatment and swifter and more appropriate evacuation of casualties. That should have saved John Atkinson’s life.

13.353 As I explained in paragraphs 13.264 to 13.268, on the night of the Attack, Inspector Sexton did not make that decision, or indeed any decision, about Operation Plato zoning. As with his other
failures, he overlooked this vital aspect of his role.

13.354 As I observed when considering the role of the FDO in the emergency response, a striking feature of the evidence is that the FDO did not give any direction at any stage about Operation Plato zoning, and no officer on the ground asked the FDO about that issue or gave him any advice in that regard.446

13.355 The evidence indicates that it was only once CI Dexter arrived at 23:23 and assumed the role of Ground Assigned Tactical Firearms Commander that there was any discussion about the important issue of Operation Plato zoning,447 even though his approach involved a degree of expediency, as I shall set out. So widespread was the failure to consider zoning on the night, that it reveals this is an issue of training and education. This issue may exist elsewhere in the country. It should be addressed by CTPHQ.

Deployment of explosives detection dogs

13.356 Although I am clear that the City Room should have been zoned under Operation Plato as cold, I recognise that the possibility of a secondary device was one that could not be ignored. In that

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446 99/45/2-46/6
447 106/175/14-177/5
regard, the layout of the Arena created an issue that needed to be resolved.

13.357 The City Room leads to the Arena concourse. This, in turn, leads to the Arena bowl. The Arena bowl is a very large area. It is capable of accommodating 21,000 people, depending upon the configuration adopted.448 Furthermore, there were rooms off the concourse and elsewhere, some of which were locked on the night. The firearms officers were understandably concerned that there might be a secondary device in the City Room or elsewhere within the Arena. They were also ensuring that there were no terrorists hiding. Making sure the entire area was safe was a considerable task.449

13.358 PC Richardson made the right decision, at an early stage, when he dispatched a team of firearms officers and CTSFOs, including PC Moore, into the Arena bowl and surrounding area in order to carry out a search. However, it would have been contrary to common sense and contrary to their training for those officers to open any of the discarded bags that were present in order to check for bombs. That is why explosives detection dogs were required. Such dogs are trained to sniff and indicate whether explosives are present. Explosives detection
dogs would, therefore, have been invaluable in the Arena on the night of the Attack.\textsuperscript{450}

13.359 From an early stage, PC Richardson made requests for an explosives detection dog. He made such requests of the FDO at 22:53\textsuperscript{451} and 23:01.\textsuperscript{452} He made direct contact with a GMP dog handler, PC Mark Kay, at 23:04.\textsuperscript{453} Inspector Sexton took steps to attempt to secure the attendance of an explosives detection dog, but it was not until 23:47 that such a dog arrived.\textsuperscript{454}

13.360 CCTV captured BTP dog handler PC Philip Healy on the raised walkway just outside the City Room with his explosives detection dog, Police Dog Mojo, at 23:47:01.\textsuperscript{455} By 23:47:24, the handler and dog were conducting a search in the City Room.\textsuperscript{456}

13.361 Both the FDO and the firearms officers on the ground were frustrated by the length of time it took for an explosives detection dog to arrive at the scene. That is no criticism of PC Healy, who I accept responded as soon as he was able. However, it is striking that no explosives detection dog arrived at the scene until more than 75

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\item 102/117/7-25
\item INQ024325/5
\item INQ024325/10
\item INQ018840T/4, 101/106/2-10
\item 101/83/9-84/7
\item INQ035612/391
\item INQ035612/392
\end{enumerate}
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minutes after the explosion and nearly 55 minutes after the first request was made. Even then, it was just a single dog. Although not entirely clear from the evidence, it seems that it was not until after 00:11 that the first GMP explosives detection dog arrived.457

13.362 The early attendance of explosives detection dogs would have enabled prompt confirmation that there was no secondary device in the City Room. Any sensible assessment at that stage would have recognised that: there was neither an active shooter nor a secondary device in the City Room; the location was encircled by firearms officers and any armed terrorist attempting to enter from outside was likely to be neutralised within seconds; and, therefore, the City Room was undoubtedly a cold zone, whatever the correct interpretation of the definitions of the zones in JOPs 3.

13.363 Given that the approach to Operation Plato zoning was wholly inadequate on the night, I cannot say with confidence that such prompt confirmation would have generated this line of reasoning. However, given the concern of those on the ground to secure the attendance of an explosives detection dog, it is a realistic possibility that it would have made a difference.
That underlines the importance of GMP and all other police services having in place an effective system for the prompt deployment of explosives detection dogs.

13.364 In the circumstances, I recommend the Home Office, CTPHQ and the College of Policing consider issuing guidance for such deployments. On the face of it, this took too long to achieve on the night of the Attack.

**GMP Operational/Bronze Commander**

**First notification**

13.365 At 21:00 on 22\(^{nd}\) May 2017, Inspector Smith commenced a night shift. He was due to work until 07:00 the next morning. During that shift, Inspector Smith was one of two Inspectors with operational responsibility for the City of Manchester Division of GMP. His specific geographical responsibility included the city centre of Manchester. This covered the Arena. His team of officers was responsible for dealing with incidents requiring an immediate or priority policing response.\(^{458}\)

13.366 By the date of the Attack, Inspector Smith was a highly experienced police officer. He had joined GMP in 1992. He was promoted to the rank of Sergeant in 1998 and to the rank of Inspector in

\(^{458}\) INQ006990/1
2008. Between those dates, he undertook a firearms training course and became qualified as a police search advisor. In 2012, as I explained in Part 12, he qualified as a public order Bronze Commander and subsequently performed the role of Operational/Bronze Commander on many occasions, although never in relation to an incident anything like as large or as serious as the Attack.\footnote{459}

13.367 In their report, the Policing Experts described Inspector Smith as “an officer with considerable experience, command ability and fortitude”.\footnote{460} I agree with that description. On the night of the Attack, Inspector Smith went to the Victoria Exchange Complex and voluntarily assumed operational/bronze command for the unarmed officers within the City Room. In that role, he conducted himself with bravery, authority, resourcefulness and skill.

13.368 Shortly after 22:30, at an early stage of his shift, Inspector Smith walked into Central Park Police Station. He intended that location to be his base for the night. Central Park Police Station is just short of three miles from the Arena to the northeast.\footnote{461}
13.369 At 22:34, almost as soon as he arrived at Central Park, Inspector Smith received a radio message from GMP Control, informing him that there had been an explosion “at the foyer McDonalds at the Manchester Arena. Upwards of 30 to 40 people injured.” The operator provided Inspector Smith with the Force Wide Incident Number. He replied to say that he would look at the incident log and then go to the Arena.

**Journey to the Arena**

13.370 Inspector Smith read the master incident log and realised that something significant was occurring at the Arena. Within two minutes of being contacted by GMP Control, Inspector Smith was in a marked patrol car, speeding to the Arena on blue lights and a siren. He was with Sergeant James McGowan. Sergeant McGowan had been working the same shift as Inspector Smith as part of his team. He was present when Inspector Smith read the master incident log, and he volunteered to accompany him to the Arena.

13.371 At 22:36, on his way to the Arena, Inspector Smith made contact with GMP Control, to seek an update. The operator asked him to
nominate an RVP and Inspector Smith selected the “parking area outside the cathedral”. This was a few minutes’ walk from the Arena and was a sensible RVP on the basis of what Inspector Smith knew at that stage. This RVP was recorded on the incident log at 22:37:16 as “RVP CATHEDRAL CAR PARK AREA”.

During this same conversation with the Control Room Operator, Inspector Smith asked the operator to do two things: first, to seek further information from a 999 caller who had provided information about casualties; and second, to contact the Night Silver, Temporary Superintendent Nawaz. No doubt Inspector Smith had in mind that it was important that a tactical plan should be in place by the time he arrived at the Victoria Exchange Complex. Temporary Superintendent Nawaz, who had been notified of the Attack by the Force Duty Supervisor at 22:39, was responsible for the preparation of that plan and should have prepared and provided that plan shortly after he assumed the role of Tactical/Silver Commander at 22:50.
13.373 Within two or three minutes of becoming aware of the events at the Arena, Inspector Smith had begun to travel to the scene of the Attack. He had nominated an RVP and taken steps to ensure that others within the command structure were aware of what he was doing. He had taken the initiative. This was good leadership.

13.374 At 22:40, four minutes away from the Victoria Exchange Complex, Inspector Smith made contact with GMP Control once more. By now, he had received information that indicated that nothing of concern was occurring directly outside the railway station. He therefore reconsidered the RVP and decided that officers could and should travel directly to the scene. As a result, Inspector Smith instructed the operator to direct all officers directly to Manchester Victoria Railway Station. His intention was that this location should be recorded on the incident log as the new RVP. That should have happened. It did not, and this was to result in problems in due course.

13.375 The 22:37 Cathedral car park RVP was communicated to NWFC but rejected by GMFRS when relayed on. I will deal with this in Part 15.
NWFC was never told about what Inspector Smith said to GMP Control at 22:40. The fact that Inspector Smith had directed “officers”, which I would have expected to have been understood as non-specialist emergency responders, to the scene was never communicated to NWFC or GMFRS. Whether knowing that non-specialist police officers were being directed to the scene would have made a difference to GMFRS’s initial decision to stay away is, in my view, unlikely. Nonetheless, an opportunity for joint working was lost because of the failure to co-locate at an agreed RVP.

13.376 This was not the fault of Inspector Smith, who had sought to establish a clear and appropriate RVP. The failures are, however, illustrative of the chaotic overall approach of the emergency services to the RVP. This was at the heart of what went wrong that night. An RVP was critical to effective joint working. The approach of the emergency services to this important issue reveals a fundamental failure across all emergency services to adhere to the vitally important principles of joint working. That is a criticism which features frequently across this Volume of my Report.
13.377 Before dealing with Inspector Smith’s arrival at the scene, it is important to record an omission on the part of Inspector Smith. Any police officer may declare a Major Incident on behalf of the police. The events in the City Room were indisputably a Major Incident within the parameters of the GMP Major Incident Plan.

13.378 Having assumed the role of Operational/Bronze Commander, Inspector Smith should have taken steps to ensure that a Major Incident had been declared and, on establishing that it had not been, should have taken that step himself. Inspector Smith himself expressed the matter as follows:

“I think it was without a doubt a major incident, but I probably assumed that either the FDO or Silver Commander had already declared that. For completeness, I certainly should have declared it and that was an oversight by me.”

13.379 While Inspector Smith was correct to acknowledge this omission, it seems to me to be largely a consequence of the FDO and the Night Silver’s lack of communication with him. The FDO never made contact with Inspector

477 102/147/3-19, 102/159/25-160/10
478 102/159/25-160/10
479 INQ007279/7
480 102/159/25-160/10
Smith. The Night Silver only made contact once, and even then only for an update. Inspector Smith performed to a high standard that night. The positive contribution he made to the emergency response far outweighs this single, limited omission.

Arrival at the Arena and initial entry into the City Room

13.380 CCTV footage shows the vehicle containing Inspector Smith and Sergeant McGowan arriving on Station Approach at 22:44:31. On leaving their patrol car, they stopped to check on casualties in the area, and Inspector Smith contacted GMP Control to direct closing off the surrounding roads.

13.381 By 22:45:21, so within 15 minutes of the explosion, Inspector Smith had entered the Victoria Exchange Complex via the War Memorial entrance. As he did so, he passed a message to GMP Control to make clear that he had been told that there were major casualties inside and that he intended to go to where those casualties were.
13.382 Following a brief discussion with firearms officers, Inspector Smith and Sergeant McGowan ran towards the City Room. On the raised walkway, Inspector Smith spoke to a BTP officer in order to gain further situational awareness. By 22:47:51, he had entered the City Room. This was within 17 minutes of the explosion and within 14 minutes of being informed by GMP Control that an incident had occurred. Inspector Smith had acted with speed.

13.383 By the time he entered the City Room, Inspector Smith had decided that he should perform the role of Operational/Bronze Commander. This meant that it was his responsibility to implement the tactical plan on the ground. The development of the tactical plan was the responsibility of the Tactical/Silver Commander. At 22:39, Temporary Superintendent Nawaz was notified of the Attack. He became Tactical/Silver Commander for the incident at 22:50 when he spoke to the FDO. He was replaced by Temporary Superintendent Hill at 00:00 on 23rd May 2017. At no stage did

488 INQ035612/102
489 INQ035612/104
490 INQ035612/106
491 INQ035612/113
492 102/191/23-193/18
493 INQ007279/21-22
494 INQ007279/17, INQ007279/18
495 103/51/16-52/5
Temporary Superintendent Nawaz provide Inspector Smith with a tactical plan or indeed with any tactical direction. 496

13.384 The only contact Temporary Superintendent Nawaz made with Inspector Smith was at 23:38, 497 when communication occurred by telephone. In evidence, Temporary Superintendent Nawaz explained that he had made contact with Inspector Smith because he knew he was “Bronze on the ground”. 498 In this conversation, Temporary Superintendent Nawaz sought an update, 499 which was an appropriate request given that Inspector Smith was at the scene. However, Temporary Superintendent Nawaz provided no tactical guidance, which represents a failure on his part. This contact by Temporary Superintendent Nawaz was also, as I shall make clear when considering the role of tactical/silver command in due course, far too late.

13.385 Omitting to provide a tactical plan to Inspector Smith represents a significant failure of the GMP command structure on the night. Temporary Superintendent Nawaz is principally at fault in that regard, but ACC Ford, the Strategic/Gold Commander, should have realised that tactical...
command had failed.\textsuperscript{500} She should have ensured that the failure was corrected.

13.386 In this respect, Inspector Smith’s experience resembles that of PC Richardson. In the City Room, PC Richardson was Operational Firearms Commander and therefore Operational/Bronze Commander for the firearms operation. Inspector Smith was Operational/Bronze Commander for the unarmed operation. Like Inspector Smith, PC Richardson was provided with no tactical plan. In his case, the failure was that of the Initial Tactical Firearms Commander, Inspector Sexton. The failure within the GMP command structure in relation to tactical planning was therefore wide-ranging and not restricted to a single individual.

**Inspector Smith’s plan**

13.387 Inspector Smith was left to devise and implement his own plan. To his credit, he did so. That involved making decisions at a strategic, tactical and operational level.\textsuperscript{501} Once he had arrived in the City Room, his plan had two stages.\textsuperscript{502} First, there were many severely injured people in the City Room. Their lives needed to be saved, if possible. That meant expert treatment and evacuation. Second, in the longer term, once

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lives had been saved, steps needed to be taken to preserve the area as a crime scene.\textsuperscript{503}

13.388 This was the correct plan. It gives rise to two questions.

13.389 The first question is: who was to provide the treatment that Inspector Smith identified as necessary?

13.390 In evidence, Inspector Smith was clear that the first aid training he had received prior to the Attack was: “really basic first aid; it was nothing like trauma training”.\textsuperscript{504} For example, he had never received training in the application of a tourniquet.\textsuperscript{505} This lack of training was not unique to Inspector Smith. The unarmed officers generally lacked the skills necessary to deal with catastrophic bleeding and other life-threatening conditions, something they found frustrating in the extreme.\textsuperscript{506} This was not the fault of Inspector Smith or the other unarmed officers. It was a reflection of a training regime across the country that needed to be improved if unarmed officers were to meet the challenge they faced on 22\textsuperscript{nd} May 2017. This is an important issue to which I shall return in Part 20 in Volume 2-II.
13.391 The upshot was that Inspector Smith and the unarmed officers were never going to be able to provide the life-saving interventions that the severely injured casualties in the City Room required. It is clear from the evidence that Inspector Smith recognised that reality immediately. As the radio messages and the footage from the body-worn video cameras of certain unarmed officers reveal, it was the clear view of Inspector Smith from the outset that paramedics in numbers were needed in the City Room.507 He repeatedly made that clear and did so robustly. I will deal with examples of that shortly.

13.392 The second question is: in view of the declaration of Operation Plato, how was Inspector Smith’s wish for the attendance of paramedics to be achieved? As I have made clear, a declaration of Operation Plato, as had occurred by that stage, ought to be accompanied by a designation of zones. Such zoning will affect which emergency responders are able to respond in which areas.

13.393 A striking feature of the evidence was the limited extent to which Inspector Smith was aware of the meaning and the consequences of an Operation Plato declaration.508 He had heard of Operation Plato and knew that it was the response to a
terrorist attack but did not know that it related specifically to a Marauding Terrorist Firearms Attack. He had received no training in zoning, so if someone had mentioned a particular zone that night, he would have needed to ask questions in order to understand what was meant by that zone. In fact, no one mentioned zoning until after 23:30, following the arrival of CI Dexter.

13.394 Inspector Smith’s usual job was as response inspector in an extremely busy inner-city area. It is obvious that, in the event of a declaration of Operation Plato in Manchester, he might have a role to play. It is unacceptable that he should have had such an inadequate knowledge of Operation Plato. This does not represent a failure by Inspector Smith. It represents a failure in his training.

13.395 Inspector Smith was not operating on the firearms channel that night, so did not hear the FDO’s 22:47 broadcast declaring Operation Plato. In evidence, Inspector Smith explained that he was unaware of the declaration until told of it by CI Dexter following the Ground Assigned Tactical Firearms Commander’s arrival in the City.
The first meeting between Inspector Smith and CI Dexter that night can be seen on CCTV at 23:25:56. This was just before CI Dexter switched on his Dictaphone.

The two men spoke again after switching on the Dictaphone, and those discussions were captured in the recording. Operation Plato was not mentioned on those occasions. I am satisfied, however, that CI Dexter informed Inspector Smith of the declaration of Operation Plato in the unrecorded 23:25 conversation.

Accordingly, even if Inspector Smith had had a detailed and accurate understanding of Operation Plato, that would have been irrelevant to the work that he undertook during his first 38 minutes in the City Room, during which period he was unaware of the declaration having been made. This serves further to illustrate the extent of Inspector Sexton’s failure. Not only were NWAS and GMFRS unaware of the declaration of Operation Plato, but a significant figure within GMP command on the ground that night was similarly unaware of the declaration and discovered it only by chance.
13.398 While he was in the City Room and desperate for paramedics to arrive, Inspector Smith was not making his decisions by reference to zones. Instead, he made his assessment on the basis that it was “safe enough” for unarmed GMP officers, BTP officers, Arena staff and members of the public to enter and remain in the City Room.\textsuperscript{517} The City Room was under the control of firearms officers. There was no sign of any armed terrorist. While Inspector Smith could not exclude the presence of a secondary device, he considered that unlikely.\textsuperscript{518} Hence, it was his judgement that the area was safe enough for his staff, for the staff of the other emergency services and for the public who were helping the injured.

13.399 It is regrettable that no attempt was made by GMP strategic/gold or tactical/silver command to obtain the views of Inspector Smith about the issue of safety in the City Room. Inspector Smith was a highly experienced and accomplished officer who was on the ground and had situational awareness. He had some experience of firearms and a background in police searching. He had an invaluable insight that was simply never sought. His view of the issue of safety in the City Room would have been the best-informed view. It should have been obtained.

\textsuperscript{517} 102/173/3-174/25, 102/195/6-197/23, 103/5/7-12

\textsuperscript{518} 102/195/6-196/10
13.400 It follows from this analysis that Inspector Smith’s wish for the attendance of paramedics was not facilitated, as it ought to have been, by a careful, systematic designation of Operation Plato zones.

Implementation of the plan in the City Room

13.401 At 22:48:39, 48 seconds after he had entered the City Room, Inspector Smith made contact with GMP Control. He said: “It looks to me like a bomb’s gone off here. I would say there’s about 30 casualties. Could you have every available ambulance to me please.” In evidence, Inspector Smith made clear that his expectation was that this request would result in paramedics coming to the City Room in large numbers. Inspector Smith confirmed that he would not have asked for paramedics to come to the City Room unless he had thought it was safe enough for them to carry out their work there.

13.402 Fewer than 90 seconds later, at 22:50:03, Inspector Smith passed a very similar message to GMP Control. He said:

“I need the station sealing off, please. We’ve got some ARV [Armed Response Vehicle] officers here. It looks as though what I said..."
before was right. The booking hall is the seat of the explosion. It’s not the arena itself. There’s some walking wounded outside the arena but we’ve got a lot of casualties in here. Some of them look life threatening. I need every NWAS facility that we’ve got in here, please. Directly in here.”

13.403 At 22:51:19, in a further conversation by radio with GMP Control, Inspector Smith emphasised that he wanted the entrances to the railway station sealed off and added: “Sent one of the PCs outside to tell any NWAS staff they need to get in here as soon as.”

13.404 Advanced Paramedic Patrick Ennis was the first NWAS resource at the scene. At 22:50:32, just after he had entered the station through the War Memorial entrance, Patrick Ennis spoke to GMP PC Grace Barker. It is clear that Inspector Smith’s message had reached her. The following exchange took place:

“[PC Barker] Every NWAS. They want every NWAS there.”

“[Patrick Ennis] Where?”
“[PC Barker] At the booking office which is just … [upstairs].”\textsuperscript{526}

13.405 Patrick Ennis made his way to the City Room, entering at 22:53.\textsuperscript{527} Almost straight away, he was approached by Inspector Smith, and the two men spoke.\textsuperscript{528} By the time they gave evidence, neither could recall what was discussed.\textsuperscript{529} However, given Inspector Smith’s strong determination that paramedics come to the City Room and given that Patrick Ennis was readily identifiable as a paramedic, it is overwhelmingly likely Inspector Smith raised this issue with him at that stage. When he gave evidence, Patrick Ennis agreed that in this conversation it was likely that Inspector Smith was communicating not only the seriousness of the situation, but also the need for paramedic resources to attend the City Room.\textsuperscript{530}

13.406 At the end of this conversation, Inspector Smith made contact with GMP Control. He said that Patrick Ennis, whom he incorrectly but understandably identified as “Paramedic Bronze”, had arrived. Inspector Smith added: “He’s just having a look round to assess but still, if we get
any more NWAS resources, send them in as soon as, please.”

13.407 Inspector Smith showed determination and resourcefulness in seeking to get paramedics to the City Room in numbers. In his communications with GMP Control, he repeatedly made the need for paramedics clear. He ensured that an officer on Station Approach communicated that need for paramedics to Patrick Ennis. He told Patrick Ennis this himself. Inspector Smith could not realistically have done more than he did in this regard, given the other work that he was undertaking in the City Room.

13.408 At 22:49:14, shortly before Inspector Smith spoke to Patrick Ennis, a group of eight GMP officers ran into the railway station via the Todd Street entrance. They were all members of a Tactical Aid Unit. The role of such a unit is to deal with, for example, high-profile public gatherings, public order situations and large-scale disturbances. Such units operate at the sharp end of policing.

13.409 This particular Tactical Aid Unit had become aware of the events at the Arena at 22:35 and had travelled from their base immediately. Commanding the team was Sergeant Kam
Hare. His leadership that night was exemplary, as was the performance of his team.

13.410 Having arrived and liaised with officers at the scene, Sergeant Hare’s team made their way to the City Room, with Sergeant Hare in the lead. By that stage, Sergeant Hare had switched on his body-worn video camera. As the team walked along the raised walkway, Sergeant Hare’s body-worn video camera records him telling the officers to stay together and remain calm. The team entered the City Room at 22:55. Inspector Smith saw them arrive. He understood the role of a Tactical Aid Unit and the capabilities of such a team. He described them as a “can-do team” and was pleased to see their arrival.

13.411 Sergeant Hare had been told by GMP Control that Inspector Smith was in charge in the City Room. He made straight for Inspector Smith, who directed him and his team to check the casualties. Sergeant Hare shouted to his team: “Guys, first aid, first aid, first aid.” He then instructed his officers to work in pairs. One of the team asked about the arrival of ambulances, and

534 78/23/23-36/17
535 78/36/3-37/8
536 78/37/9-22
537 INQ035612/151, 78//47/15-49/7
538 103/24/11-25/3
539 78/38/17-40/3
540 78/49/1-50/10
Sergeant Hare replied: “They’re coming mate. They’re co-ordinating.” In evidence, Sergeant Hare explained that he said this on the basis that the number of injured people made the attendance of paramedics necessary, and he therefore thought this would happen.

In the period that followed, Sergeant Hare spoke to the injured, reassuring them that expert assistance was on its way; he encouraged his officers to help the casualties and exhorted his team to support each other. He and his team had received basic first aid training, but no more than that. As I have made clear, Inspector Smith was in exactly the same position: he had never received anything but basic training.

It was obvious to Sergeant Hare that many of the casualties were seriously injured and required treatment by personnel who were better skilled and equipped than his team. As time passed and it became apparent to him that paramedics were not entering the City Room, he became concerned. At 23:00, a second Tactical Aid Unit team led by Sergeant John Goodwin entered the
City Room. Sergeant Hare spoke to Sergeant Goodwin, saying: “We need the fucking medics John.” He was referring to paramedics.

13.414 Sergeant Hare continued to experience significant frustration at the fact that paramedics did not enter the City Room in numbers. At one stage, at 23:04, he shouted: “Come on paramedics.” At 23:13, another officer shouted out to him, “Kam, are the paramedics coming?” to which he replied: “Paramedics mate, they need to be coming in in droves.”

13.415 A highly unsatisfactory situation had developed. If NWAS and GMFRS were not going to enter the City Room promptly in sufficient numbers to preserve life and safely evacuate casualties, Inspector Smith needed early notice so that he could arrange an evacuation plan urgently. Ultimately, the fact that help was not coming in numbers dawned gradually on Inspector Smith, Sergeant Hare and others in the City Room.

13.416 In the absence of any significant NWAS deployment, Sergeant Hare, his team and indeed others in the City Room did what they could to provide support and treatment for casualties.

547 INQ035612/160, INQ035612/174
548 78/55/24-56/16
549 78/55/24-57/6
550 78/56/22-57/19
551 78/62/1-13
They also became heavily involved in the evacuation of casualties. 552

Involvement with those who died

13.417 GMP officers also sought to give help to those who were dying or had died.

13.418 PC Anthony Sivori covered Alison Howe. 553

13.419 PC Owen Whittell, 554 Sergeant Hare, 555 PC Lauren Moore, 556 PC David Lawrenson, 557 Sergeant Stephen Wood, 558 PC Gareth Wray, 559 PC Nicholas White, 560 Officer F2 561 and Sergeant Peter Anwyl 562 assisted Georgina Callander.

13.420 PC Whittell, 563 Sergeant Anwyl 564 and PC Thomas Ho-McKenna 565 gave CPR to Jane Tweddle. GMP officers PC Whittell 566 and Sergeant Anwyl 567 and BTP PC Corke 568 covered Jane
Tweddle when attempts at resuscitation were unsuccessful.

13.421 PC Ho-McKenna and PC Chelsea Meaney both checked on John Atkinson while he was in the City Room. When the improvised stretcher on which John Atkinson was being carried failed, PC Leon McLaughlin went to seek help from NWAS together with Special Constable Michael Dalton. GMP Sergeant Darren Prince was involved in John Atkinson’s evacuation.

13.422 Sergeant Hare sought to assist Kelly Brewster with a defibrillator. However, he found that, when he unpacked it, there were no defibrillator pads. PC Michael Williams assisted with evacuating Kelly Brewster from the City Room.

13.423 PC Sivori and Sergeant Anwyl assisted Megan Hurley. Sergeant Hare assisted Megan Hurley, her father and brother. PC Whittell gave CPR to Megan Hurley and, with others, used a defibrillator in an attempt to resuscitate her.

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569 158/18/3-6, 158/20/14-21/14
570 158/47/20-48/22
571 158/50/24-54/19
572 154/10/19-14/2
573 154/13/11-23
574 154/12/14-18
575 153/13/16-19/15, 153/20/21-22/9
576 153/11/11-12/21
577 153/8/23-10/24
578 153/9/23-18/5
Officer F2 provided CPR to Megan Hurley. Officer F2 covered Megan Hurley when the attempts at CPR were unsuccessful. PC Gareth Dennison checked Megan Hurley for signs of life.

13.424 PC Sivori checked on Nell Jones. He believed that she had died when he saw her. PC McLaughlin also checked Nell Jones for a pulse.

13.425 Special Constable Dalton was involved in finding a makeshift stretcher for Saffie-Rose Roussos. PC McLaughlin helped carry Saffie-Rose Roussos from the City Room to Trinity Way.

13.426 Sergeant Hare assisted Sorrell Leczkowski. PC McLaughlin gave CPR to Sorrell Leczkowski. Sergeant Anwyl and PC Hill also gave CPR to Sorrell Leczkowski. PC Hill was assisted by PC Michael Ball. PC Whittell used
a defibrillator in an attempt to resuscitate Sorrell Leczkowski.\textsuperscript{590}

13.427 PC McLaughlin checked on Wendy Fawell.\textsuperscript{591}

Evacuation of the casualties

13.428 Just before 23:00, NWAS Consultant Paramedic Daniel Smith arrived at Manchester Victoria Railway Station.\textsuperscript{592} Shortly afterwards, he designated himself the NWAS Operational Commander.\textsuperscript{593} Patrick Ennis left the City Room\textsuperscript{594} and went to the station concourse, where he spoke to Daniel Smith and others from NWAS.\textsuperscript{595} He then returned to the City Room at 23:05.\textsuperscript{596} I will consider these events in further detail below.

13.429 By that stage, the work of evacuating the casualties had just started. Inspector Smith was heavily involved in that work and in directing it.\textsuperscript{597} In evidence, Inspector Smith explained that, absent expert assistance and equipment: “My view was … we need to get them out as quickly as possible and we’ll use whatever we...
can to do that.” This was the correct decision. Inspector Smith understood by this time, shortly after 23:00, that resources able to evacuate casualties in a conventional way were not going to arrive imminently. He rightly took a ‘needs must’ approach.

13.430 At 23:12, having returned to the City Room, Patrick Ennis spoke to Inspector Smith. From that discussion, Inspector Smith learned that the Casualty Clearing Station was being set up on the station concourse. The evidence reveals that, from that point, the work of evacuating casualties from the City Room increased in pace. Between 23:12 and 23:42, when the last casualty arrived in the Casualty Clearing Station, 33 casualties were evacuated from the City Room. All but eight of them were evacuated on makeshift stretchers.

13.431 These casualties and their families were entitled to expect that evacuation would have occurred more promptly and in a way that was more appropriate and comfortable. That this did not occur was not the fault of Inspector Smith or any of the officers under his direction. They were...
doing the best that they could in extremely difficult circumstances.

13.432 At this stage, GMFRS had no presence in the City Room or indeed in the Victoria Exchange Complex. It is striking that neither Inspector Smith nor any of the others working to evacuate casualties were aware of their absence. On the evidence I heard, GMFRS possessed significant expertise in the extrication of casualties and considerable capacity in that regard. I would have expected their absence to have been obvious. That it was not, highlights a lack of education across the police in the capability of GMFRS. This reveals, too, that joint training had failed. The evidence revealed this to be an issue within NWAS too. I was left with a concern that there was a lack of adequate awareness on the part of each emergency service about the specialist capabilities of each other emergency service. Moreover, I am concerned that this problem may exist beyond Greater Manchester. This is an issue that needs to be addressed urgently by the Home Office, HMICFRS, the College of Policing, the Fire Service College, the National Ambulance Resilience Unit and all local resilience forums.

603 78/12/11-23, 103/38/5-39/3
604 119/78/23-79/11, 119/104/17-109/2
By 23:42, the last casualty had been evacuated from the City Room. Inspector Smith remained at the scene for many hours thereafter, eventually leaving after 04:00. While the system by which the casualties were treated and evacuated was entirely inadequate for the reasons I have set out and will develop further later in this Part, Inspector Smith had done all that he could in circumstances that were extremely trying. He provided real leadership to the rescuers and compassion to the injured. His decision-making was prompt and effective.

GMP Tactical/Silver Commander (Night Silver)

Role of Night Silver

In dealing with the actions of Inspector Smith in the policing response to the Attack, I referred to his contact with Temporary Superintendent Nawaz, the Night Silver. I will turn next to address the role of Temporary Superintendent Nawaz in further detail.

First, it is relevant to recall where Night Silver fits in to the GMP command structure. As I have explained, the command structure for the response to any Major Incident will have three levels: gold command, also known as strategic
command; silver command, also known as tactical command; and bronze command, also known as operational command.607

13.436 There will generally be a single Strategic/Gold Commander. That person’s role is to set the strategic plan. The purpose of that plan is to manage and resolve the incident.608 On the night of the Attack, ACC Ford was Strategic/Gold Commander.609 I will turn to her role specifically in due course. It will, however, be necessary for me to address some aspects of her decision-making in considering the actions of the Night Silver.

13.437 There will often be more than one Tactical/Silver Commander.610 That will enable separate Tactical/Silver Commanders to set the tactical plan for different functional areas.611 For example, where a policing response involves the deployment of both armed and unarmed assets, it may be appropriate for the armed assets to be under the command of one Tactical/Silver Commander and the unarmed assets to be under the command of a second Tactical/Silver Commander.

13.438 On the night of the Attack, a number of officers held tactical/silver command for different
functional areas. Inspector Sexton held tactical command for the overall firearms operation as Initial Tactical Firearms Commander until he was later relieved of that role by Superintendent Thompson.\textsuperscript{612} CI Dexter took the role of Ground Assigned Tactical Firearms Commander on his arrival at the scene at 23:23.\textsuperscript{613} Temporary Superintendent Nawaz was Night Silver and, in that capacity, became Tactical/Silver Commander for the scene up until he was replaced, at around 00:00 on 23\textsuperscript{rd} May 2017, by Temporary Superintendent Hill.\textsuperscript{614}

13.439 There will usually be several Operational/Bronze Commanders.\textsuperscript{615} Their role will be to organise separate resources to carry out the tactical plan.\textsuperscript{616} On the night of the Attack, PC Richardson held operational command for the firearms officers at the Arena,\textsuperscript{617} and Inspector Smith held operational command for the unarmed officers in the City Room.\textsuperscript{618} As I have explained, neither was provided with a tactical plan by their respective Tactical/Silver Commanders and that represents a significant failure of GMP command on the night.

\textsuperscript{612} 97/3/5-13, 97/109/21-24
\textsuperscript{613} 106/100/8-11
\textsuperscript{614} 104/60/21-61/1
\textsuperscript{615} INQ007279/11
\textsuperscript{616} INQ007279/21-22
\textsuperscript{617} 101/10/12-12/10
\textsuperscript{618} 102/141/14-18
13.440 As I explained in Part 12, GMP produced guidance entitled ‘Silver Commanders Guide’ for those undertaking the role of Tactical/Silver Commander. The evidence indicates that the version in force at the time of the Attack was Version 1.4. This had been introduced in 2010.619

13.441 The Silver Commanders Guide dealt with the role of Night Silver. Night Silver is the most senior GMP officer on duty at night. It is an important role so will commonly be undertaken by a Superintendent. The Silver Commanders Guide provided that:

“The night silver superintendent provides an active role within the force and attends any serious, major or unusual events; ensuring incidents are effectively managed and properly resourced. You will need to implement appropriate command and control structures, recognise the potential for an event becoming or escalating into a critical incident and protect the interests / reputation of the force.”620

13.442 Scott Wilson, one of the Policing Experts, described the role as being Chief Constable of the police service during the night.621
13.443 The Silver Commanders Guide made clear that a Tactical/Silver Commander, whether Night Silver or otherwise, commands and co-ordinates the overall tactical response pursuant to the Strategic/Gold Commander’s strategy. As part of that role, the Tactical/Silver Commander has the following responsibilities, among others: developing and co-ordinating the tactical plan; being suitably located in order to maintain effective tactical command of the incident or operation; providing the pivotal link in the command chain between Operational/Bronze Commanders and the Strategic/Gold Commander; ensuring that the tactics employed by Operational/Bronze Commanders meet the strategic intention and tactical plan; managing and co-ordinating, where required, multi-agency resources and activities during the response to an incident or operation; and ensuring that Operational/Bronze Commanders understand the strategic intentions, the key points of the wider tactical plan, and tactical objectives that relate specifically to their area of responsibility.622

Temporary Superintendent Nawaz

13.444 Temporary Superintendent Nawaz joined GMP in 2000. In 2004, he was promoted to the rank of Sergeant. He was promoted to the rank of
Inspector and, in March 2012, to the rank of Chief Inspector. In 2013, he was accredited as a public order Bronze Commander and thereafter performed that role at a number of pre-planned events, such as football games. Spontaneous events such as the Attack will present greater challenges than pre-planned incidents. In 2015, this officer was appointed as Temporary Superintendent, undertaking the role of Divisional Superintendent for Manchester City Centre. In 2016, he was accredited as a Silver Commander for public order and public safety events and thereafter performed that role at a number of pre-planned events.

13.445 On his appointment as a Temporary Superintendent in 2015, he was placed onto the Night Silver rota. Temporary Superintendent Nawaz estimated that in the two years prior to the Attack, he had performed that role on no more than ten occasions, probably fewer.

13.446 I accept that Temporary Superintendent Nawaz has sound qualities in areas of policing. However, he was not competent to perform the role of Night Silver on the night of the Attack if for no other reason than he had not had the requisite training.

623 104/1/11-25
624 104/2/9-16
625 104/2/1-21, 104/19/3-20/2
626 104/3/24-4/18, 104/19/3-14
13.447 There were a number of glaring omissions in the training, knowledge and experience of Temporary Superintendent Nawaz as of 22nd May 2017. First, he had received no training in what his role as a Superintendent would be in the event of a terrorist attack and had no recollection of ever having been involved in a training exercise involving terrorism.627

13.448 Second, he had never heard of Operation Plato. He had no idea that this represented the response to any form of terrorist attack, let alone the response to a Marauding Terrorist Firearms Attack.628

13.449 Third, as I have explained, at an early stage, Inspector Sexton authorised an emergency search. Temporary Superintendent Nawaz had no idea what this was. Indeed, he had no experience of firearms command at all.629

13.450 Fourth, Temporary Superintendent Nawaz’s experience of tactical/silver command of any type was limited and was restricted to pre-planned public order and public safety events. A spontaneous event, particularly one on the scale of the Attack, was always going to be significantly more challenging than anything Temporary

627 104/16/11-25
628 104/18/5-19/2
629 104/38/20-40/1
Superintendent Nawaz had experienced previously.  

13.451 In drawing attention to these inadequacies of Temporary Superintendent Nawaz, I have not overlooked the fact that in an Operation Plato situation, tactical firearms command will sit with the Initial Tactical Firearms Commander, and later Tactical Firearms Commander, not with the Night Silver. However, the Night Silver has a critical role in an Operation Plato response by providing tactical command for those at the scene (or scenes). The Night Silver will need to work with the firearms commanders and so will need to understand their operation. It is not possible for the Night Silver to perform that role with the level of training, knowledge and experience that Temporary Superintendent Nawaz had. The reality is that Temporary Superintendent Nawaz had little idea what was going on during the period that he held tactical command. That is unacceptable.

13.452 Temporary Superintendent Nawaz himself recognised in evidence that his training and experience did not equip him to deal with a terrorist incident.
13.453 This was also the view of ACC Ford, who was Strategic/Gold Commander on the night. She gave the following straightforward evidence:

“[Counsel to the Inquiry] I think that’s a fair assessment because he hadn’t been given training and knowledge that he should have had in order to fulfil that role that night.

[ACC Ford] That does or may reveal a systemic problem that you had someone in that critically important role that was not qualified for it.
[ACC Ford] Absolutely. And finding out in the midst of an incident, an attack, that someone doesn’t know what Plato is – and I have seen the broader evidence, sir, from the force duty officer’s team – the lack of awareness of Plato was something that organisationally GMP needs to or should have considered beforehand, which it certainly needs to consider now.}\(^{634}\)

13.454 In May 2017, as I have emphasised many times, the Joint Terrorism Analysis Centre Terrorism Threat Level was at ‘severe’. This meant that an attack was highly likely. On the night of 22\(^{nd}\) to 23\(^{rd}\) May 2017, the Night Silver on duty was not competent to perform that role in the event that such an attack occurred. GMP should have identified that fact given that it had been responsible for Temporary Superintendent Nawaz’s training and career development since 2000. Temporary Superintendent Nawaz should never have been in the position he was in. That he was represents a significant failure on the part of GMP.
Actions of Temporary Superintendent Nawaz

13.455 In the early evening of 22\textsuperscript{nd} May 2017, Temporary Superintendent Nawaz located himself at Central Park Police Station in order to perform his Night Silver duties. He was with an officer who was shadowing him for career development purposes. There could be no criticism of that officer.

13.456 At 22:39, Temporary Superintendent Nawaz received a telephone call from the Force Duty Supervisor, Ian Randall. Ian Randall informed him of the explosion at the Arena.\textsuperscript{635} Temporary Superintendent Nawaz then took steps to locate and print out a contingency plan for the Arena.\textsuperscript{636} This may have been a sensible step to take, but it took time and is something he should have delegated to the officer who was shadowing him. In fact, the plan was outdated, and Temporary Superintendent Nawaz made no real use of it. What he had done was a waste of his time. Even if the plan had proved relevant, there were more pressing things for him to have done. He should have set off for the scene immediately.

13.457 At 22:50, Inspector Sexton telephoned Temporary Superintendent Nawaz.\textsuperscript{637} He informed the Night Silver that there were confirmed deaths as a
result of a suicide bombing. The following exchange then took place:

“[Inspector Sexton] … So, I’ve declared an Op Plato, which is a terrorist attack.

[Temporary Superintendent Nawaz] Op What?

[Inspector Sexton] Op Plato, which is a terrorist attack.

[Temporary Superintendent Nawaz] Yeah.”

13.458 I am critical of GMP for putting Temporary Superintendent Nawaz into a role that he was not competent to perform. However, in this conversation, Temporary Superintendent Nawaz effectively kept his lack of knowledge from the FDO. At no stage in that conversation or in any other conversation, including in his conversations with the Strategic/Gold Commander, did Temporary Superintendent Nawaz reveal his ignorance of Operation Plato. He allowed others within the command structure to believe that he understood what was happening, when he did
not. Temporary Superintendent Nawaz should have explained that he did not understand what Operation Plato was and that he did not know what his role was within it.

13.459 If Temporary Superintendent Nawaz had done that, it is likely he would have been replaced at an earlier stage. As it was, Temporary Superintendent Nawaz retained tactical/silver command for nearly 70 minutes longer. During that time, he made no contribution of substance to the emergency response. A more experienced and knowledgeable Tactical/Silver Commander would have made a positive contribution.

13.460 At 22:52, Temporary Superintendent Nawaz telephoned ACC Ford. There is no recording of that conversation, which lasted just short of three minutes. The result of the call was that Temporary Superintendent Nawaz, who had initially intended to travel to the scene and could have been there by 23:00, instead went to GMP HQ to set up the Silver Control Room.

13.461 Throughout much of the evidence in relation to the emergency response, there was a debate between witnesses about whether the Tactical/Silver Commander should go to the scene or to
GMP HQ. 642 I will consider this issue when I deal with the involvement on the night of CI Dexter, the Ground Assigned Tactical Firearms Commander. My view is there will undoubtedly be situations in which a Tactical/Silver Commander must be at GMP HQ. That does not mean that a Tactical/Silver Commander cannot be at the scene. In most complex incidents, it is likely to be necessary to have separate Tactical/Silver Commanders at GMP HQ and the scene or scenes.

13.462 At 23:00, Temporary Superintendent Nawaz telephoned the Force Duty Supervisor. 643 In evidence, he explained that at this stage he had not reached GMP HQ. He was either still at Central Park or on his way to GMP HQ with the officer who was shadowing him. 644 In the call, Temporary Superintendent Nawaz explained that he considered a number of people ought to be contacted. With the possible of exception of the North West Counter Terrorist Unit, the Force Duty Supervisor had already contacted them all. 645 This is not a criticism of Temporary Superintendent Nawaz. It was sensible for Temporary Superintendent Nawaz to make those checks.

642 104/45/25-49/10
643 INQ018840T
644 104/50/1-51/17
645 INQ018840T
13.463 Temporary Superintendent Nawaz and the officer who was shadowing him arrived at GMP HQ at about 23:10 and entered the Silver Control Room. They were the first to arrive, but within a short time many others joined them. 646

13.464 At 23:34, Temporary Superintendent Nawaz made a radio call to ascertain “who’s the commander at scene?” He was told that it was “6694, Inspector Smith”. 647 Temporary Superintendent Nawaz was the Tactical/Silver Commander for the scene. I have listened to the recording of this call a number of times. That left me in no doubt that, at 23:34, Temporary Superintendent Nawaz was unaware of the critical role Inspector Smith was performing at the scene. 648 It is difficult to understand how he lacked that knowledge. Inspector Smith had been in the City Room for 47 minutes by this time. 649 His collar number had appeared on the incident log 40 times during that period. His voice had been heard repeatedly on the radio, seeking the attendance of paramedics.

13.465 That Temporary Superintendent Nawaz did not know what Inspector Smith was doing at the scene, and did not know what Inspector Smith

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646 104/52/15-54/8
647 INQ018616T/4
648 104/115/17-116/14
649 102/191/10-192/1
desperately wanted for the City Room in terms of help and resources, is inexplicable and inexcusable.

13.466 At 23:38, Temporary Superintendent Nawaz telephoned Inspector Smith, and they communicated for just over three minutes.\(^{650}\) As I explained when dealing with Inspector Smith’s role at paragraph 13.384, in this call, Temporary Superintendent Nawaz sought an update but provided no tactical plan or tactical guidance.

13.467 In evidence, Temporary Superintendent Nawaz was pressed on what appeared to be a failure to discharge one of his core responsibilities, namely to provide a tactical plan for implementation by the Operational/Bronze Commander.\(^{651}\) He accepted that he had not handed over what he described as “a documented plan”.\(^{652}\) However, he maintained that he had developed a 20-point tactical plan, albeit one that he had not committed to writing.\(^{653}\)

13.468 By the time he gave evidence, Temporary Superintendent Nawaz had set out those points in writing. I am not clear at what point he did so, save that it was plainly after the night of the

\(^{650}\) 104/115/17-117/12
\(^{651}\) 104/10/2-15
\(^{652}\) 104/73/10-11
\(^{653}\) 103/72/20-75/13
Attack. He provided the list to the Inquiry Legal Team following the completion of his evidence.\textsuperscript{654} It contains 19 items. It is not an impressive document. Most of the listed items are descriptions of activities rather than tactical decisions or directions. For example: “\textit{review the FWIN [Force Wide Incident Number]}” and “\textit{locate Arena plan}”.\textsuperscript{655}

13.469 Many others on the list are things that had already been done before any active involvement by Temporary Superintendent Nawaz, as any review of the master incident log would have revealed to him, such as: “\textit{BTP to be made aware and attend}”; “\textit{ARVs [Armed Response Vehicles] to scene}”; and “\textit{unarmed Bronze Commander to the scene}”.\textsuperscript{656} Where the list described sensible tactical decisions, Temporary Superintendent Nawaz had done nothing to implement them himself or to communicate to the Operational/Bronze Commander the need to do so. “\textit{GMFRS to be notified and attend}” and “\textit{Collocate, coordinate and communicate with partners}” are examples of these.\textsuperscript{657}

13.470 If this document represents Temporary Superintendent Nawaz’s cotemporaneous but
undocumented tactical plan, it serves only to emphasise how ill-equipped he was in the role of Tactical/Silver Commander that night.

13.471 Among the things that the tactical plan should have addressed were the following: ensuring that a Major Incident declaration was made and communicated within GMP and to emergency service partners; directing that a METHANE message be obtained and communicated within GMP and to emergency service partners; directing the implementation of the Major Incident Plan; setting tactical objectives, including the treatment and evacuation of casualties; joint working with emergency service partners; appointing Operational/Bronze Commanders; liaising with the FDO; establishing multi-agency tactical communications; directing the setting up of the FCP; and ensuring adequate tactical command at the scene.

13.472 None of that was addressed by Temporary Superintendent Nawaz, nor did he make any substantial attempt to address any of these important actions. He also failed to discharge all or almost all of the responsibilities of a Tactical/Silver Commander listed in the Silver Commanders Guide, perhaps because he had not read it.658 His failures are mitigated but not

658 104/6/3-7/3, 104/79/16-82/16, INQ034751/39-40
excused by the fact that GMP had not trained him adequately for the role.

Replacement of Temporary Superintendent Nawaz

13.473 As ACC Ford made her way to GMP HQ, she spoke to Temporary Superintendent Nawaz on two further occasions: at 23:10 for 13 seconds\textsuperscript{659} and at 23:12 for just short of two minutes.\textsuperscript{660} As a result of those conversations, ACC Ford developed “a growing unease”.\textsuperscript{661} She explained:

“I felt that in terms of tactical command and updates and command being applied to the situation that little had moved on or progressed since the original conversation. So, while I hadn’t – I don’t believe I’d consciously decided at that point that Arif [Temporary Superintendent Nawaz] didn’t really understand or didn’t know what Plato was, but the fact that Chris [Temporary Superintendent Hill] had offered and I had previous experience of him as an experienced commander, that gave me reassurance that he would be able to come in and apply the command and control needed.”\textsuperscript{662}

\textsuperscript{659} 105/80/25-81/6
\textsuperscript{660} 105/80/25-81/6
\textsuperscript{661} 105/84/3-17
\textsuperscript{662} 105/84/18-85/5
13.474 She agreed that even as she drove towards GMP HQ she was developing a sense that Temporary Superintendent Nawaz was “not the right man for the job in these circumstances”.663

13.475 The “Chris” to whom ACC Ford referred was Temporary Superintendent Hill, an officer who had experience in operational/bronze, tactical/silver and strategic/gold command roles and who was also an experienced firearms commander.664 He had become aware of the Attack and offered to help. He spoke to ACC Ford, and she instructed him to attend GMP HQ and take up the role of Tactical/Silver Commander.665 I find that ACC Ford acted promptly to replace Temporary Superintendent Nawaz once she became aware of the extent of the problem.

13.476 Temporary Superintendent Hill relieved Temporary Superintendent Nawaz at about 00:00 on 23rd May 2017, 90 minutes after the explosion.666 By that stage, all casualties had been removed from the City Room.667 Despite his experience and preparedness to help, by that stage there was nothing of substance Temporary Superintendent Hill could do to make a difference.

663 105/85/6-20
664 104/140/3-141/6
665 104/171/11-172/9, 105/83/8-84/17
666 104/60/21-61/1
667 INQ041266
to the emergency response at the Victoria Exchange Complex.

13.477 ACC Ford was asked whether for a prolonged period that night she lacked a Tactical/Silver Commander who was qualified and equipped to the extent that she was entitled to expect. She agreed that was so. She was right to acknowledge that fact. The role of Night Silver failed that night to an extent that was fundamental and major.

GMP Strategic/Gold Commander

Assistant Chief Constable Ford

13.478 In 2017, as now, GMP operated a rota that ensured a Strategic/Gold Commander was available when an incident required strategic command. That person, known as ‘duty Gold’, was always a qualified Strategic Firearms Commander so that if a firearms deployment was needed, duty Gold could provide strategic oversight for this deployment as well as for the response more generally.

13.479 On the night of the Attack, ACC Ford was rostered as duty Gold and duty Strategic

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668 105/84/3-86/5
669 INQ029177/9 at paragraph 40
670 105/32/8-33/14
Firearms Commander. She was a highly trained and experienced senior officer.\textsuperscript{671}

13.480 ACC Ford became accredited as a Gold Commander in early 2015, while an officer in Northumbria Police. The focus of this training was on public order.\textsuperscript{672} Having become accredited, ACC Ford performed the role of Strategic/Gold Commander on many occasions at major events in the North East. Each of those events was pre-planned, such as the Great North Run and football derby games. Spontaneous events are likely to present greater challenges than pre-planned incidents, as ACC Ford identified and emphasised when she reflected on the Attack.\textsuperscript{673}

13.481 ACC Ford had significant experience of firearms command. She became a Tactical Firearms Commander in 2010 and passed the Strategic Firearms Commander course in 2015. Between 7\textsuperscript{th} and 12\textsuperscript{th} May 2017, only days before the Attack, she attended a specialist firearms commander course.\textsuperscript{674} The aim of that course was to prepare senior firearms commanders for the additional demands of the policing response.

\begin{itemize}
\item \textsuperscript{671} 105/32/8-33/14
\item \textsuperscript{672} 105/2/20-3/13, 105/24/21-27/25
\item \textsuperscript{673} 105/166/15-168/1
\item \textsuperscript{674} 105/14/19-15/5, 105/25/25-27/25
\end{itemize}
to the most demanding operations, including counter-terrorism operations.\textsuperscript{675}

\subsection{13.482} ACC Ford stated in evidence that, although her training as a firearms commander provided a good foundation for responding to the Attack, she thought more could have been done to prepare her for the specific demands of an Operation Plato situation.\textsuperscript{676} She explained that a way needed to be found to prepare commanders for the exceptional pressures involved in responding to a spontaneous incident such as a terrorist attack.\textsuperscript{677}

\subsection{13.483} After completing her evidence, at my request, ACC Ford set out her views about this and other areas for change and improvement in a witness statement dated 28\textsuperscript{th} May 2021.\textsuperscript{678} I am grateful for her views, which are informed and instructive. She summarised her position in relation to training in Operation Plato in this way:

\begin{quote}
\textit{In my opinion, a more stringent approach is needed to testing and exercising. We need to create the stress, pressure and pace of a no notice attack to test decision making in an intense, dynamic atmosphere.}\textsuperscript{679}
\end{quote}

\begin{flushleft}
\textsuperscript{675} 105/27/8-28/12
\textsuperscript{676} 105/29/8-30/11
\textsuperscript{677} 105/221/20-226/24
\textsuperscript{678} INQ041475
\textsuperscript{679} INQ041475/7
\end{flushleft}
13.484 ACC Ford may well be describing a concept about which Pre-Hospital Care Expert Lieutenant Colonel Dr Claire Park gave evidence when the Inquiry considered the Care Gap, namely high-fidelity training.\textsuperscript{680} I will consider this in Part 20 in Volume 2-II. In any event, having performed the role of Strategic/Gold Commander on the night of the Attack, ACC Ford’s insight in this regard is one that CTPHQ and the College of Policing should take on board.

13.485 Notwithstanding that ACC Ford considered that she would have benefited from additional training, she was well aware of what Operation Plato was and what its declaration would require of her and others.\textsuperscript{681} She expressed a serious concern in evidence that not all of those involved in the emergency response were as well informed as her or, in some cases, informed at all. She explained that, as the events of the night of the Attack unfolded, it became apparent to her that many members of staff who were directly involved in the response lacked knowledge of Operation Plato, including the Night Silver and her own staff officer.\textsuperscript{682} This was plainly a surprising and disturbing revelation for ACC Ford.

\textsuperscript{680} 191/85/21-88/12  
\textsuperscript{681} 105/29/20-31/8  
\textsuperscript{682} 105/19/5-22/13, 105/116/7-117/11
13.486 I share ACC Ford’s concern. As I have explained, all officers, whether armed or unarmed, should be educated in what Operation Plato involves and what will be expected of them in the event of such a declaration. That should be so across the country.

13.487 ACC Ford had received specific training in JESIP, both on the introduction of those principles and subsequently. When she attended the College of Policing strategic command course in early 2016, part of the training involved an exercise that was focused on the importance of joint working for Strategic/Gold Commanders.\footnote{683} ACC Ford also had substantial practical experience of working in collaboration with the emergency service partners of the police and other bodies. For example, when an officer of Northumbria Police, ACC Ford had been a member of the local resilience forum.\footnote{684}

13.488 In evidence, ACC Ford gave a clear account of the training she received over the course of her career. However, her recollection was not fully reflected in her training records.\footnote{685} I am satisfied that ACC Ford’s recollection is to be preferred to the records. Her police training records were not the only ones that I heard about in evidence.
which were incomplete or inaccurate. The records relating to Temporary CI Buckle were also incomplete, and the thrust of the evidence was that this was a more generalised problem.\(^{686}\) As ACC Ford agreed, that is an unsatisfactory state of affairs.\(^{687}\) For obvious reasons, it should be possible to identify what training an officer has undertaken. This problem is not restricted to GMP, because ACC Ford’s Northumbria records were also incomplete.\(^{688}\)

13.489 This is a problem that needs to be resolved. In her witness statement of 28\(^{th}\) May 2021, ACC Ford said:

“I think that each officer and staff member should have an electronic training record held by their force, which is transferable with the individual if they change forces and that is consistent in the type of training recorded. The individual should be able to view their record, review its accuracy and agree it on an annual basis. This would enable identification of training or exercising gaps which would need to be addressed. This could include all courses, including the nationally accredited courses held by the College of Policing and for example, table tops, testing and

\(^{686}\) 100/111/2-18  
\(^{687}\) 105/5/17-7/6,  106/1/17-4/12  
\(^{688}\) 105/4/11-5/25
exercising, and national exercises within Counter Terrorism policing.”

13.490 I agree and recommend the College of Policing consider the introduction of a national scheme that achieves this.

Notification of Assistant Chief Constable Ford

13.491 Ariana Grande is a major US performing artist. Her concert at the Arena was a sell-out. It brought approximately 14,500 people, many of them children, into the centre of Manchester from all around the country. ACC Ford was unaware that any event was taking place at the Arena that night, let alone one of that size or with that profile. It is unacceptable that duty Gold did not know that such a major event was taking place in Manchester. That is so for a number of reasons, including the fact that the event presented a potential target for terrorists and, in the event of an attack, GMP would be required to respond. In future, all police services should ensure that mechanisms are in place to ensure that the duty command structure is aware of any major event taking place within the force area.

13.492 Each duty Gold shift is lengthy. Accordingly, where the demands of the role allow, the duty

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689  INQ041475/2
690  105/34/1-39/16, 105/71/22-73/20
Gold is permitted to rest. 691 On the night of the Attack, ACC Ford was at home and asleep in bed when she was woken by a telephone call from Temporary Superintendent Nawaz at 22:52. 692 He informed her that an attack had taken place at the Arena and that many were dead and injured. He also told her that Operation Plato had been declared. As I have explained, Temporary Superintendent Nawaz did not inform ACC Ford that he was unaware what Operation Plato was. ACC Ford did not check on his knowledge, but I am not critical of her in that regard. 693 She was entitled to expect that the Night Silver would have known what the declaration of Operation Plato meant and, if not, to have informed her of that gap in his knowledge, something he did not do.

13.493 Given the declaration of Operation Plato, ACC Ford would have expected to have been contacted by the FDO, but that had not happened. At the end of the call, which lasted for nearly three minutes, ACC Ford asked Temporary Superintendent Nawaz to open up the Gold and Silver Control Rooms at GMP HQ. ACC Ford explained to me that she did this because she was keen to get command and control established as quickly as possible. Accordingly,
it was her expectation that Temporary Superintendent Nawaz would go to GMP HQ, not to the scene.\textsuperscript{694}

13.494 This takes me back to the debate over whether the Tactical/Silver Commander should go to the scene of an incident.

13.495 I am not critical of ACC Ford for sending Temporary Superintendent Nawaz to GMP HQ. I accept that it was reasonable to direct someone senior to establish the hub of command operations. I accept also that ACC Ford recognised the possibility that the Attack might be the start of a series of attacks at multiple sites, as had occurred in Mumbai in November 2008 and in Paris in November 2015.\textsuperscript{695} If that had occurred, having a Tactical/Silver Commander at GMP HQ as opposed to at just one of a number of scenes would have been beneficial in terms of ensuring an overall tactical plan was in place and was implemented.

13.496 Equally, however, from the first notification to ACC Ford of the Attack, it was obvious that many officers would be needed at the Arena, both armed and unarmed. ACC Ford should have given consideration at that early stage to the question of which officer would provide tactical

\textsuperscript{694} 105/42/9-45/24
\textsuperscript{695} 105/175/5-176/21
command for the unarmed officers at the scene and should have ensured that such command was achieved. She did not do so.

13.497 Instead, whether the unarmed assets would come under effective command was left to chance. Inspector Smith stepped up to command those officers in the City Room, and CI Dexter, following his arrival at 23:23, stepped up to command the unarmed assets at and around the Victoria Exchange Complex.\textsuperscript{696} CI Dexter did so notwithstanding that his principal focus was on the armed assets in his role as Ground Assigned Tactical Firearms Commander.\textsuperscript{697} The emergency response to the Attack benefited from the presence of two such experienced and committed officers at the scene. They made it work, within the limits of their control. However, there can be no guarantee that would happen in the aftermath of a terrorist attack. In future, those responsible for the response to a terrorist attack must ensure that an experienced officer arrives at the scene or scenes promptly with the sole or principal task of providing tactical command to the unarmed assets. This is an issue upon which CTPHQ and/or the College of Policing should issue clear guidance.

\textsuperscript{696} 97/3/5-13, 106/100/8-11
\textsuperscript{697} 106/100/8-11
13.498 While still at home, ACC Ford took steps to ascertain the nature of the concert at the Arena, and the demographic of the audience. Those steps would have been unnecessary if the system I recommend above had been in place. She then called the Chief Constable, Ian Hopkins, and the Head of the North West Counter Terrorist Unit, Chief Superintendent Russell Jackson, to let them know what was happening. Next, she called her staff officer and Chief Superintendent John O’Hare, a highly experienced firearms commander. Those were sensible steps for ACC Ford to take in her role as Strategic/Gold Commander. They show that she was thinking in a clear and structured way about the response to the Attack.

13.499 Throughout this period at home, ACC Ford also made attempts to contact the FDO. This, too, was sensible. She was unable to get through despite a number of attempts. This is illustrative of the problem to which I referred when considering the role of the FDO that night. The FDO line had become overloaded. The upshot was that one significant figure within
the command structure was unable to make contact with another significant figure within that structure. That the Strategic/Gold Commander, who was also Strategic Firearms Commander, was unable to get through to the FDO, who was also Initial Tactical Firearms Commander, was unacceptable.

13.500 There is an obvious degree of speculation involved in seeking to ascertain what ACC Ford would have learned if contact had been made with the FDO at this stage, namely around 23:00. She may simply have assumed that Inspector Sexton had done all that he ought to have done, as she did in respect of others. However, given her keenness to speak to the FDO and to do so at an early stage, there exists the reasonable possibility that she would have learned that the declaration of Operation Plato had not been communicated to NWAS, NWFC or GMFRS. If so, she may have discovered that the issue of Operation Plato zoning had not been addressed. At the very least, the difficulties in communication deprived the Strategic/Gold Commander of the opportunity to discover that things were going wrong.

13.501 After 22nd May 2017, ACC Ford took part in a debrief. One of the recommendations that

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704 99/45/2-46/6, 148/111/5-17
705 INQ000790/1
emerged was for the creation of a dedicated hotline by which senior staff within the command structure could contact the FDO.\textsuperscript{706} Unsurprisingly given her experience on the night, ACC Ford wholeheartedly supports that recommendation.\textsuperscript{707} So do I, not only within GMP but across the country. This should be a hotline that those within the command structure of all three emergency services are able to use. I recommend CTPHQ and the College of Policing take this forward.

13.502 By 23:05, ACC Ford was on the road, driving to GMP HQ. The journey was just under five miles. During the course of it, she made and received calls. She made contact with Temporary Superintendent Nawaz on two occasions.\textsuperscript{708} In those calls, ACC Ford gained no additional information from the Night Silver.\textsuperscript{709} As I explained earlier, she therefore began to develop a concern about the competence of Temporary Superintendent Nawaz.\textsuperscript{710} Later this was to cause her to replace him.

13.503 At 23:13, while still travelling to GMP HQ, ACC Ford was telephoned by CI Dexter.\textsuperscript{711} He was
travelling towards the Arena and had not yet switched on his Dictaphone. CI Dexter could not get through and left a voicemail.\textsuperscript{712}

\textbf{Force Command Module}

13.504 ACC Ford arrived at GMP HQ at about 23:15 and entered the Force Command Module at about 23:20.\textsuperscript{713} In Part 12, I explained that Force Command Module housed both the Gold and Silver Control Rooms. ACC Ford agreed that, usually, and certainly for pre-planned operations, the Gold and Silver Control Rooms would be separate from each other.\textsuperscript{714} That has the advantage of ensuring that there is delineation between strategic and tactical decision-making. On the night, ACC Ford considered that combining the two was the better approach:

\begin{quote}
\textit{It felt entirely appropriate on the night given the fact that there was so much information, so many views, so much on the log, that to separate that out, it would have drawn me away from the ability to have that communication in the room and understand if there were issues from other agencies, issues for my own staff in terms of the tactical command of the firearms operation, the tactical command room and [CI] Mark Dexter}
\end{quote}

\textsuperscript{712} 106/152/2-13
\textsuperscript{713} 105/86/13-16
\textsuperscript{714} 105/166/15-168/1
at that scene. To separate them out would have left me isolated from all the information that was coming into that location."715

13.505 ACC Ford’s explanation made sense to me. However, as I shall explain, there were things missed by her that night. I formed the impression that there may have been too much going on in the combined command room, too many people present and too much information being passed to enable ACC Ford to maintain focus on her strategic role. Ultimately, the evidence did not provide a clear answer to the question of whether a combined command room is a good or bad idea, or whether it depends on the nature of the incident. I recommend CTPHQ and the College of Policing consider this issue with a view to issuing guidance.

13.506 Once inside the Force Command Module, ACC Ford called the Chief Constable again,716 updating him. At 23:41, she telephoned CI Dexter in response to his earlier voicemail message.717 By that stage, CI Dexter had been at the scene for 18 minutes718 and had spent time in the City Room.719 He had good situational awareness.

715 105/167/16-168/1
716 105/91/2-21
717 INQ025409/10-11
718 INQ035612/302
719 INQ035612/310, INQ035612/332
The call between ACC Ford and CI Dexter lasted for just over four minutes. Shortly after he arrived at the scene, CI Dexter activated his Dictaphone. I have been able to listen to his side of the conversation. It is clear that the call enabled ACC Ford to gain some situational awareness, but she does not appear to have provided any strategic or other direction to CI Dexter. I acknowledge that she had a lot to think about and do at the time, but she should not have overlooked this.

13.507 Shortly after coming off the telephone from CI Dexter, ACC Ford set out her working strategy in writing in her Gold Duty Book. It read:

“* Protect the public from harm
* Minimise the risk to the public
* Maximise safety of officers/staff/first responders
* Provide information to victims and families that is accurate and up to date”

13.508 In evidence, ACC Ford accepted that this was somewhat general, but maintained that she considered the strategy was adequate.
The Policing Experts were not critical of ACC Ford’s strategy. On the evidence, however, she did not communicate her plan, at least not adequately, to the Tactical/Silver Commanders. This is a further example of an issue that arose across the night and across the command structure because, as I have pointed out, no tactical plan was formulated or, if formulated, was not adequately communicated to the Operational/Bronze Commanders. Most of the GMP commanders tackled what was in front of them. That is not unreasonable given the enormity of what they each faced. However, planning at the three levels of command is of obvious importance as is the communication of those plans.

13.509 I recommend the College of Policing consider whether the current requirements are too onerous or unwieldy and whether some simpler approach may be achievable. It may be that there is a view that the strategic plan in this type of incident is so obvious that it doesn’t need specifically to be set out to Tactical/Silver Commanders but, if so, that needs to be understood by all in the command structure and needs to be communicated in the plans.

13.510 ACC Ford is a highly professional officer with strong qualities. The Force Command Module
was an extremely busy and stressful place. Many decisions were made as part of what ACC Ford described as “the consequence management” of the Attack. By this, she meant, for example, ensuring that the families of casualties and the dead should receive information and support, that Manchester should get back up and running as soon as possible, and that the investigation into what had happened and who was responsible should be progressed. All of that, I acknowledge, was important, and ACC Ford and her team in the Force Command Module worked hard to achieve those aims. The Policing Experts considered that, in the circumstances of great stress and pressure, ACC Ford got much right. I agree, but if lessons are to be learned and change implemented, what did not go right needs also to be acknowledged.

13.511 It is important to ask what difference the Force Command Module and those within it made to the emergency response as distinct from the aftermath of that response. ACC Ford gave the following candid evidence on that issue:
“[Counsel to the Inquiry] In terms of what actually happened on the ground and in particular in the period … to one hour after the declaration of Plato, so we are at 11.47, did anything happen, either in the Gold Command Suite or in the Silver Command Suite that made any difference to what happened on the ground?

[ACC Ford] In the actual response to as opposed to things that happened after?

[Counsel to the Inquiry] Yes.

[ACC Ford] Probably not, no.”

13.512 In my view, ACC Ford and those she commanded within the Force Command Module were capable of making a difference to the emergency response and should have done so. As Strategic/Gold Commander, ACC Ford could and should have done the following things in the period after her arrival at GMP HQ.
13.513 First, by the time of ACC Ford’s arrival into the Force Command Module, GMP had not declared a Major Incident.\textsuperscript{729} As I have explained, the events at the Arena were, without doubt, a Major Incident within the meaning of the GMP Major Incident Plan. ACC Ford was entitled to expect that someone would have addressed this issue in the period before her arrival, indeed even before she was alerted to the events at the Arena at 22:52. However, this step was sufficiently important that she should have checked that it had been done. She did not do so.\textsuperscript{730} Had she made that check, she would have realised that this important step had not been taken and would have dealt with it herself. ACC Ford accepted this in evidence.\textsuperscript{731} For the reasons I identified earlier, the declaration of a Major Incident would have made a difference to the emergency response.

13.514 Second, ACC Ford knew that Operation Plato had been declared.\textsuperscript{732} She knew that zoning was critical to such a declaration. She knew that this would influence which emergency responders could deploy into which areas.\textsuperscript{733} As ACC Ford correctly acknowledged, she had an obligation to

\begin{itemize}
\item \textsuperscript{729} 105/133/21-134/17
\item \textsuperscript{730} 105/133/21-134/17
\item \textsuperscript{731} 105/133/21-134/17
\item \textsuperscript{732} 105/40/17-41/12
\item \textsuperscript{733} 105/46/24-47/16
\end{itemize}
review the declaration.\textsuperscript{734} That necessarily involved a review of zoning. Annemarie Rooney, the NWAS Tactical Commander, was present within the Force Command Module. ACC Ford did not discuss with her or with anyone else in the Force Command Module whether the declaration of Operation Plato should continue and, if it should, what the zoning within the Arena and surrounding area should be.\textsuperscript{735}

13.515 ACC Ford proceeded on the basis that others knew that Operation Plato had been declared and were addressing that issue.\textsuperscript{736} She was right to expect that others were engaged in this important matter. However, she was in ultimate control and should have taken a grip of this issue or at least shown an active interest. She did not do so. That was an omission. However, it was not ACC Ford’s omission alone. There was simply no discussion about zoning within the Force Command Module at all until 00:22, when the issue was first discussed between ACC Ford and CI Dexter.\textsuperscript{737} That is unacceptable.

13.516 Third, by the time of ACC Ford’s arrival in the Force Command Module, Inspector Smith had been making clear for some time that paramedics

\begin{itemize}
\item \textsuperscript{734} 105/69/4-70/7
\item \textsuperscript{735} 105/69/4-70/7, 105/100/21-102/15
\item \textsuperscript{736} 105/100/21-102/15
\item \textsuperscript{737} INQ025409/36, INQ025409/37, 105/195/11-196/2
\end{itemize}
in numbers were needed in the City Room.\textsuperscript{738} ACC Ford was unaware of this, and no one seems to have drawn it to her attention.\textsuperscript{739} Equally, no member of GMFRS had arrived at the Victoria Exchange Complex, let alone entered the City Room by that stage. In the call at 23:41, CI Dexter informed ACC Ford: \textit{“We’ve got no fire.”}\textsuperscript{740} She accepted in evidence that this was significant information but explained that she had not registered it given everything that was going on.\textsuperscript{741} She should have done. Had ACC Ford registered what she had been told, she would have taken steps to investigate why GMFRS was not at the scene.\textsuperscript{742}

13.517 GMFRS had significant value to add to the emergency response at the Arena. GMFRS had the ability to provide some treatment and, importantly, had expertise in the extrication of casualties.\textsuperscript{743} Had GMFRS attended during the critical period of the response at the Victoria Exchange Complex, it would have made a difference. ACC Ford assumed that all of this was in hand.\textsuperscript{744} It was understandable that she considered that others in the command structure

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\begin{itemize}
\item \textsuperscript{738} 76/78/10-79/12, 103/2/11-3/17, INQ018644T/9
\item \textsuperscript{739} 105/172/24-173/19
\item \textsuperscript{740} INQ025409/11
\item \textsuperscript{741} 105/161/2-166/9
\item \textsuperscript{742} 105/161/13-166/9
\item \textsuperscript{743} 119/104/17-108/10
\item \textsuperscript{744} 105/161/13-166/9
\end{itemize}
were addressing this obvious and important issue. Nonetheless, I consider that she should have taken steps herself to ascertain what the situation was in the City Room.

13.518 Fourth, in common with all senior officers, ACC Ford was aware that, in the event that Operation Plato was declared, there was a significant risk that the FDO would become overwhelmed.\textsuperscript{745} Indeed, as I explained in Part 12, ACC Ford was aware of the conversation between Associate Inspector Andrew Buchan of HMICFRS and Temporary ACC Catherine Hankinson in November 2016 about this very issue because she had received the email of 3\textsuperscript{rd} November 2016.\textsuperscript{746} One of the things ACC Ford could have done to support the FDO was to ensure he was relieved of the Initial Tactical Firearms Commander role. Temporary CI Buckle was cadre Tactical Firearms Commander on the night of the Attack and the person who would naturally be expected to have relieved the Initial Tactical Firearms Commander.\textsuperscript{747} She arrived at GMP HQ at about the same time as ACC Ford. She was in a position to relieve Inspector Sexton by 23:20 or shortly afterwards.\textsuperscript{748}
13.519 In a 51-second call at 23:10, Superintendent Thompson informed Temporary CI Buckle that he intended to take the role of Tactical Firearms Commander following his arrival at GMP HQ.\(^749\) I acknowledge that Superintendent Thompson was more experienced as a Tactical Firearms Commander than Temporary CI Buckle and that he had additional qualifications that she did not have.\(^750\) However, what neither Temporary CI Buckle nor ACC Ford ascertained was how much longer it was likely to take Superintendent Thompson to arrive at GMP HQ than Temporary CI Buckle.\(^751\) They should both have ascertained this. The upshot was that Superintendent Thompson arrived at GMP HQ at 23:45 and did not relieve Inspector Sexton until 00:18, much later than Temporary CI Buckle could have done so.\(^752\) ACC Ford should have informed herself about likely timescales. Had she done so, she would have appointed Temporary CI Buckle as Tactical Firearms Commander, at least until Superintendent Thompson was in a position to receive a handover from her, a role that she was entirely competent to perform. That would have relieved Inspector Sexton of a significant part of his burden at a much earlier stage.

\(^{749}\) 100/134/24-139/21, 105/183/15-190/9, 108/17/4-19/14
\(^{750}\) 108/17/4-19/14
\(^{751}\) 108/34/16-36/19
\(^{752}\) 108/34/16-36/19, 108/26/19-27/3
13.520 Fifth, by the time ACC Ford arrived at GMP HQ, no common RVP had been established, nor had an FCP been identified. These steps are vital to joint working. ACC Ford failed to establish that these steps had not been taken. She should have done, and others within the Force Command Module should have established this and alerted her to the problem. These failures played an important part in why JESIP failed that night.

13.521 Sixth, one of the reasons why effective coordination between the three emergency services did not happen was because of a delay in the Force Command Module in organising a meeting of the Strategic Co-ordinating Group, a concept I explained in Part 12. ACC Ford explained the purpose of such a meeting:

"Its purpose is to bring the strategic commanders together from all the organisations who are involved in the response. Again, that’s beyond the initial response, to draw together where we’re at, to agree the strategy and to agree priority actions and activities that need to be
undertaken to further progress the response to the incident.”

13.522 Had such a meeting taken place at an early stage, it would have had an impact on the emergency response, as ACC Ford candidly acknowledged. It is likely that the issues with the non-attendance of GMFRS and the JESIP failures more generally would have been identified. Ultimately, the first meeting of the Strategic Co-ordinating Group did not take place until 04:15 on 23rd May 2017. By this time, the ability of the group to have any impact on the immediate emergency response had long gone.

13.523 ACC Ford explained that, in the first hours following her attendance in the Force Command Module, her focus was upon managing what was, or might be, coming and on “recovery planning”. This thwarted her attempts to organise the meeting earlier. I entirely accept that much important work was undertaken by ACC Ford during this period. I also accept that she was seeking to address less formally what a Strategic Co-ordinating Group would be expected to address. That was, however, no substitute
for a Strategic Co-ordinating Group. An early meeting of the Strategic Co-ordinating Group should have been prioritised by ACC Ford. The fact that it was not represents a missed opportunity on the part of the Strategic/Gold Commander to identify that things were going wrong.

13.524 In evidence, ACC Ford acknowledged that many things went wrong in the Force Command Module. She explained that a substantial part of the explanation for this was that she expected that others would have been attending to these important issues. She said:
“[ACC Ford] … In my head, the response to the arena in the initial stages was very much a bottom-up approach, it was happening at the scene and it was evolving from the scene, so the people with the best decision making capability and the most relevant information as to whether they’d applied zones or otherwise, but what was happening at the scene that would allow people to get into the actual area to deal with the casualties was there. I could have applied my limited understanding and made assumptions that I thought I was not in a position to make because I would then have applied something to a situation that I couldn’t assess.
[Chairman] So, in the command suite what you’re actually all saying is: on the ground, they know what’s going on, they’ve got – we just have to leave it to them?

[ACC Ford] Leave it to them whilst you start to understand what’s going on and also that broader kind of understanding of what else needs to be done. But the there-and-then situation needs to be addressed by those who are physically present at the scene and they understand what should be done, and then seek resources, seek an understanding, and then, when we’re able to, step back from it.”\(^{761}\)

13.525 Later in evidence, ACC Ford stated:

“If however you are responding to an incident where a plan has been initiated, I have a lot of responsibilities in terms of the response, but is
it the role of the strategic commander to be checking what should have already been done in the plan? Because that is going to take an inordinate amount of my time to do. And you would have to, bearing in mind this is a spontaneous response, presume that people are initiating the plan that we have all been trained to work to.”

13.526 I accept that ACC Ford was entitled to expect that others in the command structure beneath her would understand their roles and perform them. I acknowledge, too, that for a lengthy period, she lacked the support of a competent Tactical/Silver Commander. However, as ACC Ford accepted in evidence, the buck stopped with her that night in terms of command. It was, as she put it, “my responsibility to make sure that the response is as good as it can be”. While a Strategic/Gold Commander must be entitled to expect that others within the command structure will perform their roles, ACC Ford placed too much confidence in that approach. The reality is that the emergency response was failing on multiple levels, and JESIP was not working. She should have established that fact and intervened.

762 106/18/10-19
763 105/139/7-12
764 106/49/21-50/7
ACC Ford is, in my view, a good and committed senior police officer. When she was telephoned by Temporary Superintendent Nawaz at 22:52 on the night of 22nd May 2017, it was the end of what had already been a long day for her. In the period that followed, she demonstrated clarity of thinking and decisiveness in many respects. She made a significant difference to what followed after the emergency response. However, as Strategic/Gold Commander, she should have made a difference to the emergency response itself. She did not do so. In substantial part, she was let down by systemic failures of education and by the inadequacies and failures of individuals. She was also let down by those from the other emergency services who should have known what was going wrong but did not draw it to her attention. However, for the reasons I have outlined, ACC Ford does bear some responsibility herself for the failures in the emergency response.

ACC Ford gave evidence with candour and insight. She recognised that there are important lessons for the emergency services to learn from that night. Her evidence has assisted the Inquiry to learn from her experience and will, I hope, be part of the drive for improvement.
Ground Assigned Tactical Firearms Commander

Role of Ground Assigned Tactical Firearms Commander

13.529 On the night of the Attack, the role of Ground Assigned Tactical Firearms Commander was performed by CI Dexter.\(^{766}\)

13.530 First, it is necessary to identify where the Ground Assigned Tactical Firearms Commander fits into the GMP command structure. This was a controversial issue during the Inquiry.

13.531 The term Ground Assigned Tactical Firearms Commander appears to have been introduced by the CTPHQ refreshed Operation Plato guidance.\(^{767}\) I considered this guidance in Part 12. It was issued by CTPHQ in March 2016 and provided:

“7.1 Forces should review their Operation PLATO plans in relation to command locations and should consider their structures in relation to deploying dedicated (Cadre) TFCs [Tactical Firearms Commanders] as part of the response.”

\(^{766}\) 106/100/8-11

\(^{767}\) INQ016688/1
7.2 In particular Forces should review their Operation PLATO plans in relation to their ability to deploy a TFC(s) to undertake the role of on-scene commander (or ground assigned TFC) in a timely manner. A ground-assigned tactical command function is essential in order to develop command situational awareness, the overall ability to resolve the incident and to meet the requirements of the multi-agency approach to an Operation PLATO incident.

7.3 As part of this assessment, Forces may wish to take into account that the initial command structure will already have a suitably trained and competent commander within the police control room (Initial TFC) and that the immediate identifiable need will be a Cadre TFC in the role of on-scene/ground assigned commander.

7.4 As subsequent Cadre TFCs become available, consideration should then be given to the transition from an Initial TFC to a Cadre TFC within the police control room or similar police operations room.”

768 INQ016688/16, INQ016688/17 (emphasis added)
The term ‘on-scene commander’, used in the refreshed guidance, is one that was also used in JOPs 3. It was defined there as:

“An appropriate police, FRS [fire and rescue service] or ambulance commander at the scene who is responsible for undertaking an ongoing joint assessment of risk and for decision-making on the deployment of their organisation’s assets at that location. On-scene commanders will therefore ensure the emergency services’ response is effectively co-ordinated at scene.”

These sources of guidance have generated two competing arguments about the role and responsibilities of the Ground Assigned Tactical Firearms Commander. The rudiments of those arguments can be summarised in the following way.

First, officers such as ACC Ford have contended that, since the refreshed guidance used the terms on-scene commander and Ground Assigned Tactical Firearms Commander interchangeably, the roles are one and the same. Because JOPs 3 made an on-scene commander responsible for decision-making on the deployment of police assets at the scene, without distinguishing

769 INQ008372/4 (emphasis added)
770 105/94/23-95/7, 105/112/1-113/12, 106/82/9-20, INQ008372/5
between armed and unarmed assets, the on-scene commander is responsible for the tactical command of all police officers at the scene of an Operation Plato incident.\footnote{INQ008372/5} Because the on-scene commander is the Ground Assigned Tactical Firearms Commander, the Ground Assigned Tactical Firearms Commander therefore has that broad responsibility for all officers. Hence, it is not necessary for an additional Tactical/Silver Commander to go to the scene in order to command the unarmed assets only. Such a person would merely duplicate the role of the Ground Assigned Tactical Firearms Commander.\footnote{105/109/21-115/5}

13.535 Second, officers such as CI Dexter have contended that the Ground Assigned Tactical Firearms Commander is responsible, as ‘Firearms’ in the title suggests, for the tactical command of the armed assets at the scene of an Operation Plato incident.\footnote{106/133/5-135/2, 107/77/21-79/8, 107/125/23-127/22} The Ground Assigned Tactical Firearms Commander is responsible for the deployment of unarmed assets only to the extent that such officers are required for the purposes of the firearms operation. Thus, the Ground Assigned Tactical Firearms Commander is responsible for the
forward-facing officers,\textsuperscript{774} whether armed or unarmed. The unarmed officers more generally are under the tactical command of a Tactical/Silver Commander dedicated to that role. The term ‘on-scene commander’ was used in a different and broader way in JOPs 3 to denote the Tactical/Silver Commander with the JESIP role. That commander would commonly be expected to be present at the FCP. Hence, it is necessary for an additional Tactical/Silver Commander to go to the scene/FCP in order to command the unarmed assets who are carrying out roles for which the Ground Assigned Tactical Firearms Commander is not responsible.\textsuperscript{775}

13.536 Both arguments make sense and represent reasonable interpretations of the guidance available. Both arguments were advanced by senior and experienced officers driven by a desire to ensure that the policing response to an Operation Plato incident is as effective as possible. Both sides of the debate recognise that those on the other side have a reasoned argument.

13.537 As I made clear in the course of the evidence, I do not consider it important to rule on this

\textsuperscript{774} This term was introduced during the questioning of CI Dexter on behalf of CTPHQ: 107/89/22-92/1. The term was helpful. The questioning on behalf of CTPHQ tended to indicate a broad agreement on the part of CTPHQ with the interpretation of CI Dexter

\textsuperscript{775} 106/133/5-135/2, 107/125/23-127/22
dispute, as the clarity of the documents left something to be desired. I do, however, regard it as my role to identify what approach to the command structure is likely to work best in the response to an Operation Plato situation.

13.538 On the night of the Attack, CI Dexter took tactical command of unarmed police officers beyond those necessary for the purposes of the firearms operation.\(^{776}\) In other words, he assumed command of unarmed officers in addition to those who were forward-facing. He explained that he did so because there would otherwise have been a command vacuum.\(^{777}\) CI Dexter also explained that he had been able to manage because, as it turned out, the events of 22\(^{nd}\) May 2017 did not involve further attacks at the Arena or multi-site attacks elsewhere. Had events developed along the lines of a Mumbai- or Paris-type attack, CI Dexter said, things might have been very different: “That’s why I have taken this position because I have been there and I’ve done it and I know that to do both roles is not achievable.”\(^{778}\) He explained this further:

“I adopted the role of the Plato on-scene commander and took on additional responsibilities that should have been taken

\(^{776}\) 106/132/14-134/12
\(^{777}\) 106/133/1-24
\(^{778}\) 106/143/11-13
up by a tactical commander at the scene regardless of who that should have been. And the reason I raised this … is that it was broadly manageable on the night. But had it developed into an MTFA [Marauding Terrorist Firearms Attack] … it definitely would not have been manageable under one commander. So, I accept the point, and in fairness to you, on the night by the time I arrived it didn’t make a massive difference to me, but it could in the future and that’s what’s really important, I think, to learn.”

13.539 In my view, Cl Dexter is correct. To expect the Ground Assigned Tactical Firearms Commander to take on the principal role for liaising with the Tactical/Silver Commanders of the other emergency services in the FCP, and to command unarmed officers in relation to tasks such as the creation of cordons, gives rise to the real risk that the Ground Assigned Tactical Firearms Commander’s ability to perform their core firearms role will be compromised. How, for example, is the Ground Assigned Tactical Firearms Commander to perform those tasks if actively involved in commanding firearms officers in the search for and neutralisation of an armed terrorist?
13.540 The events in Manchester demonstrate that the policing response to any Major Incident is likely to be enhanced by the deployment of Tactical/Silver Commanders to the scene or scenes. In the event that the Major Incident is one in which Operation Plato is declared, or indeed in which there is any involvement of firearms officers in numbers, it is likely to be desirable for that deployment to involve the mobilisation to the scene of a Ground Assigned Tactical Commander for the armed response, the Ground Assigned Tactical Firearms Commander, and a Ground Assigned Tactical Commander for the unarmed response, the Ground Tactical/Silver.

13.541 I recommend this issue be the subject of review by CTPHQ, the Home Office and the College of Policing. Clear guidance should then be issued. There should never again be a situation in which senior commanders, from the same organisation and who responded to the same Major Incident, are unable to agree on the responsibilities of someone performing a key role in the command structure for the response to a Major Incident.
Chief Inspector Dexter’s experience and training for the role of Ground Assigned Tactical Firearms Commander

13.542 CI Dexter was an experienced senior police officer.\textsuperscript{780} He joined GMP in 1999 and progressed through the ranks. During 2014 and 2015, he qualified as a Tactical/Silver Commander and as a Tactical Firearms Commander. Thereafter, he carried out each role. In particular, he regularly performed the role of Tactical Firearms Commander and did so in relation to a number of complex firearms operations, both planned and spontaneous. Just days before the Attack, CI Dexter attended the same specialist firearms commander course as ACC Ford.\textsuperscript{781} By May 2017, CI Dexter was one of GMP’s most experienced firearms commanders.\textsuperscript{782}

13.543 As a result of his training, CI Dexter was aware of Operation Plato and what such a declaration would mean in terms of the deployment of capabilities. Following his experiences on the night of the Attack, he reflected on whether this training had given him all the knowledge he needed about Operation Plato. CI Dexter concluded that his training had given him an insufficient understanding of how Operation Plato...
would be applied by the commanders of the other emergency services and how, on the ground, Operation Plato zoning should be applied. On the night, this gap in CI Dexter’s training had an impact on his management of the scene and on his communications with the other emergency services.

13.544 CI Dexter was a straightforward witness whose views had been formed on the basis of mature and intelligent reflection. In identifying this gap in his training, he was not seeking to excuse inadequacies in what happened on the night of the Attack. Instead, he was providing a considered account of respects in which he believed different and better training would have made him more prepared for what confronted him on 22nd May 2017. The gap in knowledge described by CI Dexter was something I recognised across a number of witnesses. CI Dexter’s evidence reinforces my view that Operation Plato training needs to be better across the board.

Notification of Chief Inspector Dexter

13.545 At 22:45 on 22nd May 2017, CI Dexter was telephoned by PC Kevin Winyard of GMP’s Specialist Operations Branch. In that call,
PC Winyard explained that there had been an explosion at the Arena and that Operation Plato had been declared.\(^\text{785}\) This call was, in fact, before Inspector Sexton’s declaration of Operation Plato at 22:47. However, Operation Plato had been referred to over the GMP radio firearms channel by PC Lee Moore, a firearms officer, at 22:41.\(^\text{786}\) This explains what would otherwise be an odd feature of the evidence.

13.546 CI Dexter was not on duty on 22\(^{\text{nd}}\) May 2017 and was at home asleep when PC Winyard telephoned.\(^\text{787}\) CI Dexter explained that the Specialist Operations Branch, of which he was a senior member, is at the sharp end of policing.\(^\text{788}\) It includes the GMP armed policing units and other teams such as the Tactical Vehicle Intercept Unit. Members of these teams are regularly involved in acute incidents across Greater Manchester. Senior line management might not be immediately available. Hence, CI Dexter had an arrangement that he would be called, even when off duty or on leave, in the event of any significant incident within Greater Manchester. PC Winyard was putting this arrangement into effect on the night of 22\(^{\text{nd}}\) May 2017.\(^\text{789}\)
13.547 CI Dexter responded to PC Winyard’s call by deploying to the Arena.\footnote{106/129/11-130/8} He took steps to inform the command structure of what he was doing.\footnote{106/152/2-13} So, to describe his actions as self-deployment would not fully or accurately reflect what he did. Nonetheless, it was a notable feature of the evidence that a number of those who deployed on the night of the Attack into significant positions in the command structure were not rostered to do so. Instead, they volunteered. That included Superintendent Thompson, who replaced Inspector Sexton as Tactical Firearms Commander.\footnote{108/2/3-6} These two officers made a significant contribution on the night, and I am not critical of them. On the contrary, each stepped up.

13.548 I was, however, left with a lingering concern about the informality with which important roles were filled on the night. That was a concern shared by the Policing Experts.\footnote{147/29/22-31/6} Even though I am satisfied it did not cause problems on 22\textsuperscript{nd} May 2017, such an approach is capable of causing difficulties during the response to an emergency. CI Dexter acknowledged that this was so.\footnote{106/154/1-24} I recommend every police service take
steps to ensure they have in place a system that ensures appropriately qualified and experienced personnel are rostered 24 hours each day so that, in the event of a terrorist attack, or any Major Incident, a prepared and effective command structure can be geared up swiftly.

Chief Inspector Dexter’s journey to the Arena

13.549 Having received PC Winyard’s call, CI Dexter immediately dressed, got into his car and drove towards the Arena. At 22:51, he made contact with the FDO by radio asking whether a Ground Assigned Tactical Firearms Commander had been assigned. CI Dexter had it in mind that this would be the appropriate role for him to fulfil, and he was sensibly checking to see whether anyone else had already been allocated to this job. They had not.

13.550 In a radio communication at 22:52, CI Dexter was made aware that Temporary CI Buckle was “making her way in”. By implication, this was to GMP HQ. He indicated that she should continue to do so and that he would perform the role of Ground Assigned Tactical Firearms Commander, at least initially. At 22:54, CI Dexter telephoned Temporary CI Buckle. They spoke for just over
a minute and agreed that these were the appropriate deployments, that is to say CI Dexter to the scene and Temporary CI Buckle to GMP HQ. 799

13.551 At an early stage, I was concerned that CI Dexter was ‘pulling rank’ in what was decided about Temporary CI Buckle’s deployment. However, I have been able to hear parts of subsequent conversations between the two in the recording from CI Dexter’s Dictaphone. I also heard evidence from each of them as witnesses. CI Dexter said of the discussion at 22:54: “It was a very adult, professional conversation … I would never pull rank on Rachel.” 800 I am satisfied on the evidence that this is correct. It is clear that the two had respect for each other. They made a mutual decision about what was the best deployment in the circumstances. Given CI Dexter’s greater experience and his recent attendance on the specialist firearms commander course, the decision that he should deploy to the scene was an appropriate one. My initial concerns were dispelled.

13.552 At 22:56, CI Dexter made a short call to Superintendent Thompson, and at 23:02 and at 23:09 the two spoke for slightly longer periods. 801
At this stage, CI Dexter was still travelling. Superintendent Thompson was CI Dexter’s line manager. He was also a Specialist Tactical Firearms Commander. At some stage that night, a Counter Terrorism Police Operations Room would need to be opened, and a Specialist Tactical Firearms Commander would be required for that purpose. CI Dexter suggested to Superintendent Thompson that he head in to GMP HQ for that purpose. This made good sense, as the Policing Experts agreed, but is an example of the informality with which some important roles in the command structure were filled that night.

While travelling in his car, CI Dexter was involved in further radio communication relevant to the Attack. He also took steps to liaise with military assets. At 23:13, he telephoned ACC Ford, the Strategic/Gold Commander and the Strategic Firearms Commander. He was unable to get through and left her a voicemail message. She called him back at 23:41.

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802 106/150/1-4
803 This is, in effect, the control room for the counter-terrorism part of the response to a terrorist attack. It is set up separately from the main control room because it would be expected to receive sensitive information: 59/42/12-19
804 106/149/15-151/18
805 INQ018839T/18-19, INQ018840T/6
806 107/31/10-32/12
807 106/152/2-6
808 106/152/2-13
809 106/64/2-6
13.554 CI Dexter stopped off at a police station on the way to the Arena. He did so to obtain necessary equipment, including body armour, and to make logistical arrangements for certain specialist capabilities. These were appropriate actions. He arrived at the Arena at 23:23.

13.555 CI Dexter had travelled to the Arena as quickly as he could following notification of the Attack by PC Winyard. On the way there, he made sure that his deployment as Ground Assigned Tactical Firearms Commander was the appropriate one and took steps to establish that others would be in place within the structure of firearms command. Although there was a degree of informality involved in some of his actions, CI Dexter was doing what he could to make the emergency response work. What he did represented good leadership.

**Events between 23:23 and 23:30: Arrival and gaining situational awareness**

13.556 The arrival of CI Dexter at the Victoria Exchange Complex at 23:23 was captured by the CCTV system. On reaching Station Approach, he wanted to find the Operational Firearms Commander and therefore headed straight inside the railway station. He went to the City Room,

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810 106/152/14-25
811 INQ035612/302
812 106/157/20-158/23
entering at 23:25.\textsuperscript{813} He then spoke to Inspector Smith.\textsuperscript{814} On his first visit to the City Room, CI Dexter remained for five minutes, leaving at 23:30.\textsuperscript{815}

13.557 While still in the City Room, at 23:26, CI Dexter made radio contact with the FDO, dealing with the need to deploy firearms resources to Manchester Piccadilly Railway Station given the risk of a further attack.\textsuperscript{816} This demonstrates that he was, as he told me, concerned about a multi-site attack.

13.558 CI Dexter owned a Dictaphone because of a previous role as a crisis negotiator.\textsuperscript{817} He had sensibly brought it to the scene. At 23:27, while still in the City Room, CI Dexter activated this device.\textsuperscript{818} The recording lasts, unbroken, for 4 hours and 12 minutes.

13.559 As I recommended when considering the role of the FDO, the practice of emergency service commanders using audio-recording devices to record their decisions and rationale should be universal at any Major Incident. CI Dexter did not always record the rationale for his decisions that
night. He said, in evidence, that this was because of the pace of the events he was dealing with and also because to have done so would have felt “unnatural”.

13.560 This represents a useful insight from someone who has been involved in the response to a Major Incident. It suggests that, if my recommendation as to the use of recording devices is to be implemented, it will need to be accompanied by training designed to enable commanders to overcome what might otherwise be regarded as the difficult and artificial approach of speaking their rationale out loud during the course of stressful events.

13.561 In Part 19 in Volume 2-II, I will say more about the way in which decision-making might be recorded.

13.562 Notwithstanding that CI Dexter did not always record the rationale for his decisions, the recording from his Dictaphone provides an invaluable insight into his decisions and what he did. It gives a sense of what confronted him and the other emergency responders in the hours after 23:25. In the course of the hearings, only short sections of the recording were played. To have played it in public in its entirety, or even just the most important first 90 minutes, would have
been inappropriate because of the distressing
nature of some of what is captured on the
recording. I have, however, listened to the whole
of the recording. I agree with Counsel to the
Inquiry’s assessment, explained in the course of
the hearings, that it reveals commitment, hard
work and active decision-making by CI Dexter
throughout that night. 820

13.563 The first conversation that is recorded is a
discussion between CI Dexter and Sergeant
Cawley of BTP. That took place at 23:27 while
they were both in the City Room. 821 Sergeant
Cawley informed CI Dexter of what was known of
the number of fatalities. CI Dexter asked about
cordons and established that the City Room was
secure with firearms officers at each entrance.
He then spoke to the Operational Firearms
Commander, PC Richardson, and established
that a search of the Arena bowl was under way.
He also took steps to arrange the extraction of
any members of the public who remained within
the bowl. 822

13.564 In evidence, CI Dexter explained that, on this first
visit to the City Room, he considered that there
was no immediate firearms threat and did think
that there was a risk of secondary devices.\textsuperscript{823} His recollection was that he considered the City Room to be warm in terms of Operation Plato zoning.\textsuperscript{824} I have already explained, in dealing with the role played by the firearms officers, that the correct application of JOPs 3 would have resulted in the City Room being designated as an Operation Plato cold zone from 22:50 or shortly afterwards. PC Lee Moore and PC Simpkin had carried out a raw check by 22:45 and had established that there was no firearms threat in the City Room, that being the relevant factor so far as Operation Plato zoning was concerned, and the City Room was contained with firearms officers at all entrances.\textsuperscript{825} There existed what PC Richardson described as a “spiky bubble”.\textsuperscript{826} If anything, by 23:25, there was even less reason than there had been at 22:50, to designate the City Room as anything other than an Operation Plato cold zone.

13.565 There were no specialist assets, beyond the firearms officers and two HART operatives, in the City Room while CI Dexter was there between 23:25 and 23:30, but there were unarmed GMP and BTP officers, Arena staff and members of the

\textsuperscript{823} 106/175/6-13
\textsuperscript{824} 106/175/14-176/11
\textsuperscript{825} 102/105/10-106/6
\textsuperscript{826} 101/126/4-12
public present. JOPs 3 dictated that non-specialist assets and members of the public should not ordinarily be present in an Operation Plato warm zone. However, CI Dexter did not direct that they should leave. In evidence, he explained that he balanced the risk of a secondary attack against the risk to those who were present and decided that they should remain. He made the right decision, but his reasoning was flawed because he had wrongly concluded that the City Room was an Operation Plato warm zone. He should have made the decision to leave non-specialist assets and the public in this area on the basis that it was an Operation Plato cold zone and that there was no other compelling reason to remove them. I consider that had CI Dexter received better and more specific training in Operation Plato, as should have been the position, he would have reached his decision by the correct route.

13.566 While in the City Room, it was obvious to CI Dexter that a Major Incident had occurred. In evidence, he agreed that GMP should have declared it as a Major Incident and explained, as others have done, that an early declaration would have enhanced co-ordination between the

827 106/177/24-178/8
828 106/180/16-25
829 106/181/6-23
emergency services. As I have explained already, the failure of GMP to declare a Major Incident was a significant omission.

13.567 Principal responsibility for that failure rests with Inspector Sexton, who should have made the declaration shortly after becoming aware of the explosion at 22:34. However, others also bear some responsibility. Many GMP officers simply assumed that the declaration had been made, making that assumption because it was so obvious that it should have occurred. As he acknowledged, CI Dexter fell into that category. He arrived in the City Room 54 minutes after the explosion and assumed that this basic step would have been taken by someone involved at an earlier stage.

13.568 That so many officers, including senior officers, did not check that a Major Incident had been declared reveals a systemic issue within GMP and possibly beyond. GMP needs to ensure that all officers understand the need to declare a Major Incident along with the need to ensure that such a declaration is widely communicated. GMP needs also to ensure that all officers, particularly senior officers, understand the need, once they become involved, to check that a declaration has been made if they have not received confirmation.
that this has occurred. The College of Policing should consider ensuring that this message is understood more generally within policing.

Events between 23:30 and 23:40: Operation Plato zoning

13.569 Having gained situational awareness in the City Room, CI Dexter walked out onto the raised walkway with PC Richardson.832 He then walked down the stairs leading to the station concourse.833 As the CCTV footage shows, CI Dexter was on the telephone as he did so. He was speaking to Temporary CI Buckle who was at GMP HQ.834 She had called him. In that call, CI Dexter made clear that the City Room was contained and that he had deployed firearms officers to Manchester Piccadilly Railway Station.835

13.570 As the call ended, CI Dexter reached the station concourse. That is the place that NWAS had established the Casualty Clearing Station. CI Dexter was still with PC Richardson, to whom he turned and said: “Are we declaring this warm?”836 It was now 23:32. PC Richardson

832 INQ035612/336
833 INQ035612/337
834 107/2/14-23
835 INQ040657/4
836 INQ040657/5
replied: “Yes.”\textsuperscript{837} In evidence, Cl Dexter explained that in this short conversation he was referring to the area of the Casualty Clearing Station.\textsuperscript{838} It follows that by this stage, at 23:32, Cl Dexter regarded both the City Room and the Casualty Clearing Station/concourse as an Operation Plato warm zone. That assessment was wrong within the context of Operation Plato zoning for the reasons I gave in paragraphs 13.336 to 13.344. Each was, in fact, an Operation Plato cold zone. That was the view of the Policing Experts\textsuperscript{839} and also of Cl Thomas of CTPHQ.\textsuperscript{840} Cl Dexter’s error was the consequence of the inadequacies in his training. However, at least he was giving the issue of zoning under Operation Plato some thought.

13.571 In evidence, Cl Dexter agreed that he had not communicated his Operation Plato zoning assessment in relation to the City Room and Casualty Clearing Station/concourse to the other emergency services directly or to the FDO to enable him to communicate it on.\textsuperscript{841} He explained that he did not consider his assessment would affect deployments within the City Room and that

\textsuperscript{837} INQ040657/5 [the transcript wrongly attributes the speech of PC Richardson to PC Moore]
\textsuperscript{838} 107/6/9-20
\textsuperscript{839} 147/105/6-23
\textsuperscript{840} 141/70/23-71/21
\textsuperscript{841} 106/176/15-177/5
the issue of Operation Plato zoning was therefore not “massively relevant or critical at the time”\textsuperscript{842}. Furthermore, he assumed that the declaration of Operation Plato and associated zoning assessments must already have been communicated given that it was by now just over 60 minutes post-explosion\textsuperscript{843}.

13.572 Each of those explanations requires examination.

13.573 First, on balance, I am satisfied that prompt communication by CI Dexter of his Operation Plato zoning assessment would not have made a material difference to the emergency response in the City Room for the reasons outlined in the following paragraphs.

13.574 By 23:32, when CI Dexter had his conversation with PC Richardson, all but 10 of the 38 patients who ultimately received treatment in the Casualty Clearing Station were already there\textsuperscript{844} and Saffie-Rose Roussos, who by-passed the Casualty Clearing Station, had arrived at hospital nine minutes earlier\textsuperscript{845}. Of the remaining ten, all had arrived in the Casualty Clearing Station by 23:42\textsuperscript{846}. Of those ten, two were already being

\textsuperscript{842} 107/8/12-9/5
\textsuperscript{843} 107/8/18-9/15
\textsuperscript{844} INQ041266
\textsuperscript{845} 174/92/3-9
\textsuperscript{846} INQ041266
moved on makeshift stretchers at 23:32, and all but one were being evacuated by 23:37. 847

13.575 Everyone acknowledges that firefighters would have made a real contribution to the evacuation of casualties from the City Room had they been present at a relevant time. 848 However, notification to GMFRS of CI Dexter’s Operation Plato zoning assessment shortly after 23:32 could not have made any difference to the casualties in the City Room. There was no prospect of any asset of GMFRS arriving before the casualties all reached the Casualty Clearing Station in any event.

13.576 There were, of course, NWAS assets present at the Victoria Exchange Complex, both specialist and non-specialist. There were two HART operatives and one non-specialist paramedic in the City Room. There were HART operatives at the Casualty Collection Point on Station Approach and non-specialist resources at the Casualty Clearing Station on the station concourse. Two questions arise. First, had CI Dexter informed the NWAS Operational Commander, Daniel Smith, of his Operation Plato zoning decision at or shortly after 23:32, would Daniel Smith have committed additional NWAS resources forward? Second, if Daniel Smith had

847 INQ041266, 106/89/5-19
848 119/78/23-79/11, 119/104/17-109/2
committed additional NWAS resources forward at that stage, was that capable of making any difference to the casualties who were still in the City Room in that period? The evidence provides a clear answer to both questions.

13.577 Had CI Dexter communicated his zoning decision to Daniel Smith, he would have been telling the NWAS Operational Commander that he considered the City Room an Operation Plato warm zone. As I explained in Part 12, Daniel Smith believed he did not have a discretion to deploy non-specialist paramedics into an Operation Plato warm zone. As I shall explain in Part 14, Daniel Smith’s approach to the deployment forward of NWAS resources that night was unduly cautious. In the circumstances, I am sure that knowledge of CI Dexter’s Operation Plato zoning decision would not have caused Daniel Smith to commit further NWAS resources, whether specialist or non-specialist, into the City Room. Whether Daniel Smith should have adopted a different approach is a separate question.

13.578 Had CI Dexter communicated his decision to Daniel Smith, it would have taken him at least some time to do so. There would then inevitably have been a discussion between the two. If Daniel Smith had been persuaded by that discussion to deploy additional NWAS resources
into the City Room, that too would have taken some time. The HART operatives would have had to have been deployed from the Casualty Collection Point and the non-specialist assets from the Casualty Clearing Station.

13.579 Once deployed, the resources would have had to have made their way to the City Room. It is probable they would not have arrived in the City Room before 23:36. By 23:36, the final living casualties were about to be moved to the City Room. They had been triaged. This included an assessment of whether any immediate life-saving intervention was required. The casualties were in a ratio of fewer than three to one paramedic. There were members of the public and a large number of police officers who helped with the evacuation. The final living casualty was removed from the City Room at 23:39.

13.580 In those circumstances, I consider it most unlikely that any additional NWAS resources could in any event have reached the City Room in time to make a material difference either to the treatment of casualties or their evacuation, save in one potential respect. Even at that late stage, taking stretchers up to the City Room to transport those who could not move themselves would have improved the safety, comfort and dignity of those who had yet to be evacuated.
13.581 The real failure of communication in relation to Operation Plato zoning was not CI Dexter’s. It was Inspector Sexton’s. Having declared Operation Plato, he did not make any or any appropriate Operation Plato zoning assessment and did not communicate such an assessment to the other emergency services, or even the fact that he had declared Operation Plato. As I have explained already, I am satisfied that if Inspector Sexton had engaged in a careful and systematic assessment of risk, having consulted the firearms officers at the scene for their views, he would have concluded, by no later than 22:50, that the City Room was an Operation Plato cold zone. A clear decision communicated at that stage should have given Daniel Smith the confidence to commit both additional specialist and non-specialist resources forward shortly after that time. Whether it would have done so is less likely, as Daniel Smith’s main concern was that there may be secondary devices in the City Room. Properly understood, a declaration that the City Room was an Operation Plato cold zone would not have given him any reassurance as to that.

13.582 Had Daniel Smith been reassured at 22:50 or shortly afterwards by the declaration of an Operation Plato cold zone and sent in more paramedics, that would have made a meaningful difference to the 38 casualties who ultimately
received treatment in the Casualty Clearing Station. Those 38 were all still in the City Room at 22:50. Indeed, the first evacuation of any of the 38 did not commence until 23:02, and that person did not arrive in the Casualty Clearing Station until 23:07.

13.583 For a number of reasons, effective treatment was delayed for many if not all of the 38. One of those was John Atkinson, who arrived in the Casualty Clearing Station at 23:24. The delay probably cost him his life. As I have observed, Saffie-Rose Roussos did not go to the Casualty Clearing Station. Instead, she was taken to Trinity Way, arriving there at 22:58. She transferred into an ambulance at 23:06 before travelling on to hospital. Any delay in treatment in her case, along with the nature of the treatment, may have made a difference to survival. However, it almost certainly did not do so for the reasons I have explained. I will deal with this in further detail in Part 18 in Volume 2-II.

13.584 The second reason CI Dexter gave for not having communicated his Operation Plato zoning
assessment was that he presumed that this would have been dealt with before his arrival. I consider it was reasonable for CI Dexter to assume that the FDO had made prompt and accurate decisions about Operation Plato zoning and communicated these to NWAS, NWFC and GMFRS. However, on making his own assessment at the scene, CI Dexter should have made contact with the FDO to inform him of that assessment and to ensure it was communicated to the other emergency services.

13.585 I consider that CI Dexter’s failure to communicate with the FDO on this issue was the consequence of a number of factors: the inadequacies in his training; the failure in common with other GMP commanders to appreciate the importance of Operation Plato zoning, which flows from an inadequacy of training; his assumption that the issue must already have been addressed; his correct belief that communication of his assessment would make no difference to deployments into the City Room; and the pressure that he was otherwise under. These factors make his omission understandable. They serve to emphasise that, in future, Operation Plato training must instil in commanders an understanding of the need to review regularly a declaration of Operation Plato and the consequent zoning decisions and ensure
that there is proper communication about those matters both within the police and to the emergency service partners of the police.

13.586 To return to the chronology, as he spoke to the Operational Firearms Commander about Operation Plato zoning, CI Dexter walked through the Casualty Clearing Station, the station concourse and out onto Station Approach.\(^{856}\) He remained there between 23:32 and 23:40.\(^{857}\) While there, he was involved in deploying firearms officers, including sending CTSFOs to the Cathedral to deal with reports of a suspicious male.\(^ {858}\)

**Events between 23:40 and 00:00**

13.587 By 23:40, CI Dexter had deployed firearms assets to Manchester Piccadilly Railway Station and the Cathedral.\(^ {859}\) Later, he deployed firearms officers to a hospital in Oldham.\(^ {860}\) In evidence, CI Dexter accepted that in making these deployments he was to some extent stepping outside the role of Ground Assigned Tactical Firearms Commander and into the role of Tactical Firearms Commander.\(^ {861}\) This is what Inspector Sexton described later during the response as
“crossing over”. Cl Dexter accepted, in evidence, that this might cause problems in some situations, although he was clear, and I accept, it had not done so that night.

13.588 My impression was that, in making these deployments, Cl Dexter was seeking to assist the FDO because he knew of the pressure that he was under. However, Cl Dexter also had responsibilities that were too wide-ranging. By this stage, he was commanding both the armed and unarmed police assets at the scene. This cross-over serves to illustrate that these two roles, the FDO and the Ground Assigned Tactical Firearms Commander, simply came under too much pressure that night. In future, in the ways in which I have recommended, that burden must be reduced.

13.589 During the period prior to 23:40, Cl Dexter had also checked on the cordons and ensured that a safe location had been established for those who had been evacuated from the Victoria Exchange Complex with no or limited injuries. He addressed the potential role of military assets, and had a discussion with James Allen, the Arena General Manager for SMG, about SMG’s staff...
and SMG’s assessment of risk.\textsuperscript{865} He then gave further instructions in relation to the broader search.\textsuperscript{866} In addition, CI Dexter spoke to Superintendent Leor Giladi, alerting him to the fact that Superintendent Giladi was likely to be needed for duties the following day.\textsuperscript{867}

\textbf{13.590} Throughout the period from his arrival until 23:40, CI Dexter had dealt with matters that were for the commander of firearms officers to deal with. He had also dealt with matters that were for the commander of unarmed officers to deal with. I have already explained my view that the latter responsibilities ought to have been discharged by a Tactical/Silver Commander at the scene, not the Ground Assigned Tactical Firearms Commander. CI Dexter’s view, in evidence, was that, on the night, he coped with this combined responsibility.\textsuperscript{868} I agree in the sense that he dealt with whatever was put in front of him and was also proactive in certain important respects. He showed a strong commitment to both roles.

\textbf{13.591} However, if a Tactical/Silver Commander had been at the scene with responsibility for the unarmed officers only, there are things that the Tactical/Silver Commander would probably have

\begin{itemize}
  \item \textsuperscript{865} INQ040657/8-9
  \item \textsuperscript{866} 106/172/7-176/5
  \item \textsuperscript{867} INQ040657/9
  \item \textsuperscript{868} 106/133/5-134/123
\end{itemize}
done that CI Dexter simply did not have time to do. In particular, such a commander would have been able to focus to a much greater extent on JESIP. That, I am satisfied, would probably have resulted in the establishment of an FCP and earlier co-ordination between the emergency services. Ultimately, such co-ordination was, of course, sorely lacking on the night.

13.592 At 23:41, CI Dexter took the call from ACC Ford to which I have already referred.\textsuperscript{869} In their discussion, CI Dexter provided her with an update. It was in this conversation that he said: “\textit{We’ve got no fire.}”\textsuperscript{870} CI Dexter confirmed, in evidence, that he was referring to the fact that GMFRS was not at the scene.\textsuperscript{871} In the Dictaphone recording, after CI Dexter said this, there is a short pause, following which CI Dexter said: “[\textit{Y}ou might as well.]”\textsuperscript{872} In evidence, his understanding of this was that, in the pause, ACC Ford indicated that she would put right the absence of GMFRS.\textsuperscript{873} ACC Ford explained, conversely, that she simply had not registered the reference to fire and so did not accept this interpretation.\textsuperscript{874}

\textsuperscript{869} INQ040657/10-11
\textsuperscript{870} INQ040657/11
\textsuperscript{871} 107/22/4-24
\textsuperscript{872} 107/23/7-13
\textsuperscript{873} 107/22/25-23/25
\textsuperscript{874} 105/228/12-229/24
13.593 Each witness was trying to help in relation to a conversation that took place in circumstances of great pressure, several years earlier. I do not regard the resolution of the difference between their accounts as having value. The real significance of this conversation is it reveals that, at the time, CI Dexter registered the absence of firefighters. However, as he explained, by the time of his call this was of little real significance to him because he knew that the final casualties were being removed from the City Room. The skills of firefighters in providing trauma treatment and evacuating casualties were therefore no longer of use.\[^875\]

13.594 CI Dexter was right. As he was on the telephone to ACC Ford, the final casualty arrived in the Casualty Clearing Station from the City Room.\[^876\] That brought to an end the opportunity for GMFRS to contribute to the evacuation of casualties from the City Room that night.

13.595 As the call with ACC Ford came to an end, CI Dexter was still on Station Approach.\[^877\] At 23:45, he spoke again to the Operational Firearms Commander and was introduced to PC Healy, the BTP dog handler who had arrived

\[^875\] INQ041266, 110/172/9-18
\[^876\] 107/24/9-25/19
\[^877\] 107/26/5-16
with Police Dog Mojo.\textsuperscript{878} He established that PC Healy was content to go into the City Room and Arena bowl and then left it to the Operational Firearms Commander to direct him.\textsuperscript{879} CI Dexter then left Station Approach\textsuperscript{880} to return to the City Room, arriving there at 23:47.\textsuperscript{881} He remained in that location until 00:15.\textsuperscript{882}

13.596 Once in the City Room, CI Dexter liaised with Inspector Smith and others.\textsuperscript{883} They ascertained that no living casualty remained in the City Room.\textsuperscript{884} He ensured that the City Room remained secure and that the cordon was in place around Manchester Victoria Railway Station.\textsuperscript{885} He again became involved in the deployment of firearms officers to Manchester Piccadilly Railway Station.\textsuperscript{886}

13.597 At 23:52, Inspector Sexton made a telephone call to CI Dexter.\textsuperscript{887} The conversation is captured on the Dictaphone recording of each,\textsuperscript{888} and it is therefore possible to understand the whole of it.

\begin{itemize}
\item \textsuperscript{878} INQ040657/12, 107/26/7-26/24
\item \textsuperscript{879} INQ040657/12, 107/26/7-24
\item \textsuperscript{880} INQ035612/388
\item \textsuperscript{881} INQ035612/392, 107/29/2-16
\item \textsuperscript{882} INQ035612/432, 107/29/2-16
\item \textsuperscript{883} 107/29/2-23
\item \textsuperscript{884} 107/29/2-23
\item \textsuperscript{885} INQ040657/13
\item \textsuperscript{886} INQ040657/12-17
\item \textsuperscript{887} INQ040657/18
\item \textsuperscript{888} INQ024325/37, INQ040657/18
\end{itemize}
It was in this conversation that Inspector Sexton said: “I am very much aware we’re erm crossing over each other on command and control.”

It was agreed that CI Dexter would “take command at Victoria and the MEN” and Inspector Sexton would speak to Temporary CI Buckle about command at Manchester Piccadilly Railway Station. It is correct to say that there had been cross-over of responsibility for firearms command. Even at this stage, however, it was not resolved and the Ground Assigned Tactical Firearms Commander continued to exercise control for deployments well beyond the Victoria Exchange Complex. This demonstrates that the firearms structure was not working as it ought to have done, even at a late stage.

13.598 Subsequently, in the period between the end of this conversation and 00:00 on 23rd May 2017, CI Dexter was again involved in the arrangements for the search of the wider premises. As part of that, he spoke again to ACC Ford at 23:54, seeking access to additional dogs through the process of mutual aid. Mutual aid refers to seeking assistance from other police services. I have already drawn attention to the
apparent delay in securing the attendance of explosives detection dogs and have made a recommendation in that regard.

Events between 00:00 and 00:23

13.599 The period between 00:00 and 00:23 takes events up to the point one hour after the arrival of CI Dexter. Between 00:00 and 00:15, he remained in the City Room, where he liaised with a number of people both directly and by telephone or radio.\(^\text{893}\) That included speaking to ACC Ford in order to disclose the outcome of certain enquiries he had directed be undertaken in relation to the Arena CCTV system\(^\text{894}\) and to the FDO in relation to the deployment of sensitive assets.\(^\text{895}\) At 00:06, CI Dexter spoke to Superintendent Thompson, who was shortly to take over as Tactical Firearms Commander from the Initial Tactical Firearms Commander, Inspector Sexton. CI Dexter provided Superintendent Thompson with a briefing.\(^\text{896}\)

13.600 While still in the City Room, CI Dexter continued to be involved in a variety of tasks, including speaking by telephone to the FDO line in order to seek the deployment of a further unarmed Operational/Bronze Commander to command the

\(^{893}\) INQ040657/24-33
\(^{894}\) INQ040657/26
\(^{895}\) INQ040657/26-27
\(^{896}\) INQ040657/27-29
unarmed assets on what he described as “the outer perimeter”.\textsuperscript{897} This conversation, along with others that night, indicates that Cl Dexter regarded himself as responsible for the armed assets and wanted support in relation to the unarmed assets.

13.601 Cl Dexter continued to progress the broader search. He met James Allen in person to ensure that he understood the layout of the Arena and the search that Arena staff had carried out.\textsuperscript{898}

13.602 At 00:15, Cl Dexter left the City Room.\textsuperscript{899} The recording from his Dictaphone indicates why. At 00:13:53, he appears to be speaking to the Operational Firearms Commander, when he said:

\begin{quote}
\textit{“Right let us just go and just have a round. I just want to understand the Forward Command Point, I want to see what’s at Forward Command Point and in terms of Armed Resources and I want to see what the cordons, if any is on ...”}\textsuperscript{900}
\end{quote}

13.603 In his evidence, Cl Dexter explained that he had developed an understanding that the FCP was on Station Approach.\textsuperscript{901} In a sense, that is what Station Approach was to become because that

\begin{itemize}
\item \textsuperscript{897} INQ040657/29-30
\item \textsuperscript{898} INQ040657/29-30
\item \textsuperscript{899} 107/29/7-16
\item \textsuperscript{900} INQ040657/32
\item \textsuperscript{901} 106/160/9-22
\end{itemize}
is where commanders met, although it was never a nominated and agreed FCP for the three emergency services. I have already made clear that the failure to identify an FCP was a major failure that had occurred long before CI Dexter’s involvement.

13.604 When CI Dexter went towards Station Approach at 00:15, that was his first attempt to co-locate with other emergency service commanders. I do not criticise CI Dexter for that. He had been extremely busy. However, this is precisely what a Tactical/Silver Commander with responsibility for the unarmed assets and with a greater focus on JESIP would have been expected to do much earlier, if at the scene.

13.605 At 00:16, while in the Casualty Clearing Station on his way to Station Approach, CI Dexter asked NWAS Operations Manager Derek Poland: “Who is the NWAS Incident Commander?”902 Derek Poland directed him outside, where NWAS Deputy Director of Operations Stephen Hynes who had taken over as NWAS Operational Commander from Daniel Smith, was situated.903

13.606 Outside, CI Dexter was asked by Stephen Hynes if he was in charge, and he answered: “I am from

902 INQ040657/33
903 INQ035612/435, INQ040657/33
the firearms point of view.” This reinforces yet further the view that CI Dexter consistently expressed that he considered that his role was to command the firearms officers.

13.607 Stephen Hynes asked CI Dexter if it was safe. CI Dexter understood him to be referring to the Casualty Clearing Station, as I accept he was. In response, CI Dexter said: “I’d say warm. That you’re okay anywhere in there, fine. I’ll border on cold but I will stick with warm.” Stephen Hynes pressed him and CI Dexter then said: “I would declare this cold for now.”

13.608 In evidence, CI Dexter acknowledged that this represented, on his part, “a rather vague or non-technical approach to zoning”. It was plain to me that he was adopting a pragmatic approach. He did not want to discourage emergency responders from working in an area that he regarded as safe. CI Dexter effectively accepted that this was his approach, in evidence.

13.609 I consider that CI Dexter’s aim was laudable, but the problem would have been avoided if his training had equipped him to carry out an
accurate Operation Plato zoning assessment. If it had, he would have had no hesitation in informing Stephen Hynes that the Casualty Clearing Station was an Operation Plato cold zone, as was the City Room.

13.610 In the subsequent minutes leading up to 00:23, Cl Dexter spoke to PC Lee Moore and again to ACC Ford. In his discussions with them, Cl Dexter’s references to Operation Plato zoning were also vague.

Events after 00:23

13.611 At 00:24, a radio broadcast on the firearms radio channel reported shots fired at a hospital in Oldham. In evidence, Cl Dexter described how this report hit him hard. He explained the fear it generated that a Paris-style attack was under way. Coincidentally, a CTSFO team from outside Greater Manchester contacted him at 00:25, and Cl Dexter was therefore able to deploy them to Oldham. The report was later discovered to be false.

13.612 In the ten minutes that followed this report, Cl Dexter was heavily involved in managing the events at Oldham. Then, at 00:37, he was
spoken to again by Stephen Hynes. Stephen Hynes continued to be concerned about the issue of safety. CI Dexter explained that the Casualty Clearing Station was “getting near to cold”. In fact, there is no doubt that the Casualty Clearing Station was an Operation Plato cold zone and had been for a long time. If CI Dexter had been adequately trained, he would have understood that.

13.613 In evidence, CI Dexter again accepted that this was not the language of JOPs 3 but explained that he was seeking to communicate the quantum of risk to Stephen Hynes in language he thought would be understood. My views about this conversation are identical to the views I expressed about the earlier conversation between CI Dexter and Stephen Hynes.

13.614 CI Dexter then returned to the City Room and liaised with Inspector Smith about the progress of the search. He then briefed a group of firearms officers on the Arena concourse before returning to the City Room and then going again to Station Approach, where he spoke to Superintendent Thompson, Temporary

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915 107/64/12-67/7
916 INQ040657/52-53
917 107/66/4-67/7
918 INQ035612/492, INQ040657/58-59
919 INQ035612/497
920 INQ035612/516
Superintendent Hill and Temporary CI Buckle by telephone and radio. 921

13.615 At 00:54, CI Dexter spoke again to Stephen Hynes on Station Approach. 922 The NWAS Operational Commander asked for a briefing. 923 The GMFRS NILO, Station Manager Berry, had now arrived. Station Manager Berry explained that he had the Chief Fire Officer on the telephone, who even at this late stage required reassurance before committing the assets of GMFRS into the Victoria Exchange Complex. 924

13.616 CI Dexter said, “It’s warm going cold”, and then spoke directly to Chief Fire Officer Peter O’Reilly by telephone, using the term “Plato standby”. 925 This was not a term used in JOPs 3 or in the CTPHQ refreshed guidance. It was, as CI Dexter accepted in evidence, an attempt to find a pragmatic solution to a situation in which, 2 hours and 25 minutes after the explosion, the Chief Fire Officer of GMFRS was still not prepared to sanction his staff entering the Victoria Exchange Complex. 926 Again, I applaud CI Dexter’s purpose and his imagination, but once more I observe that this confusion of language would have been
avoided if his training had given him the ability and the confidence accurately to zone the station concourse and the City Room under Operation Plato as cold and then communicate that assessment.

13.617 CI Dexter did not leave the Victoria Exchange Complex until 03:30. Before leaving, he updated NWAS and GMFRS and handed over scene security to an unarmed Operational/Bronze Commander supported by an Operational Firearms Commander. He had spoken to the Senior Investigating Officer and undertaken a whole series of additional tasks, including assisting in the identification of the murderer.

13.618 I have not detailed everything CI Dexter did in the period of more than four hours that he was at the Victoria Exchange Complex. As for any person responding in circumstances of great pressure, it is possible to identify things that he could, and sometimes should, have done differently on the night. In particular, his approach to Operation Plato and zoning was deficient. Overall, however, the emergency response benefited greatly from CI Dexter’s presence at the scene. He commanded those on the ground with intelligence, authority and resourcefulness. I agree with Counsel for the families that his
dedication and efforts that night should be recognised.\textsuperscript{929}

Conclusion

13.619 The GMP firearms officers discharged their primary responsibility with skill and efficiency. Individual officers of GMP who entered the City Room acted with courage and resourcefulness. Inspector Smith and CI Dexter made significant contributions to the response.

13.620 However, others within the GMP command structure did not make the contribution that the public was entitled to expect they would make in the event of a terrorist attack in the heart of Manchester. Although there were individual failures, the principal responsibility for that rests with GMP at a corporate level.

13.621 GMP’s failures are very significant, but are not the only explanation for why joint working between the emergency services broke down on the night of the Attack.
Counter Terrorism Policing Headquarters response

Key findings

- Counter Terrorism Policing Headquarters (CTPHQ) was able to gain good situational awareness, including of the declaration of Operation Plato.

- The CTPHQ response was well co-ordinated and the network of Counter Terrorist Specialist Firearms Officers was deployed rapidly.

- There was an element of good fortune in the initial notification and co-location of CTPHQ officers. CTPHQ should ensure that all police services have in place a robust mechanism for the early notification of CTPHQ of any potential terrorist attack.

Introduction

13.622 CTPHQ was established by an agreement between policing bodies in England and Wales. The agreement required regional policing bodies to work together to counter effectively the threat posed to the national interest from terrorism. CTPHQ was created to provide direction, support
and co-ordination to the counter terrorism policing network in England and Wales.\(^{930}\)

13.623 In May 2017, CI Thomas was the Head of Specialist and Counter Terrorism Armed Policing Capabilities at CTPHQ. This unit led police service engagement with the Home Office for the development of the JOPs programme and national Operation Plato policy.\(^{931}\) It also oversaw the CTSFO network. This is a group of highly trained firearms officers equipped to respond to terrorist incidents. Members of the CTSFO network are embedded within police services across the country.\(^{932}\)

**Initial notification**

13.624 On 22\(^{nd}\) May 2017, CI Thomas was attending a two-day meeting of the CTSFO network Tactical Co-ordinating Group.\(^{933}\) He was also the CTSFO on-call co-ordinator.\(^{934}\) In the event of a terrorist incident, this role liaises with the CTSFO hubs around the country in order to provide support and resourcing if demand in one part of the country requires CTSFO resources from another police service.\(^{935}\) Inspector David Murtagh from

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930 [INQ035915/1] at paragraphs 5 and 6
931 [60/2/6-4/4]
932 [60/90/15-91/13]
933 [60/91/14-16]
934 [60/95/25-96/1]
935 [INQ029536/2] at paragraph 11
GMP was also in attendance. He was the operational lead for the regional CTSFO hub.936

13.625 At 22:40, Inspector Murtagh received a call from Sergeant Frederick Warburton, the duty CTSFO Sergeant at GMP. Sergeant Warburton reported that an explosion had just occurred at the Arena and that it was believed that a terrorist attack was under way.937 Three minutes later, Inspector Murtagh called CI Thomas to inform him. They agreed to meet immediately and began working from a meeting room in their hotel.938

Mobilisation of the wider CTPHQ network

13.626 Within three minutes of the call from Inspector Murtagh, CI Thomas had contacted two of the Operational Firearms Commanders from the Intervention Response Teams.939 CI Thomas explained that the Intervention Response Team is “the immediate response option from the CTSFO network”.940 He told the two Operational Firearms Commanders that it was believed that a terrorist attack was under way at the Arena. He instructed them to call out their Intervention Response Team staff immediately and get them

936 INQ029536/1 at paragraphs 4 and 7
937 60/91/19-92/12
938 60/91/19-92/18
939 60/93/2-6
940 60/92/24-93/1
fully equipped, then to contact him again when they were ready to deploy from their base. 941

13.627 At the same time as these calls, Inspector Murtagh accessed the GMP Force-Wide Incident Log via his police laptop. 942 This allowed him to receive updates on what was known about the developing situation at the Arena. He was also able to monitor the Airwave radio system for real-time updates. 943 CI Thomas and Inspector Murtagh were quickly joined by a number of CTSFO operational leads. They helped to set up a temporary operations room in the hotel to monitor the situation. 944

13.628 At 22:50, CI Thomas spoke to Assistant Commissioner Neil Basu to inform him of the Attack. 945 Assistant Commissioner Basu was the Senior National Co-ordinator. 946 The role of the Senior National Co-ordinator in response to a terror attack is to assume national strategic command of the incident and co-ordinate the investigative response. 947 The Senior National Co-ordinator will be aware of the wider threat picture and what assets can and cannot be

941 60/93/14-22
942 60/94/9-12
943 60/95/7-17
944 60/95/18-96/4
945 60/94/13-23
946 59/16/18-20
947 59/29/15-24
deployed. In that call, CI Thomas told Assistant Commissioner Basu that gunshots may have been heard at the Arena. This was information that Inspector Murtagh had passed on to him.

Assistant Commissioner Basu explained that, in the event of a terrorist attack, the usual protocol was for the relevant FDO to inform SO15 Reserve, who would then inform the Senior National Co-ordinator. Assistant Commissioner Basu said that the FDO would have a long list of actions, including contacting the CTSFO on-call co-ordinator and the Senior National Co-ordinator. Speed was critical to ensure that as many armed assets as possible could be deployed as quickly as possible. Assistant Commissioner Basu said that it did not matter that the CTSFO on-call co-ordinator was called before the Senior National Co-ordinator.

Assistant Commissioner Basu noted: “If we all relied on one individual doing all of those actions that would be too slow.” This evidence encapsulated both the weight of responsibility on the FDO and how it was understood by the wider counter-terrorism network that the FDO could become a critical point of failure.
13.631 Approximately ten minutes after CI Thomas had spoken to Assistant Commissioner Basu, another GMP Inspector staying at the hotel, Inspector Mark Nutter, began a contemporaneous log in the hotel room where they were working. This was to help keep an accurate log of communications.\textsuperscript{952}

13.632 At 23:03, the Deputy Senior National Co-ordinator, ACC Terri Nicholson, received a telephone call from her husband, who was a manager of the national counter-terrorism Firearms Training Unit. He advised that there was a suspected explosion at the Arena and that the CTSFO on-call co-ordinator had been notified. ACC Nicholson passed this information on to Assistant Commissioner Basu. She said that the Attack had taken the form of a person-borne Improvised Explosive Device and that there may have been gunshots.\textsuperscript{953}

\textbf{Awareness of Operation Plato declaration}

13.633 After speaking to CI Dexter, at 23:05 Inspector Murtagh rang the GMP FDO line and asked for confirmation that Operation Plato had been declared.\textsuperscript{954} He was told that it had been. He shared this information with CI Thomas.\textsuperscript{955} Assistant Commissioner Basu was informed

\textsuperscript{952} 60/94/2-8, 60/93/7-13
\textsuperscript{953} 59/59/5-60/18
\textsuperscript{954} INQ029536/2 at paragraph 16
\textsuperscript{955} 60/96/5-7
about the declaration of Operation Plato in a further call with ACC Nicholson at 23:12. At that stage, he was told that it was thought there were upwards of 15 fatalities. Armed Response Vehicles and CTSFOs had been deployed to the Arena. Assistant Commissioner Basu was working on the assumption that there was one explosion, but was aware of confusion on social media about reports of gunfire.  

13.634 Around the same time, CI Thomas instructed the on-call Intervention Response Teams to travel from their home bases to an RVP in Manchester. It was confirmed that GMP would be responsible for the mobilisation of its own CTSFOs, both those off duty and on duty, and that CI Thomas, as the on-call co-ordinator, would oversee the mobilisation of CTSFOs from other parts of the country.  

13.635 I heard evidence about the need to ensure that all police resources deployed to a Major Incident, both from within and outside GMP, are managed effectively. This is particularly important for firearms officers. In light of this, CTPHQ may wish to review how it ensures effective co-ordination of local and national assets so that no
issues arise where the situation requires a rapid deployment of CTSFOs.

13.636 Inspector Murtagh spoke to CI Dexter about a suspicious male at Manchester Cathedral just over one hour after the explosion. Shortly afterwards, Inspector Murtagh called the GMP FDO line again and asked them to use the Airwave multi-agency channels.\(^\text{960}\)

13.637 By 00:05, Inspector Murtagh updated CI Thomas and others at the hotel that it was believed that 18 people had died and a number of others were injured. Approximately eight minutes later, this was updated to 17 confirmed dead and over 50 people injured.\(^\text{961}\)

**Continuing involvement in response**

13.638 As the situation developed, Assistant Commissioner Basu took steps to begin the post-incident investigation. Shortly before 01:00 on 23\(^{\text{rd}}\) May 2017, he arrived at New Scotland Yard and met various senior officers, including the Assistant Commissioner of Specialist Operations, Sir Mark Rowley, and ACC Nicholson. By that stage, there was a high degree of confidence that the Attack was a terrorist incident. A public statement was agreed to say that the Attack was

\(^\text{960}\) INQ029536/3 at paragraphs 21 and 23
\(^\text{961}\) INQ029536/4 at paragraphs 25-26
being treated as terrorism and that CTPHQ had assumed national strategic command.\textsuperscript{962}

This declaration can only be made by the Senior National Co-ordinator.\textsuperscript{963}

13.639 Over the following hours, CI Thomas continued to co-ordinate the response of CTSFOs from outside Greater Manchester. CI Thomas made provision for other CTSFO teams to be available from 07:00 on 23\textsuperscript{rd} May 2017. He said that it was clear that armed support from the CTSFO network would be required over the coming days.\textsuperscript{964} He spoke to the National Police Co-ordination Centre to ensure that there was adequate Armed Response Vehicle support available to GMP.\textsuperscript{965}

13.640 CI Thomas remained at the temporary operations room at the hotel until the late afternoon on 23\textsuperscript{rd} May 2017. He did so in order to fulfil his duties as the on-call CTSFO co-ordinator and maintain an overview of armed policing national capacity and resilience.\textsuperscript{966}
Conclusion

13.641 Although the CTSFO network did not play a central role in the response to the Attack, CI Thomas and his colleagues gained situational awareness of the Attack quickly and used that knowledge to good effect. They were able to begin steps for the deployment of non-GMP CTSFO assets within 15 minutes of the explosion. They kept a contemporaneous log and they were proactive in confirming the declaration of Operation Plato. It was confirmed within 18 minutes of the declaration.

13.642 The CTPHQ response showed how effectively resources can be co-ordinated, even with no notice, when those in charge are working remotely and in different locations. It provides an example of what a well-co-ordinated, police-led response to the Attack might have been and how quickly resources could have been deployed on the scene. The use of the CTSFO network in particular is an issue that I will return to in reviewing the Care Gap in Part 20 in Volume 2-II.

13.643 Inspector Murtagh commented that it was “in some ways fortunate”\(^\text{967}\) that a number of people who would have been involved in a response to a terrorist incident were all located in one place.\(^\text{968}\)

\(^{967}\) INQ029536/5 at paragraph 42
\(^{968}\) INQ029536/5 at paragraph 42
I agree with that. While the CTPHQ response was swift and effective, the initial notification from GMP and timely co-location came because of the attendance of Inspector Murtagh of GMP, CI Thomas and other CTPHQ officers at the same two-day event. Had it not been for this, CTPHQ officers were likely to have found out later than they did. Communication would have been more difficult. This would have delayed CTPHQ’s response. CTPHQ should reflect upon this and ensure that the mechanism for notifying CTPHQ of any potential terrorist attack by any police service is an early priority.
Part 14
Ambulance service response to the Attack

Introduction

14.1 In Part 12, I set out North West Ambulance Service’s (NWAS’s) state of preparedness. NWAS had taken significant steps to be ready to respond to a terrorist attack in its area of operation. Despite this, there were substantial failures in its response to the Attack. In this Part, I will consider those failures, within the following structure.

14.2 First, I will start with NWAS Control. Broadly speaking, the initial mobilisation was timely. However, there were problems in specific areas.

14.3 Second, I will look at the contribution made by Advanced Paramedic Patrick Ennis. NWAS was fortunate to have Patrick Ennis on duty that night. He self-mobilised at an early stage and played an important role.

14.4 Third, I will pause my narrative of events inside the Victoria Exchange Complex to set the role of Ambulance A344 in its proper place in the order of events. Ambulance A344 was flagged down by
those assisting Saffie-Rose Roussos at 23:00. It transported her from the scene to hospital.

14.5 Fourth, I will examine in detail the Operational Commander role until shortly before midnight. During this period, this responsibility was performed by Consultant Paramedic Daniel Smith. It was during this period that significant mistakes were made that had an adverse impact on the adequacy of the NWAS response.

14.6 Fifth, I will set out the response of the Hazardous Area Response Team (HART). The focus will be on the Greater Manchester HART (GM HART) crew as they were best placed to make the greatest contribution. I will also consider the position of the Cheshire and Merseyside HART (C&M HART) crew.

14.7 Sixth, I will review the tactical command of the incident. Annemarie Rooney was the Tactical Commander for NWAS. As I will explain, there were areas in which this role could have made a greater contribution.

14.8 Seventh and eighth, I will explore the roles of the two Tactical Advisor/National Interagency Liaison Officers (NILOs) who responded to the Attack. They were Jonathan Butler and Stephen Taylor.
14.9 Ninth, I will give brief consideration to the role of the Ambulance Intervention Team Commander. This role was expected to lead NWAS Operation Plato responders. On the night of the Attack, it was not allocated during the first half-hour, despite efforts being made to identify a person qualified to undertake the role.

14.10 Tenth, I will examine strategic command of the incident. The Strategic Commander role was undertaken by Neil Barnes. As I shall explain, he did not have an impact in any meaningful way on the response.

14.11 Eleventh, and finally, I shall return to the Casualty Clearing Station, considering the period after midnight.
North West Ambulance Service response

Key findings

• The North West Ambulance Service (NWAS) command structure was notified promptly of the Attack. During the first 30 minutes, the NWAS response to a potential Operation Plato declaration was appropriate.

• NWAS Control should have allocated the Greater Manchester Hazardous Area Response Team (GM HART) crew to respond to the Attack sooner than occurred.

• NWAS Control should have allocated the Cheshire and Merseyside (C&M) HART crew to respond to the Attack sooner than occurred.

• While it was understandable for NWAS to use a Rendezvous Point away from the scene in the minutes following the Attack, all ambulances responding to the Attack should have been dispatched to the scene before 23:00. This would have led to a greater number of ambulances and personnel being available to the NWAS Operational Commander when he made his initial deployment decisions.
• The Operational Commander should not have dispatched two paramedics to Trinity Way just after 23:00. He should have waited until he had better situational awareness.

• Two METHANE messages were passed from the scene to NWAS Control. The absence of Greater Manchester Fire and Rescue Service at the scene was not identified in either message. Neither were passed on to any other emergency service.

• The Operational Commander should have deployed more paramedics into the City Room than he did.

• The Operational Commander’s approach to the risk presented by the City Room was unduly cautious. This was substantially a product of his lack of situational awareness and the fact that he did not conduct a joint assessment of risk with the Greater Manchester Police (GMP) commanders.

• The Operational Commander should have sought to co-locate and/or communicate with the GMP Operational/Bronze Commander and GMP Operational Firearms Commander.

• The Operational Commander’s evacuation plan for the City Room was inadequate. He should have ensured that the stretchers which were available at the scene were used.
• The whole of the GM HART crew should have been deployed to the City Room. The GM HART Team Leader should have acted as a Sector Commander for the City Room.

• The NWAS Tactical Commander should have developed and communicated a tactical plan to the Operational Commander.

• The Tactical Commander should have used her meeting with the GMP Tactical/Silver Commander at around 23:15 to ensure that there was a co-ordinated response between GMP and NWAS.

• Once NWAS was notified, there was a delay in passing on the Operation Plato declaration to NWAS personnel at the scene.

• The NWAS Strategic Commander should have made a greater contribution to the emergency response. He should have set off for GMP Headquarters much sooner than he did.

• The ‘walking wounded’ should have been better managed.
NWAS Control

First 999 call (22:32)

14.12 At 22:32, a member of the public, having called 999, was connected to NWAS Control. The caller stated: “I’m at the MEN [Manchester Evening News] Arena in Manchester there’s a bomb just gone off in the foyer.” The caller said that he had been in the “foyer” when the bomb had gone off. He confirmed that the address was Hunts Bank. He identified the location of the detonation as “in the main reception near the box office.” He went on to say: “[T]here’s people everywhere, blood everywhere.” The call ended, after just over two and a half minutes, with the caller saying he needed to find his daughter.

14.13 At 22:32, there were seven vehicles within the Greater Manchester area immediately available to NWAS for deployment: four ambulances, two Urgent Care Vehicles and an Intermediate Care Vehicle.

Call to GMP Control (22:36)

14.14 At 22:36, NWAS Control telephoned Greater Manchester Police (GMP) Control. It took over
two minutes for the call to be answered by GMP Control. If there had been a multi-agency control room radio talk group which all control rooms were monitoring 24 hours a day, seven days per week, the delay in getting through to GMP Control, at this important early stage, would not have occurred.

14.15 Three minutes into the call, GMP Control said: “[W]e’ve got a lot of officers en-route … we’ve got officers on scene … Where are the ambulances?” NWAS Control replied: “[W]e’re 10 minutes away – we’ve got quite a lot of ambulances coming.” Five minutes into the call, GMP Control asked how many vehicles were en route. NWAS Control replied: “We’ve got five at least, but we’re shouting out for crews to clear if they can.” As the call was concluding, GMP Control stated: “[W]e’ve got an officer on scene … they’re just updating literally every few minutes.”

14.16 This call covered the period 22:38 to 22:44. In the course of it, GMP Control repeatedly mentioned that there were GMP officers at the scene. It is significant that this information was
passed to NWAS Control at this stage of the response. During the period of this call, NWAS Control was mobilising its personnel to a Rendezvous Point (RVP) at Manchester Central Fire Station.

Call to NWFC (22:37)

14.17 At 22:37, NWAS Control telephoned North West Fire Control (NWFC).\(^\text{12}\) This was the correct thing for NWAS Control to do. However, as it turned out, NWFC had more information to give NWAS than NWAS had information to give NWFC. This was because NWFC had already received a substantial amount of information from GMP Control.

14.18 There were unsatisfactory elements to the telephone call between NWAS Control and NWFC. I shall deal with these in greater detail when I consider NWFC’s response to the Attack, in Part 15.

Initial mobilisations

14.19 Advanced Paramedic Patrick Ennis was on duty at Central Manchester Ambulance Station when he became aware of a number of 999 calls coming in to NWAS Control related to the Arena. At 22:36, he radioed NWAS Control and asked: “[W]hat’s going on in the city?”\(^\text{13}\) NWAS Control

\(^{12}\) INQ001218

\(^{13}\) INQ015106T, 76/34/18-35/17
replied: “As at the minute we’re just taking all the call[s], we’ll get back to you in a second when we know what’s happening.”\textsuperscript{14}

14.20 On 22\textsuperscript{nd} May 2017, Nicola Pratt was the duty Manager of the Emergency Operations Centre for Greater Manchester, which was part of NWAS Control. At 22:36, Nicola Pratt made a call to another part of NWAS Control, the Regional Health Control Desk. In that call, Nicola Pratt said that there were reports of a bomb going off at the Arena. She advised that the hospitals may need to be put on standby.\textsuperscript{15} It was important that this step was taken at an early stage. Nicola Pratt did well to do so at the point she did.

14.21 At 22:38, Patrick Ennis contacted NWAS Control again. He said: “I’m just on my way … I’m just going to follow the police.”\textsuperscript{16} He also requested: “[J]ust see if anybody in Manchester has spoken to … Silver.”\textsuperscript{17} “Silver” was a reference to the on-call NWAS Tactical Commander.

14.22 As Patrick Ennis was confirming that he was on his way to the Arena, NWAS Control called Annemarie Rooney. Annemarie Rooney was the on-call NWAS Tactical Commander. The call was made by Nicola Pratt. Nicola Pratt informed
Annemarie Rooney: “[W]e are getting reports of a bomb gone off at the Manchester Arena.” 18
Annemarie Rooney asked: “When did this come in?” 19 She is one of the few commanders across the entire emergency response who asked this question. It was appropriate that she did so. 20

14.23 Nicola Pratt informed Annemarie Rooney that NWAS Control would contact the on-call Operational Commanders: Derek Poland and Matthew Calderbank. 21 Nicola Pratt can be heard asking for someone in NWAS Control to contact both of these men. 22 It was identified that the on-call NWAS Strategic Commander was Neil Barnes. Annemarie Rooney said that she would contact him. 23

14.24 Annemarie Rooney said: “[W]e need to get HART, we need to find out who’s the … AIT on duty.” 24 It was 22:39 when HART was first mentioned. ‘AIT’ stands for Ambulance Intervention Team. 25

14.25 While Annemarie Rooney was correct to identify that HART was required, in light of the clear

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18 INQ015353T/1
19 INQ015353T/1
20 INQ015353T/1, INQ025679/2
21 INQ015353T/1, 112/16/2-4, 114/140/13-18
22 INQ015353T/1
23 INQ015353T/1
24 INQ015353T/1
25 INQ015353T/1-2, 77/123/12-124/3
report at 22:32 that “a bomb”\textsuperscript{26} had detonated, it would have been better if the need for HART had been identified before 22:39 by NWAS. One of the issues with HART is the limited number of teams covering a large area. For this reason, it is essential that contact is made with the nearest HART crew as early as possible. It should be possible for the control room to do this as part of a standard response. NWAS should review its policies for mobilising the HART resource, to seek to ensure that it is available as soon as possible for any emergency where its specialist skills are required. This important issue is examined in further detail in Part 20 in Volume 2-II.

14.26 While the telephone call between Annemarie Rooney and Nicola Pratt was ongoing, NWAS Control called the GM HART crew.\textsuperscript{27}

14.27 At 22:40, NWAS Control telephoned Derek Poland. He was mobilised to Manchester Central Fire Station. Two minutes later, Matthew Calderbank was also mobilised to Manchester Central Fire Station by NWAS Control.\textsuperscript{28}

14.28 At 22:41, Annemarie Rooney telephoned Consultant Paramedic Daniel Smith. In that call,
they agreed that he would travel to the scene. This call was as a result of an existing informal agreement between Annemarie Rooney and Daniel Smith. It was not part of any formal or approved plan. Their agreement was to the effect that if either of them learned of an incident which they thought the other might want to mobilise to, they would let the other know. Although Daniel Smith would later take up the role of Operational Commander once he was at the scene, they did not discuss this in the call. Following the call, Daniel Smith got dressed, got in his car and drove towards the Arena.29

14.29 I am not critical of Annemarie Rooney contacting Daniel Smith. As a Consultant Paramedic, Daniel Smith had a very high level of expertise he could contribute. However, contacting Daniel Smith when he was off duty gave rise to a risk to the pre-determined command structure, which had been put in place for good reason.

14.30 Shortly after 22:40, Neil Barnes telephoned Annemarie Rooney. She had telephoned him at 22:40, but he had not answered that call. She informed him of the Attack. He asked her to call him back once she had received greater situational awareness through a METHANE message. Annemarie Rooney informed Neil
Barnes that she was intending to travel to GMP Headquarters (GMP HQ). He was also made aware that two on-call Operational Commanders, Derek Poland and Matthew Calderbank, were being mobilised to the incident.  

**Call from BTP Control (22:41)**

14.31 At 22:41, British Transport Police (BTP) Control telephoned NWAS Control. The purpose of the call was “just to give you a bit of info from our officers on … scene”. BTP Control went on to provide a casualty update. There was a discussion about the information NWAS had about “an active shooter”. BTP Control said: “[We have had] it come through as a bomb threat or attack because of the use of ball bearings.”

14.32 BTP Control informed NWAS Control: “[It has been declared a major incident by [BTP] … we are working on getting more officers to the scene obviously.” BTP Control told NWAS Control: “[Fire have been made aware etc.”

14.33 The call continued, with NWAS Control saying: “[We have] got about 30 odd jobs that have come through … from the MEN reception area and from the train station with injuries, so are you
on scene at the train station[?]”35 BTP Control replied: “Yeah … I’ve got I think two officers or maybe three on scene. It is hard to say really … I have got numerous going and Greater Manchester Police will likely be on scene as well.”36 NWAS Control told BTP Control: “[A]t the moment we’ve got 1, 2, 3, 4 … it looks like 6 crews going and two officers at the minute. We have got an officer going to Thompson Street [Manchester Central Fire Station] as well.”37

14.34 By 22:45, both GMP Control and BTP Control had informed NWAS Control that each organisation had officers on scene and more were on their way. It is unclear the extent to which this information had been adequately communicated and understood by NWAS as an organisation. This information was not passed on to Daniel Smith when he telephoned at 22:50.38

Ambulance A344 (22:44)

14.35 Paramedic Gillian Yates and Emergency Medical Technician Gemma Littler were crewed together in Ambulance A344 for their shift on 22nd May 2017.39 They were in Withington dealing with a patient when they received notification of

35 INQ015145T
36 INQ015145T
37 INQ015145T
38 INQ015056T
39 175/106/4-7
the Attack. At 22:44, they told NWAS Control they were nearly ready to deploy.40

14.36 At 22:48, they contacted NWAS Control a second time. They were told: “There’s been an explosion at the MEN Arena, a nail bomb, 60 casualties so far. There’s an RV point at the fire station, I’ll pass you the details.”41 They confirmed they were on their way. The reference to “the fire station” was to Manchester Central Fire Station, sometimes referred to as ‘Thompson Street Fire Station’.

14.37 In evidence, Gillian Yates stated: “I think the rendezvous point was Thomas Street Fire Station [sic], but I think the satnav was taking us to Hunts Bank.”42 She was asked who programmed the satnav and replied: “It’s done automatically from when they send the information to our computer in the ambulance, it automatically sends it to the satnav at the same time, so we don’t manually programme it in.”43

14.38 At 23:00, Ambulance A344 drove along Trinity Way, where it was flagged down by those helping Saffie-Rose Roussos. She had been carried out of the City Room and on to Trinity Way via the
Trinity Way link tunnel.\textsuperscript{44} I will return to Ambulance A344 at paragraphs 14.189 to 14.191.

**Major Incident declaration (22:46)**

14.39 At 22:45, a call within NWAS Control took place. The Regional Health Control Desk telephoned Greater Manchester Emergency Operations Centre. In the course of the call, the caller asked: 
“[J]ust a quick one is this a major incident standby or is it declared?”\textsuperscript{45} Following a short discussion with Nicola Pratt, who was in the background of the call, the response came back: 
“[W]e will call it declared as from now 22:46.”\textsuperscript{46}

14.40 It was appropriate for this conversation to have taken place and for the decision to have been taken as it was. Even though those discussing the issue of a Major Incident declaration were remote from the scene, NWAS Control had adequate information at 22:46 to justify the declaration.

14.41 Following this call, the Regional Health Control Desk Major Incident action card was accessed. This led to a series of calls notifying local hospitals of the Major Incident declaration and giving approximate casualty numbers. NWAS

\textsuperscript{44} 175/113/3-114/23
\textsuperscript{45} INQ015335T
\textsuperscript{46} INQ015335T
records indicate that, by 23:00, six hospitals had been informed of the Major Incident declaration. More hospitals were notified in the minutes following 23:00.\textsuperscript{47} NWAS did not notify GMP, BTP, NWFC or Greater Manchester Fire and Rescue Service (GMFRS) of its Major Incident declaration, as it should have done.

14.42 The fact that both NWAS Control and BTP Control were able to declare a Major Incident in a timely way contrasts with GMP, which did not declare a Major Incident until 00:57 on 23\textsuperscript{rd} May 2017.\textsuperscript{48} GMFRS and NWFC should also have declared a Major Incident.

\textbf{Notification of Tactical Advisors/NILOs (22:49)}

14.43 At 22:49, NWAS Control contacted Jonathan Butler. Jonathan Butler was one of two on-call Tactical Advisors/NILOs.\textsuperscript{49} In accordance with the guidance provided by the National Ambulance Resilience Unit (NARU), NWAS operated a system in which the roles of Tactical Advisor and NILO were combined.\textsuperscript{50}

14.44 In the telephone call, NWAS Control gave Jonathan Butler a brief situation report. He said he would contact the other on-call Tactical

\textsuperscript{47} INQ041691/1-5
\textsuperscript{48} INQ022399/11
\textsuperscript{49} INQ015355T
\textsuperscript{50} 116/31/5-21
Advisor/NILO, Stephen Taylor. I shall return to the role the NWAS Tactical Advisors/NILOs played on the night of the Attack below, at paragraphs 14.523 to 14.574.

**Rendezvous Point**

14.45 At an early stage of NWAS’s response, it was decided that Manchester Central Fire Station would be used by NWAS as an RVP. NWAS Control informed BTP Control of this at 22:43. I am not critical of the selection of Manchester Central Fire Station as an RVP at an early stage. It was an appropriate site for an RVP. It was close to the scene. In the event that it transpired that the scene was unsafe, it was far enough away to provide ambulance crews with some protection. My criticism of its selection relates to the lack of multi-agency discussion around its use.

14.46 Joint Emergency Services Interoperability Principles (JESIP) require co-location. It was not sufficient for NWAS Control to inform BTP Control where NWAS resources were going. There should have been a concerted effort to agree on where co-location should take place. Had there been such a conversation, it would have become apparent that BTP regarded the scene itself as sufficiently safe to deploy its
unarmed responders there. By 22:43, BTP was the best placed of all the emergency services to make this judgement, having direct situational awareness from a significant number of officers within the Victoria Exchange Complex.

14.47 Having identified Manchester Central Fire Station as the RVP, it was important for NWAS Control to respond quickly to any new information emerging from the scene as to whether it was safe enough to deploy ambulances in numbers to the Victoria Exchange Complex.

Contact between NWAS Control and Patrick Ennis (22:46)

14.48 At 22:46, NWAS Control asked Patrick Ennis for a situation report. He replied from Hunts Bank to say: “We’ve had reports of a nail bomb, possibly with shooting.” He said he could see six to eight casualties whom he described as walking wounded. At 22:47, he asked for “at least four emergency ambulances” and suggested that the best access would be from Cross Street, “liaising at the [Victoria] Station”. He was describing how to get to the Victoria Exchange Complex, not Manchester Central Fire Station. Four minutes
later he entered the Victoria Exchange Complex through the War Memorial entrance. 56

Contact between NWAS Control and Patrick Ennis (22:50)

14.49 Patrick Ennis entered the Victoria Exchange Complex at 22:50. 57 Within seconds, at 22:50:22, he informed NWAS Control: “[W]e need NWAS to be at … Hunts Bank, by Victoria Station will be … the best access for the moment, we can change that … as and when Police confirm.” 58 This information should have resulted in the dispatch of all available ambulances to Hunts Bank. In the event, that did not occur.

14.50 Immediately upon sending this message, Patrick Ennis spoke to GMP Police Constable (PC) Grace Barker. I will deal with the conversation they had at paragraph 14.116.

Contact between NWAS Control and Daniel Smith (22:50)

14.51 Daniel Smith had been notified of the incident by Annemarie Rooney. At 22:50, while he was travelling to the Victoria Exchange Complex, he radioed to inform NWAS Control that he was on

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56 INQ035612/128
57 INQ035612/130
58 INQ035612/132, INQ032872T
duty. At that time, Daniel Smith’s intention was to take whatever role he was “best suited for”.59

14.52 Daniel Smith asked if there was an RVP. He was told: “Nothing down at the moment … the RVP was Thompson Street [Manchester Central Fire Station] but I’ve just had an update from the AP on scene, it’s Paddy. He has gone straight to scene … confirmed it is a nail bomb.”60 Daniel Smith replied: “Just to confirm that someone on scene is saying the scene is safe to go in.”61 In response, NWAS Control said: “He’s gone in and he’s said that he’s on scene with patients … that’s all I have at the moment.”62 Daniel Smith then informed NWAS Control that he would go to the scene. He instructed NWAS Control “to maintain RVP for now in case it is an MTFA [Marauding Terrorist Firearms Attack] type incident”.63

14.53 Daniel Smith’s instruction to maintain the RVP at Manchester Central Fire Station pending his arrival at the scene could have been significant. Daniel Smith was not part of the planned command structure.

59 110/81/12-14
60 INQ015056T
61 INQ015056T
62 INQ015056T
63 INQ015056T
14.54 Annemarie Rooney described this intervention by Daniel Smith in her second witness statement as follows: “The RVP was notified initially at Thompson Street [Manchester Central] Fire Station when a change to this was notified … then the Operational Commander intervened and confirmed that the RVP was to remain at Thompson Street [Manchester Central Fire Station].” This is a mischaracterisation of what occurred. Daniel Smith was not the Operational Commander at the point at which he made this intervention.

14.55 With what I accept were good intentions, Daniel Smith inserted himself into the chain of command. He was no better placed than either of the two on-call commanders at 22:50. He was not as well placed as Patrick Ennis to make the decision about whether or not Hunts Bank should be used. On the basis of what he had observed at the scene, Patrick Ennis had asked NWAS Control to send four ambulances to the Victoria Exchange Complex.

14.56 NWAS Control was unable to confirm to Daniel Smith that the scene was safe, because Patrick Ennis had not been asked that question directly. However, Patrick Ennis had not passed a message to say the scene was unsafe.

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64 INQ041728/29
Patrick Ennis was highly experienced. He could and should have been relied upon to inform NWAS Control if he had concerns about scene safety.

14.57 Daniel Smith did not ask NWAS Control what information had been received from any of the other emergency services. Given that Daniel Smith had decided that he would make command decisions at this early stage, he should have sought to inform himself better before making a decision that could lead to delay. He did not consult the Tactical Commander about this decision.

14.58 It is inevitable in the early stages of a Major Incident that an emergency services control room will receive simultaneous calls which will need to be reconciled. When he made his command decision to maintain the RVP at Manchester Central Fire Station, Daniel Smith did not know that Patrick Ennis, who was at the scene, had informed NWAS Control that ambulances should be sent to Hunts Bank.

14.59 By 22:50, there were two ambulances on the forecourt of Manchester Central Fire Station. These were ambulances that could immediately have been dispatched to Hunts Bank in accordance with Patrick Ennis’s request.

65 INQ040368/1-2
They could have been at Hunts Bank within three minutes. This did not occur.

14.60 Instead, those two ambulances waited at Manchester Central Fire Station. They were joined by a third ambulance at 22:53, a fourth at 22:56, a fifth at 22:59 and a sixth at 23:02. Those latter four ambulances could have arrived at Hunts Bank within seconds of their arrival time at Manchester Central Fire Station, had they been directed to go straight to the scene.66

Contact between NWAS Control and GMP Control (22:51)

14.61 As Daniel Smith’s call with NWAS Control concluded, GMP Control informed NWAS Control: “Our Inspector is saying can we have all available ambulances … to … Hunts Bank.”67 GMP Control went on to identify “the booking office … over the bridge to the main entrance” as being the exact location. GMP Control also stated: “[O]ur Inspector … is asking for all ambulances there.”68 This call took place at 22:51.

14.62 NWAS Control should have acted immediately upon the information from GMP and directed all ambulances allocated to the incident to Hunts

66 INQ040368/1
67 INQ015139T/1
68 INQ015139T/1, INQ015139T/2
Bank. The information had come directly from a senior GMP officer at the scene. It was entirely consistent with the information that Patrick Ennis was providing at the same time.

14.63 NWAS Control did start to mobilise individual resources to Hunts Bank shortly after the call with GMP Control concluded. However, it was not until 23:00 that the ambulances that were at Manchester Central Fire Station were instructed by NWAS Control to move forward to Hunts Bank.

Contact between NWAS Control and BTP Control (22:54)

14.64 BTP Control contacted NWAS Control at 22:54. The call lasted seven minutes. In the course of it, BTP Control informed NWAS Control: “[N]umerous officers are asking for ambo.” A little later, BTP Control said: “[W]e’ve got you updated that its Hunts Bank for the RVP.” Towards the end of the call, BTP Control stated: “[C]an I just pass on a bit more information … It’s just … to let you know … the cordon is in place at both ends of Hunts Bank where your RVP is.”

69 INQ015061T, INQ032874T, INQ015079T
70 INQ015093T
71 INQ028932/36-38
Contact between NWAS Control and Patrick Ennis (22:54)

14.65 Patrick Ennis entered the City Room at 22:53. At 22:54, he sent another message to NWAS Control. He said: “[T]his is a confirmed major incident we’ve got at least … 40 casualties approximately 10 … appear to be deceased on scene. We’ve got at least a dozen priority 1 … ambulance [inaudible] still need to be er Hunts Bank … Victoria Station.” NWAS Control replied: “[E]veryone is now making their way to Hunts Bank.”

14.66 Patrick Ennis’s confirmation that ambulances should go to Hunts Bank prompted a response from NWAS Control that Hunts Bank was now being used by all NWAS responders. This may have been the intention. However, for a number of ambulances already sent to Manchester Central Fire Station, it was to be another 12 minutes before they set off from that location to the Arena. In the period immediately after a Major Incident, every minute is vital.
Contact between NWAS Control and the GM HART crew (22:54)

14.67 The GM HART crew, which by 22:54 were en route to Manchester City Centre, were notified that the new RVP was “Hunts Bank Bridge”.

Contact between NWAS Control and Daniel Smith (22:56)

14.68 Two minutes after the GM HART crew were notified that Hunts Bank was the RVP, NWAS Control contacted Daniel Smith. In that contact, NWAS Control informed Daniel Smith: “[T]he new RVP is Hunts Bank.”

14.69 By 22:56, NWAS Control’s approach was to deploy some of its resources to the scene, such as Daniel Smith and the GM HART crew, while ambulances at Manchester Central Fire Station were not instructed to move forward. In light of the information received from Patrick Ennis and GMP Control, there was no good reason not to send the ambulances at Manchester Central Fire Station to the scene as well. By 22:56, there were four ambulances at Manchester Central Fire Station, three minutes’ drive from Hunts Bank. These could have been at the Victoria Exchange Complex by 23:00 had they been deployed at this point.
Contact between NWAS Control and Annemarie Rooney (22:56)

14.70 As Daniel Smith was being contacted at 22:56 by NWAS Control, so too was Annemarie Rooney. She was informed by Nicola Pratt about the location of NWAS resources in the following terms:

“We’re all at Thompson Street [Manchester Central] Fire Station but it’s been changed by the police to the bridge over Hunts Bank … Dan Smith is going straight to scene, I can’t get hold of the force duty officer to see if it’s safe, so we are all staying at that RVP for now.”

14.71 Despite the information from GMP Control about Hunts Bank, the position at the start of the call appears to be that Manchester Central Fire Station would continue to be used until Daniel Smith reached the scene. This approach was consistent with the instruction given by Daniel Smith at 22:50.

14.72 Four minutes into the call, at 23:00, Nicola Pratt can be heard to say to someone within NWAS Control: “Stay at the RVP, until we can get
confirmation ... at the RVP, yeah ... Hunts Bank is the new RVP, the new RVP’s Hunts Bank.”

Contact between NWAS Control and Derek Poland (22:57)

14.73 Shortly before he arrived at Manchester Central Fire Station, at 22:57, Derek Poland was contacted by NWAS Control and informed: “Paddy [Ennis] on scene, has been declared a major incident, there is at least 40 casualties ... the new rendezvous point is Hunts Bank near to Victoria [Railway] Station.”

Contact between NWAS Control and responding crews (23:00)

14.74 At the same time that Nicola Pratt was informed that the “new” RVP was Hunts Bank, NWAS Control broadcast on an open radio channel: “[T]o all crews on the major incident. Can you make your way across to Hunts Bank at the railway station ... back of the Arena.” This should have resulted in the immediate departure of the five ambulances that, by then, were at Manchester Central Fire Station. It did not.

78 INQ015381T [Note: the transcript for this call contains some errors. It should read: “Stay at the RVP, until we can get confirmation ... at the RVP, yeah ... Hunts Bank is the new RVP, the new RVP’s Hunts Bank”]
79 INQ015100T
80 INQ015093T
Contact between NWAS Control and Joanne Hedges (23:03)

14.75 At 23:03, Senior Paramedic Joanne Hedges contacted NWAS Control. Joanne Hedges had arrived at Manchester Central Fire Station at 22:59.\(^{81}\) Joanne Hedges said: “I’m … in charge here at the moment.”\(^{82}\) She asked if the scene was safe. In reply, NWAS Control informed her that Hunts Bank was the RVP, but that the scene had not been confirmed as safe. Joanne Hedges responded: “We’ll stay here at the fire station.”\(^{83}\) NWAS Control informed Joanne Hedges: “[W]e’ve been advised by the police for everybody, go to Hunts Bank. That’s the new RV.”\(^{84}\)

14.76 Joanne Hedges’ evidence was that there “was no clear instruction … for us to leave immediately”.\(^{85}\) I disagree. At 23:00, a clear instruction had been issued by NWAS Control to all crews. This should have led to an immediate departure by all the ambulances at Manchester Central Fire Station. What Joanne Hedges was told at 23:03 was also clear. While I recognise that an incident of this nature will create understandable concern about scene safety, Joanne Hedges should have followed the clear

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\(^{81}\) INQ040368/1  
\(^{82}\) INQ023919T  
\(^{83}\) INQ023919T  
\(^{84}\) INQ023919T  
\(^{85}\) 80/28/25-29/7
mobilising instruction by NWAS Control. The failure to do so led to further avoidable delay.

14.77 During the seven minutes she was at Manchester Central Fire Station, Joanne Hedges spent the time constructively. In evidence, which I accept, she described how she discussed the situation with colleagues, readied kit and made sure they had their Major Incident packs available.\(^86\) However, once the instruction came through at 23:00, it should have been followed immediately. Any necessary tasks that remained could have been done on arrival at Hunts Bank.

**Mobilisation from Manchester Central Fire Station (23:06)**

14.78 At 23:06, the six ambulances at Manchester Central Fire Station set off in convoy for Hunts Bank. They began to arrive on Hunts Bank at 23:08. The journey time of the lead ambulance was 2 minutes and 20 seconds.\(^87\)

**Operation Plato**

14.79 In the call at 22:38 described at paragraph 14.22, Annemarie Rooney advised Nicola Pratt: “Go through your Plato card.”\(^88\) This was a reference to the Operation Plato action cards for NWAS Control. This was reasonable advice for

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86  80/18/11-20
87  81/84/15-88/6
88  INQ015353T
Annemarie Rooney to give in light of the fact that Nicola Pratt had said: “[W]e are getting … multiple calls … saying there may be somebody shooting as well.”

14.80 Annemarie Rooney also said: “[W]e need to find out who’s the AITC.” AITC stands for ‘Ambulance Intervention Team Commander’. The Ambulance Intervention Team was NWAS’s specialist response team for Operation Plato. It comprised HART operatives and other employees drawn from NWAS’s wider operational staff.

14.81 At 22:43, Nicola Pratt spoke to Kevin Mulcahy, an on-call Tactical Commander. She asked him: “Do you want me to go through Plato?” He asked if the police had “declared it … a marauding terrorist incident”. She replied: “I don’t know, I will speak to the Force Duty Officer now.”

14.82 At 22:56, Nicola Pratt spoke to Annemarie Rooney again. As set out at paragraph 14.70, towards the beginning of this call, Nicola Pratt stated: “I can’t get hold of the force duty
Later in the call, Nicola Pratt said: “We’re not treating it as a marauding terrorist as there are no reports of that and the police have said it’s not, so I’ve not gone down Plato, I’m just going down the major incident card, is that ok?” Annemarie Rooney replied: “Right.”

Towards the end of the call, Annemarie Rooney asked: “[H]ave we identified an AITC?” Nicola Pratt replied: “AITC, other than the HART team leader?” Annemarie Rooney replied: “[Y]es.” The two discussed who that might be. The call ended with NWAS Control saying: “I’ll find one.”

NWS Control had been unable to contact the Force Duty Officer (FDO). This was in common with the experience of GMFRS’s NILO during the period between 22:43 and 22:56. In the absence of direct contact with the FDO, Annemarie Rooney’s decision to mobilise an Ambulance Intervention Team Commander was correct. Overall, in my view, NWAS’s approach to the issue of Operation Plato during the first half-hour was appropriate. I shall return to the issue of the Ambulance Intervention Team Commander when
14.85 I am satisfied that NWAS Control was right to have in mind the possibility that it may be responding to a Marauding Terrorist Firearms Attack. The decision to approach the response on the basis of the Major Incident action card was appropriate given the information NWAS Control had at that time.

Position 30 minutes post-explosion

14.86 As set out at paragraph 14.49, the first paramedic on scene was Patrick Ennis. He entered the Victoria Exchange Complex at 22:50. He headed straight for the City Room. He entered the City Room for the first time at 22:53. He then left the City Room at 22:59 to return to the station concourse.

14.87 At 22:58, the first ambulance arrived on Station Approach. One minute later, Daniel Smith approached the War Memorial entrance with Dr Michael Daley. They entered the Victoria Exchange Complex seconds later. Following almost immediately behind Daniel Smith and
Dr Daley were two paramedics and a student paramedic: Martyn Nealon, Callum Gill and Leigh-Sa Smith. These five NWAS staff were joined by on-call Operational Commander, Derek Poland.

14.88 By 23:01, Advanced Paramedic Patrick Ennis had entered the City Room, he had made his assessment and was making his way down to the station concourse. A dual-crewed ambulance, Ambulance A344, was stationary on Trinity Way. Five ambulances were waiting on the forecourt of Manchester Central Fire Station just under one mile away. Another ambulance was just one minute away from Manchester Central Fire Station. The GM HART crew and other non-ambulance resources were on their way to Hunts Bank.

First paramedic on scene

Background, experience and training

14.89 At the time of the Attack, Patrick Ennis was a highly experienced paramedic.

14.90 He joined the ambulance service in October 2005 as a trainee ambulance technician, and in December 2008, he qualified as a paramedic.
In 2012, having undertaken a higher education diploma in paramedic studies, he was promoted to the role of Senior Paramedic. In 2015, he completed a degree in paramedic practice and was promoted to the role of Advanced Paramedic.

14.91 In May 2017, Patrick Ennis was one of three Advanced Paramedics who covered Central Manchester and Salford.¹⁰⁹

14.92 In evidence, Patrick Ennis described the role of an Advanced Paramedic in this way:

“An Advanced Paramedic is a more senior clinician able to provide clinical support to ambulance clinicians, both on scene at incidents and also remotely via telephone or radio in order to assist ambulance clinicians in being able to provide a high level of care … Advanced Paramedics have additional training and are able to administer a wider variety of drugs and medicines and other procedures as well … with responsibility for the clinical management of a team of senior paramedics and also a large team of paramedics and emergency medical technicians.”¹¹⁰

14.93 In the course of his career prior to May 2017, Patrick Ennis had received extensive training.

¹⁰⁹ 76/6/13-11/23
¹¹⁰ 76/9/14-10/6
14.94 He had been trained in each role he had undertaken. He had also received mandatory training each year and was clear in evidence that on each of those occasions he had received training in JESIP and Major Incident management.\(^\text{111}\) He also had personal experience of the response to a Major Incident, having been on board the air ambulance during the emergency services’ response to the mass shooting in Cumbria on 2\(^{nd}\) June 2010.\(^\text{112}\)

14.95 Patrick Ennis’s Major Incident training had, he explained, educated him in the declaration of a Major Incident, the passing of a METHANE message, the actions required of the first and subsequent ambulance resources on scene, the role of an Operational Commander, and the NWAS zoning of the area of an incident. Prior to the Attack, Patrick Ennis had also received training in how the ambulance service might respond to a Marauding Terrorist Firearms Attack, although it emerged in evidence that he had never heard of Operation Plato prior to 22\(^{nd}\) May 2017.\(^\text{113}\) I will say more about that later in this Part.

14.96 Asked in evidence whether his training had equipped him for what he was confronted with on

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\(^{111}\) 76/16/19-30/25

\(^{112}\) 76/11/17-16/8

\(^{113}\) 76/25/3-26/19, 76/142/2-12
the night of the Attack, Patrick Ennis explained that no training could ever provide adequate preparation for such an event. He felt, however, that he had been sufficiently trained for the role he performed that night.  

14.97 I accept that the formal training of Patrick Ennis was of a good standard. There was, however, an important respect in which his training was lacking. He had never taken part in any live exercising. That should not have happened. By May 2017, Patrick Ennis had held a supervisory paramedic role for five years, two of which as an Advanced Paramedic. In the event of a Major Incident in Central Manchester or Salford, there was every chance that he would form part of the response. He should have taken part in live exercises with emergency service partners in order to see how JESIP worked, or did not work, and in order to see and understand the capabilities of each service. Responsibility for this rests with NWAS, not Patrick Ennis.

14.98 In Part 20 in Volume 2-II, I will address the issue of JESIP training further, including what has been described as ‘high-fidelity training’.

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114 76/28/1-14  
115 76/29/5-31/12
Journey to the Victoria Exchange Complex

14.99 On 22nd May 2017, Patrick Ennis came on duty at 19:00. He was the only Advanced Paramedic working across Greater Manchester that night. 116

14.100 Patrick Ennis had no idea that a major event was taking place at the Arena that evening. There was, he explained, no system in place to ensure that NWAS was informed of major events, such as music concerts or sporting events, taking place in Manchester. 117 I find that surprising, just as I found it surprising that there was no system in place to ensure that GMP’s duty command structure was informed of such events. Where an event brings people in large numbers into a particular area, it is obvious that the demand upon the emergency services may increase. A system in which they have advanced notice of major events in their area seems to me to be a good idea. Ambulance services and other Category 1 responders should ensure that they have this information. That would enable the emergency services to consider whether additional resources might be needed or other steps of preparation taken. In the first instance, in the case of ambulance services, this is an issue for the Department of Health and Social Care (DHSC) and NARU to reflect upon.

116 76/32/14-17
117 76/37/21-39/15
14.101 At 22:31, Patrick Ennis was at Central Manchester Ambulance Station in South Manchester. He was dealing with administration and keeping an eye on incidents on the Control screen. He became aware of a number of calls coming in about an incident at the Arena. Patrick Ennis gave evidence that the calls were all coded by the system as amber on a scale of purple (the highest priority), red, amber and green (the lowest priority).\textsuperscript{118} Each call was shown as involving "bomb or explosion", so to prioritise them in the second lowest category would seem to be wrong.\textsuperscript{119}

14.102 Patrick Ennis explained that the system used by NWAS is called the Advanced Medical Priority Dispatch System (AMPDS). He stated: "One of the very much understood things about the AMPDS ... is that it vastly underemphasises the priority of traumatic calls."\textsuperscript{120} Patrick Ennis was clear that this had not delayed his departure for the scene that night, and I accept this. Nonetheless, as he acknowledged, this is capable of creating a misleading impression and is therefore capable of causing confusion and delay.\textsuperscript{121}

\begin{itemize}
\item \textsuperscript{118} 76/34/18-36/21
\item \textsuperscript{119} 76/39/16-40/16
\item \textsuperscript{120} 76/41/2-4
\item \textsuperscript{121} 76/54/9-56/14
\end{itemize}
14.103 My understanding is that AMPDS is applied generally around the country, so this issue is not restricted to NWAS. I did not conduct a detailed investigation into this system, but from all of the information I have received, I am concerned that it needs review. I recommend that DHSC and NARU consider whether AMPDS is fit for purpose and, if it is, whether it can be improved. Particular consideration should be given to how the AMPDS prioritises emergency calls.

14.104 As Patrick Ennis was learning of the events at the Arena from the Control screen, a pager that he carried also sounded to alert him to the incident.\(^\text{122}\) He realised that something significant was happening. He went straight to his response car and began to drive to the Arena, a location he knew. At 22:36, Patrick Ennis radioed the Emergency Operations Centre within NWAS Control to say he had seen a message on his pager. He asked: “[W]hat’s going on in the city?”\(^\text{123}\) NWAS Control said that they would get back to him.\(^\text{124}\) Patrick Ennis explained that he was already in the car at this time.\(^\text{125}\) It follows that within five minutes of the explosion, Patrick Ennis was already on his way to the Arena. He responded swiftly.

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122 INQ015106T
123 76/45/18-47/12, INQ015106T
124 INQ015106T
125 76/44/8-18
14.105 Patrick Ennis drove on lights and sirens, following a police vehicle that he correctly assessed was going to the scene. At 22:38, while still on the way, he spoke to Advanced Paramedic Jackie Carney. It appears from the conversation that Patrick Ennis called her. Jackie Carney was based in the part of NWAS Control called the ‘Trauma Cell’ in the Emergency Operations Centre in Preston. The purpose of the Trauma Cell was to ensure that incidents involving trauma were rapidly identified, and the correct resources allocated to them.\textsuperscript{126}  I introduced the Trauma Cell in Part 12. In this call, Patrick Ennis made clear that Major Incident command needed to be established.\textsuperscript{127} Patrick Ennis was taking appropriate steps to set up the NWAS response to what he knew was likely to be a significant incident.

14.106 Patrick Ennis followed the police vehicle all the way to the Arena and parked his response car on Hunts Bank. He believed he arrived at the scene at 22:42. This timing is likely to be broadly correct given that Patrick Ennis is captured on the body-worn video footage of a GMP officer outside the station at 22:45:46.\textsuperscript{128}
Equipment

14.107 Patrick Ennis’s response car had on board a Basic Life Support bag, an Advanced Life Support bag, a Commander Pack and a Medicines Bag. Patrick Ennis explained that the general approach, and his own approach, was for the first on the scene, as he rightly understood himself to be, to deploy initially with the Basic Life Support bag, collecting other equipment later if needed. On arriving on Hunts Bank, Patrick Ennis decided to deploy with the Basic Life Support bag and an extra pouch, which duplicated some of the equipment in the Basic Life Support bag, including dressings and an extra tourniquet.¹²⁹ I am not critical of Patrick Ennis for deploying with the Basic Life Support bag as opposed to the Advanced Life Support bag, but whether he should have deployed with the Commander Pack as well or later taken steps to obtain it requires careful consideration.

14.108 The Commander Pack contains, among other things, a pack of what Patrick Ennis described as “cruciform cards”.¹³⁰ These are referred to as ‘SMART Triage Tags’ in the NWAS Major Incident Response Plan.¹³¹ Such cards represent an invaluable tool as part of triage in a mass
casualty situation. They are colour coded: P1 cards are red; P2 cards are yellow; P3 cards are green; and the dead cards are white. The cards are placed around a casualty’s wrist and provide what Patrick Ennis described as “a visual identifier of the triage category for that patient”.¹³²

14.109 When giving evidence in relation to the Care Gap, Lieutenant Colonel Claire Park, Pre-Hospital Care Expert, explained that tagging avoids casualties being unnecessarily assessed, which is highly undesirable in a mass casualty situation, where an efficient process is critical.¹³³ The cards avoid those carrying out the triage being distracted from their work by being asked the status of casualties. They ensure that, once moved to the Casualty Collection Point and/or Casualty Clearing Station, the status of the casualty is understood and treatment prioritised accordingly. They save time and avoid confusion. They may save lives.

14.110 In evidence, Patrick Ennis acknowledged that his work within the City Room that night would have been made easier if he had had the SMART Triage Tags with him.¹³⁴

¹³² 76/69/5-72/1
¹³³ 192/48/25-49/9
¹³⁴ 76/71/3-72/1
14.111 As he arrived at the Victoria Exchange Complex, Patrick Ennis knew that what had occurred was a bomb or explosion, and he must have known of the material risk of mass casualties. It would have been better if, along with the Basic Life Support bag and extra pouch, he had also taken the Commander Pack or at least the SMART Triage Tags. Alternatively, once he was in the City Room and saw the scale of what had happened, it would have been better if Patrick Ennis had instructed someone, probably a police officer, to retrieve the cards from his NWAS vehicle or had obtained them from elsewhere, for example from Daniel Smith once he arrived. He did not do so, and it was not until after the arrival of the HART members Christopher Hargreaves and Lea Vaughan at 23:15 that SMART Triage Tags were available for use within the City Room. In the meantime, Patrick Ennis was reduced to writing the number and type of casualties on his glove.135

14.112 This observation about the delayed arrival in the City Room of SMART Triage Tags must be tempered by recognition of the decisive action by Patrick Ennis that enabled him to reach the scene quickly and by what he did thereafter. Furthermore, ambulance services should in any event, to the extent possible, accommodate

135 109/175/2-179/25, 109/181/14-183/11
circumstances in which a paramedic decides to deploy to a scene without such tags and then realises they are needed, or simply overlooks the issue in the heat of the moment. I can see no reason why the Basic Life Support and Advanced Life Support bags should not contain packs of SMART Triage Tags. I recommend that DHSC and NARU give this consideration.

Arrival at the Victoria Exchange Complex

On arriving on Hunts Bank, Patrick Ennis was immediately aware of a large police presence, of many members of the public moving away from the area and of people who appeared injured. At 22:46, while still outside but having spoken to police officers and members of the public, Patrick Ennis made contact with NWAS Control via the radio. He did so in order to provide a situation report. This was the right thing to do. He said:

“Yeah, it’s a major incident … standby. We’ve had reports of a nail bomb, possibly with shooting, apparently between 6 and 8 casualties all appear to be walking wounded currently but I can’t confirm that number, I’ve got no major incident command post set up,
but for the time being, I could do with at least 4 emergency ambulances …”.

14.114 In evidence, Patrick Ennis explained that in describing the situation as “a major incident … standby” he was not declaring a Major Incident but was alerting NWAS Control to the likelihood that this was what they were dealing with. ‘Major Incident – Standby’ is, as I explained in Part 12, one of four potential Major Incident messages set out in the Major Incident Response Plan. The plan said of Major Incident – Standby:

“This alerts the NHS that a major incident may need to be declared. Major Incident Standby is likely to involve the participating NHS organisations in making preparatory arrangements appropriate to the incident … NWAS resources should be identified and held awaiting further information. EOC [the Emergency Operations Centre within NWAS Control] will effectively activate the Major Incident Plan and processes required to prepare the service for a Major Incident – Declared response. Resources can easily be cancelled later if not required.”

137 INQ015047T [Note: in evidence, Patrick Ennis clarified that he said “It’s a major incident standby” as opposed to “It’s a major incident so standby” as has been transcribed, 76/74/6-9]
138 76/73/10-74/22
139 INQ012913/11
14.115 The information contained in the 22:46 situation report of Patrick Ennis was, as it turned out, not all accurate. The consequences of the explosion were far more terrible than Patrick Ennis understood, and many more than four ambulances were needed; furthermore, there had of course been no shooting. However, in the early stages after an incident such as the Attack, there will inevitably be confusion. That this was so in the period after 22:31 was not the fault of Patrick Ennis. In his message to NWAS Control, Patrick Ennis was conveying what he knew at that time. He made clear that this was likely to require a Major Incident response. What he did was appropriate, and the information he provided should have helped NWAS to start to prepare a response to the Attack.

14.116 At 22:49:43, Patrick Ennis was captured on the CCTV system walking from the direction of Hunts Bank towards the War Memorial entrance. Just before he entered the station, at 22:50:02, he was approached by PC Barker. The officer’s body-worn video records that the two had a short conversation just after Patrick Ennis had entered. The GMP Operational/Bronze Commander, Inspector Michael Smith, was
already in the City Room at this stage. Inspector Smith had recognised that there was an urgent need for paramedics to attend in order to treat the injured. As I explained in the section dealing with GMP’s response, in Part 13, that message had reached PC Barker, and, as a result, the following exchange took place between her and Patrick Ennis:

“[PC Barker]  
Every NWAS. They want every NWAS there.”

“[Patrick Ennis]  
Where?”

“[PC Barker]  
At the booking office which is just … [upstairs].”  

14.117 Immediately after this exchange, Patrick Ennis continued his journey within the Victoria Exchange Complex. In the CCTV footage, he can be seen carrying the Basic Life Support bag on his back. He then made his way straight to the City Room, entering at 22:53. He was asked in evidence what role he was performing when he did so. Patrick Ennis said:

“At that time, I still don’t feel I was performing any specific role. I was aware that I was likely
first ambulance on scene, but I was still at the stage of gathering as much information and as much relevant information as possible in order to be able to, firstly, decide whether or not this was, as it seemed, a major incident, and also to be able to provide the remainder of the information that was required of me, i.e., a METHANE report to control.”

14.118 Patrick Ennis confirmed in evidence that he recognised he was, so far as NWAS was concerned, the first resource on the scene. He acknowledged that he knew that the role of ‘First Resource on Scene’ is one with a particular meaning in the Major Incident Response Plan. According to the Major Incident Response Plan, that person should: assume the role of Acting Operational Commander until relieved; provide a METHANE message; not become involved in treating patients but instead concentrate on establishing initial command and control of the incident; establish key functional roles; and, when possible, co-locate with commanders from other responding organisations.

14.119 Patrick Ennis agreed that, even though he was the first NWAS resource to arrive on the scene, he had not assumed the role of Operational
Commander. Early in the oral evidence hearings on the emergency response, I thought that this was likely to represent a failure on the part of Patrick Ennis. Having heard his evidence, I concluded that it did not. Patrick Ennis explained that, although he had received some information about the situation in the City Room, both while outside and just inside the railway station, he considered it crucial that he should assess the situation for himself. That would enable him to confirm whether a Major Incident had occurred, assess what would be needed in terms of resources, provide a detailed METHANE message and then assume the role of Operational Commander, unless in the meantime that role had been filled by someone else.149

14.120 Inevitably, this meant that there was an absence of operational command for a short period. But I am satisfied that what Patrick Ennis did was the right thing in the circumstances. To have stayed at the War Memorial entrance and attempt to direct events remotely would not have been appropriate.

14.121 The Major Incident Response Plan should make clear that the attendant from the ‘First Resource on Scene’ should assume the role of Operational Commander only once they have achieved

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149 109/108/24-110/6
situational awareness. Situational awareness must be the priority because, until that person has such knowledge, he or she will not be able to discharge his or her other responsibilities properly.

First visit to the City Room

14.122 Patrick Ennis entered the City Room at 22:53. Although he was an experienced paramedic, he had not received HART training and had none of the personal protective equipment (PPE) that such operatives have. What he did in going into a place that he knew might be unsafe was brave.

14.123 At or near the entrance doors to the City Room, Patrick Ennis was met by Inspector Smith, Operational/Bronze Commander for the GMP unarmed assets in that location. The two can be seen from the CCTV footage to have a conversation. While there is no recording of this conversation, the circumstances make plain what Inspector Smith was communicating to Patrick Ennis, as I shall now explain.

14.124 By 22:47:51, five minutes before his conversation with Patrick Ennis, Inspector Smith had entered the City Room. At 22:48:39, 48 seconds later,
he made contact with GMP Control. He said: “It looks to [me] like a bomb’s gone off here. I would say there’s about 30 casualties. Could you have every available ambulance to me, please?”\textsuperscript{154} Fewer than 90 seconds later, at 22:50:03, Inspector Smith passed a further, similar message to GMP Control, stating: “I need every NWAS facility that we’ve got in here, please. Directly in here.”\textsuperscript{155} At 22:51:19, in a further conversation with GMP Control by radio, Inspector Smith said that he had “sent one of the PCs outside to tell any NWAS staff they need to get in here as soon as.”\textsuperscript{156}

14.125 Inspector Smith’s conversation with Patrick Ennis occurred almost immediately after these various messages were passed. In these circumstances, as I touched upon in Part 13 dealing with GMP’s response, I find that Inspector Smith communicated to Patrick Ennis not only that the situation in the City Room was exceptionally serious, but also that there was an urgent need for paramedics in that location. Patrick Ennis could not recall the conversation, but realistically agreed it was likely that this is what Inspector Smith had conveyed.\textsuperscript{157}
14.126 In fact, Patrick Ennis did not need to be told what the situation demanded. He could see for himself the seriously injured, some of whom were shouting for help, and the dead.  \(^{158}\)

14.127 At 22:54, just a minute after his arrival in the City Room, Patrick Ennis contacted NWAS Control to provide another situation report:

"[Patrick Ennis] [F]urther update this is a confirmed major incident we’ve got at least, we’ve got at least 40 casualties approximately 10 er appear to be deceased on scene we’ve got at least a dozen priority 1 erm ambulance [inaudible] still need to be er Hunts Bank er Victoria Station over.

[Inaudible] everyone is now making their way to Hunts Bank over.

[Patrick Ennis] Yeah affirmative."\(^{159}\)

14.128 This provided useful information to NWAS Control and covered most but not all of the
requirements of a METHANE message, as outlined below:

M Patrick Ennis declared a Major Incident. This was the right thing to do, although, in fact, NWAS Control had taken the initiative and already made a declaration a short time earlier.

E The exact location was already known.

T The type of incident was already known and, in any event, in his 22:46 message, Patrick Ennis had made clear that there had been a bombing and potentially a shooting.

H The message does not indicate the presence or suspicion of any hazards.

A The message implied that the route was safe to use by requesting ambulances to Hunts Bank, where, of course, Patrick Ennis had himself parked and spoken to members of the public.

N The message did indicate an approximate number, type and severity of casualties.
The message did not indicate which emergency services were present or those that were required. A striking feature of the evidence of Patrick Ennis, in common with the evidence of a number of others, is that it simply did not occur to him at the time that no firefighters were present in the City Room. He recognised with hindsight, as did everyone, that GMFRS had real value to add to the emergency response, particularly in relation to the evacuation of casualties, which went badly on the night. It is of a high degree of importance that each emergency service should have a clear understanding of the capabilities of the others. This can only be achieved through realistic and effective joint training. This needs to improve, an issue to which I shall turn in Part 20 in Volume 2-II.

14.129 At 22:57:13, a conversation was captured between Patrick Ennis and GMP PC Christopher Dawson on the body-worn video:
“[Patrick Ennis] We’ve got Ambulances coming soon Hunts Bank we’ve got as many as we can get into Victoria Station. In a minute we need to start thinking about trying to get some casualties moved out.”

“[PC Dawson] What do you need from us now? What’s best that we can do for you now?”

“[Patrick Ennis] Basically, at the moment it’s going to be providing first aid at the moment to those that are bleeding heavily. I haven’t got enough equipment. It’s going to be basic … basic stuff until we can get some people here.”

14.130 This conversation is instructive. It reveals that Patrick Ennis was anxious at this stage to achieve two things. First, he sought to enable the evacuation of casualties onto the station concourse. In fact, no casualty was treated in the Casualty Clearing Station set up on the station concourse until ten minutes after this conversation, and the final casualty did not reach
there until 45 minutes after this conversation.\textsuperscript{164} Second, he was anxious to get other paramedics to come “here”, namely to the City Room. In fact, only two more paramedics ever arrived, and they did not reach the City Room for a further 18 minutes.\textsuperscript{165}

**Discussion with Daniel Smith**

14.131 Patrick Ennis left the City Room shortly before 22:59:46.\textsuperscript{166} He had been present there for nearly seven minutes. During that period, he gained situational awareness.

14.132 In those seven minutes, even though there were many people in the City Room in urgent need of treatment and even though he had the skills and equipment to provide some treatment, Patrick Ennis did not attend to any casualty.\textsuperscript{167} This may be thought to represent a failure on his part. It does not. The responsibility of Patrick Ennis was to gain situational awareness to enable an effective command response to be established. It is an uncomfortable reality of mass casualty incidents that for someone in the position of Patrick Ennis to start to provide treatment will risk the overall response and likely cost lives, not save them. I am aware that Patrick Ennis was the

\begin{footnotes}
\footnote{164}{INQ041266}
\footnote{165}{109/200/10-21}
\footnote{166}{INQ035612/170}
\footnote{167}{109/124/17-125/11}
\end{footnotes}
subject of some public criticism in this regard. That criticism was ill-founded and unfair. Patrick Ennis was doing his job as he had been trained to do it, and he was seeking to achieve the best outcome for the emergency response overall in what he did in those seven minutes.

14.133 As Patrick Ennis left the City Room, Daniel Smith was arriving on Station Approach with Dr Daley. Daniel Smith was a Consultant Paramedic for Greater Manchester and was Patrick Ennis’s line manager. Dr Daley was a member of the Medical Emergency Response Incident Team.

14.134 Daniel Smith and Dr Daley entered the railway station at 22:59:53. A little behind them was NWAS Operations Manager Derek Poland, who was the on-call Operational Commander but was to be appointed the Parking Officer. Daniel Smith and Dr Daley remained just inside the War Memorial entrance. At 23:01:01, Patrick Ennis started his descent down the staircase leading to the concourse. By 23:01:24, he had joined the others. There was a conversation, but by
23:02:51, Daniel Smith had walked away and left the concourse via the War Memorial entrance.\textsuperscript{175} The conversation between Patrick Ennis and Daniel Smith therefore lasted for 90 seconds, if that.

14.135 Patrick Ennis gave evidence about his conversation with Daniel Smith.\textsuperscript{176} So did Daniel Smith.\textsuperscript{177} Neither has a good recollection of the discussion, which is unsurprising given the stress of the situation. The two agree, however, that during the course of this conversation, Patrick Ennis made clear that there were fatalities in the City Room, and that there were people in that location in need of urgent medical treatment. They also agree that Daniel Smith made clear that he had assumed the role of NWAS Operational Commander.\textsuperscript{178}

14.136 The evidence indicates that a number of other issues were discussed. While he was with Daniel Smith and Derek Poland, or walking away from them on his return to the City Room, Patrick Ennis passed a message to NWAS Control informing them that he had been told that all communications were to be passed through
Daniel Smith’s channel.\textsuperscript{179} It is also clear from a conversation between Patrick Ennis and GMP PC Gareth Dennison at 23:05:29, just as Patrick Ennis re-entered the City Room, that Daniel Smith had given an instruction that casualties were to be moved down into the railway station concourse.\textsuperscript{180} That this instruction was given accords with the recollection of Daniel Smith.\textsuperscript{181} What is clear is that this instruction had been given in broad terms, with no information about how it was to be achieved.

14.137 There was an additional topic that demanded analysis between Daniel Smith and Patrick Ennis in their conversation between 23:01 and 23:02, namely how safe it was in the City Room and what the situation there meant for NWAS deployment into that location.

14.138 Both Patrick Ennis and Daniel Smith suggested that something about risk had, or may have, been said in their discussion. Patrick Ennis said that he had “probably” told Daniel Smith about the “perceived risks” in the City Room, by which he meant the possibility of a secondary device.\textsuperscript{182} Daniel Smith said: “[W]e did have … and, again, it’s seconds of a conversation, but we did have a
conversation about his risk. I think his words to
me were, ‘It’s as safe as it could be.’”

14.139 I have no doubt that each witness was doing his
best to give accurate evidence. However, each
was necessarily reconstructing a conversation
of which he had little independent recollection.
I consider it likely that, in doing so, each applied
hindsight and was, at least to some extent,
describing what he hoped or expected he would
have said or asked, rather than what he in fact
said or asked.

14.140 In my view, the reality of this 90-second
correspondence is that there was no, or no sufficient,
discussion between Patrick Ennis and Daniel
Smith about the issue of safety in the City Room
and the NWAS resources that were needed
there. Indeed, I conclude that there was no, or
no adequate, discussion between the two men
at any stage about these important issues.
I consider that Patrick Ennis gave the most
accurate account of whether the issue of safety
and deployment was discussed in the following
exchange in evidence:

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183 110/153/11-23
“[Chairman] Were you ever asked by Dan Smith, ‘Is it safe enough for me to get paramedics, when we have got enough here to do it, to come up and help you?’

[Patrick Ennis] No, I wasn’t.

[Chairman] So, you never gave an assessment to Dan Smith about it?

[Patrick Ennis] I don’t believe that there was a conversation where I … where he asked that of me or whether I explained to him that I felt it was appropriate for more paramedics to come into that area, no.”

14.141 Before turning to what Patrick Ennis could have communicated to Daniel Smith about the issue of safety in the discussion at 23:01, it is important to recognise what he could not have communicated to him.

14.142 Patrick Ennis could not have informed Daniel Smith that Operation Plato had been declared. On the night of the Attack, Patrick Ennis was not
told of Inspector Dale Sexton’s declaration.\textsuperscript{185} Even if Patrick Ennis had been told, it would have meant nothing to him because he had never heard of Operation Plato.\textsuperscript{186}

14.143 I indicated that I would come back to this issue, which relates to the training of Patrick Ennis. It is surprising that one of a small cadre of Advanced Paramedics in Greater Manchester, likely to have an important role to play in the event of a terrorist attack, was unaware of this important response plan. At least in part, this is likely to be a consequence of the fact that Patrick Ennis had not taken part in any live exercising with the emergency service partners of NWAS.\textsuperscript{187} It is imperative that all of those who may have a role to play in the response to a declaration of Operation Plato understand what Operation Plato is and what will be required of them in the event of such a declaration. NWAS ought to take steps to ensure that all of its employees have this basic knowledge. NARU should take steps to ensure that, if this lack of knowledge is an issue beyond NWAS, it is resolved.

14.144 I will now turn to the issue of what Patrick Ennis could have told Daniel Smith about the issue of safety in the City Room. Patrick Ennis had

\textsuperscript{185} 109/128/10-21
\textsuperscript{186} 109/128/10-24
\textsuperscript{187} 76/29/5-31/12
situational awareness. He knew that there were many unarmed officers of GMP and BTP, Arena staff and members of the public present in that location and seeking to help the many casualties who needed help. He also had his own firm and informed view on the issue of safety, as the following exchange in evidence reveals:

“[Chairman] Okay. If he’d [Daniel Smith had] asked you, ‘Is it safe, when we’ve got enough, can I send some paramedics in there?’ because you’re saying he must know they’re needed and you know they’re needed, what would you have said?

[Patrick Ennis] I believe I would have said that I couldn’t guarantee it was safe, the firearms police have said that there was a potential for secondary device, there are hazards in the area, such as the unstable roof, but that as far as I was concerned it appeared to be safe to work in there.”

188 110/14/10-15/4 (emphasis added)
14.145 Daniel Smith was the NWAS Operational Commander. It was his job to decide which assets of NWAS should be deployed forward into the City Room.\textsuperscript{189} The view of the experienced Advanced Paramedic who had been into that location was that it appeared to be safe to work there. While I accept that this was not determinative of the issue, this information would have been of considerable value to Daniel Smith in making his deployment decision. I am satisfied on the evidence I heard that Daniel Smith never sought or obtained the assessment of Patrick Ennis. He should have done.

14.146 What difference it would have made to Daniel Smith is a separate matter. As I explained in Part 12, Daniel Smith in fact had an operational discretion to deploy at least some of the non-specialist assets available to him into the City Room shortly after 23:00. He mistakenly considered that he had no such discretion. It is therefore a realistic possibility that, even with information from Patrick Ennis, he would have maintained his line of, as I find it to have been, excessive caution.

14.147 At the very least, however, had Daniel Smith obtained this information from Patrick Ennis, it should have provoked him to seek the views of

\textsuperscript{189} 110/105/10-16, 110/132/6-133/1, 110/141/9-143/4
the emergency service partners of NWAS about the risks involved in entering the City Room in order to treat casualties. Had he, in particular, sought out the GMP Operational/Bronze Commander for the unarmed officers, he would have discovered that Inspector Michael Smith felt that it was safe enough for his officers to operate in the City Room and that he himself was in that location.\footnote{190} Such information, which was consistent with the view of Patrick Ennis, should have caused Daniel Smith to make a different assessment of the deployment of non-specialist NWAS assets into the City Room. I consider it a realistic possibility that it would have done so, notwithstanding Daniel Smith’s caution.

14.148 Daniel Smith did not obtain any of this information. He permitted Patrick Ennis to return to the City Room. In doing so, the working assumption of Daniel Smith was that Patrick Ennis would be the only paramedic working there at that stage.\footnote{191} Daniel Smith knew that there were multiple casualties in that location in urgent need of medical assistance. Patrick Ennis had made clear to PC Dawson that more paramedics were needed, and that much was obvious. The police officers in the City Room were literally shouting out for paramedics to attend. While I

\footnotesize{190 102/172/16-173/19
191 110/130/11-131/9}
accept that Daniel Smith is a good, experienced paramedic and acknowledge the pressure he was working under, I am satisfied that the arrangements made by him were not sufficient to meet the needs of the casualties.

14.149 Daniel Smith did direct that the casualties should be evacuated from the City Room, but even that plan lacked any detail of how it was to be achieved.\textsuperscript{192} Ultimately, Patrick Ennis was left on his own for the next ten minutes, and only three paramedics, including Patrick Ennis, ever operated in the City Room during the critical period of the response. The evacuation of casualties occurred in a way that was unacceptable.

Return of Patrick Ennis to the City Room

14.150 Patrick Ennis arrived back in the City Room shortly before 23:05:30\textsuperscript{193} and remained there until 00:39:23.\textsuperscript{194} He spent almost 94 minutes in that location on this occasion. He provided no treatment to any casualty during that period.\textsuperscript{195} Instead, he understood that it was his job to perform the role of Primary Triage Officer, even

\textsuperscript{192} 110/235/18-238/1
\textsuperscript{193} INQ035612/203
\textsuperscript{194} INQ035612/476
\textsuperscript{195} 109/184/11-21
though he was never designated as such by the Operational Commander. 196

14.151 The description of the Primary Triage Officer given in the NWAS Major Incident Response Plan is as follows:

“The Ambulance Primary Triage Officer is responsible for the coordination of triage by all resources including the Hazardous Area Response Team (HART). They will ensure teams of suitably qualified staff will perform a triage sieve of all casualties at the scene of the incident. The Primary Triage Officer will report to the NWAS Operational Commander with the number and status of casualties so that appropriate arrangements can be implemented to enable their effective treatment. Dependent upon the nature of the incident and the area the incident covers, there may be the requirement to have multiple Primary Triage Officers, for example when an incident scene is ‘sectorised’. Where this is implemented, the call sign will have numerical suffixes (Primary Triage 1, Primary Triage 2 and so on).” 197
14.152 This description serves to illustrate the problem that existed in the City Room when Patrick Ennis returned to it. The Major Incident Response Plan anticipated that in the event of a mass casualty incident, best practice expected that there would be a number of pairs of paramedics carrying out triage, along with other paramedics providing treatment in a Casualty Clearing Station.\(^{198}\) In the City Room, prior to 23:15, in the nearly 45 minutes after the explosion, there were no teams for Patrick Ennis to manage. It was just him.

14.153 I understand why some may feel frustrated that Patrick Ennis applied himself to triage rather than treatment. It is important to recognise that Patrick Ennis has dedicated his life to the treatment of casualties. My strong sense during his evidence was that he, too, felt frustrated by not providing care and treatment. However, he considered that his primary responsibility was to carry out triage.\(^{199}\) He was right to take that view.

**Arrival of HART**

14.154 An illustration of the sense of feeling within the City Room at the time before the arrival of the members of HART is provided by a comment caught on the body-worn video footage of one of the GMP officers in the City Room.\(^{200}\)

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198 INQ012913/37 at paragraph 8.1
199 109/171/9-173/25, 109/183/12-184/21
200 78/62/1-13
At 23:13:32, GMP PC Matthew Hill shouted across to GMP Sergeant Kam Hare: “Kam, are the paramedics coming?” Sergeant Hare replied: “Paramedics mate, they need to be coming in droves.”

14.155 At 23:15:10, two members of HART, Lea Vaughan and Christopher Hargreaves, entered the City Room. Patrick Ennis provided them with a briefing and then left them to get on with their work. Even with the addition of two HART members, there were too few paramedics in the City Room. Three was simply not enough. There are a number of reasons for that which I will address below at paragraphs 14.310 to 14.326.

14.156 I recognise that in the period both before and after the arrival of the two HART members, Patrick Ennis was operating in circumstances of enormous pressure. Nonetheless, he should have communicated to the Operational Commander in the clearest terms that more paramedics were needed.

14.157 In the period that followed Lea Vaughan and Christopher Hargreaves entering the City Room, Patrick Ennis was involved in making arrangements for the evacuation of casualties.
At 23:40, when the last casualty had been moved, Patrick Ennis remained in the City Room. He understood that further casualties were coming from the Arena bowl, but none arrived. At 00:40, he was stood down.\(^{204}\)

14.158 As I have explained, Patrick Ennis did not get everything right that night. However, his courage and commitment should be acknowledged. The family group that was principally involved with the examination of the NWAS response observed, in their closing statement, that while it was possible to find examples of things Patrick Ennis could have done better, overall he made “an enormously positive contribution to the emergency response on 22 May 2017”.\(^{205}\) In my view, that is a fair comment with which I agree.

**Involvement of Patrick Ennis with those who died**

14.159 At 22:54, Patrick Ennis leaned over Saffie-Rose Roussos, who was being assisted at that time by two members of the public, Paul Reid and Bethany Crook.\(^{206}\)
14.160 At 22:56, Patrick Ennis approached Sorrell Leczkowski. He did not conduct an assessment at this time.207

14.161 At 22:56, Patrick Ennis assessed Alison Howe. This was the first time Alison Howe was assessed by a paramedic in the City Room. Patrick Ennis said to the police officers with Alison Howe that there was nothing that could be done for her.208 He returned to Alison Howe at 23:34 and lifted the covering which had been placed on her. At that stage, Patrick Ennis attached a label to Alison Howe identifying that she had died. He returned to Alison Howe a third time at 23:41 and lifted her arm.209

14.162 At 23:05, Sergeant Hare asked Patrick Ennis to assess Megan Hurley. Less than one minute later, Patrick Ennis spoke to the police officers who were treating Megan Hurley. Having been told Megan Hurley was not breathing and that both CPR and a defibrillator had been attempted, Patrick Ennis instructed the police officers to stop treatment on the basis that Megan Hurley was dead. He informed the police officers that there was nothing that could be done for Megan Hurley.210

207 153/75/6-8
208 152/12/21-13/13
209 152/12/21-13/13
210 153/16/23-18/3
14.163 At 23:06, Sergeant Hare encouraged Patrick Ennis to assess Georgina Callander. Patrick Ennis assessed Georgina Callander and concluded that she was a P1 casualty. This was the first time that Georgina Callander was assessed by a paramedic. Patrick Ennis considered Georgina Callander to be the most serious P1 casualty he had assessed by that point.211

14.164 It was another 20 minutes before Georgina Callander was removed from the City Room.212

14.165 At 23:07, Patrick Ennis leaned over Elaine McIver but conducted no physical check.213 This was the first time Elaine McIver was assessed by a paramedic.

14.166 At 23:08, Patrick Ennis informed the police officers who were treating Sorrell Leczkowski that if she needed CPR there was nothing they could do for her due to the number of casualties.214

14.167 At 23:08, Patrick Ennis discussed moving Georgina Callander. He described her condition as “critical” and said that Georgina Callander would “have to be moved in a minute, she’s one of the highest priorities”.215 A minute later, he

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211 155/11/22-12/23
212 155/22/12-13
213 156/50/13-15
214 153/77/6-8
215 155/13/11-20
informed another police officer that Georgina Callander was “critically unwell”. Patrick Ennis said she needed to be removed by any means possible.

14.168 At 23:10, Patrick Ennis assessed Kelly Brewster for just over ten seconds. He returned one minute later and leaned over Kelly Brewster as she was receiving treatment from police officers.

14.169 At 23:16, Patrick Ennis assessed Georgina Callander a second time.

14.170 At 23:38, Patrick Ennis lifted the covering which had been placed over Philip Tron. He attached a label to Philip Tron identifying that he was dead. This was the first time Philip Tron was assessed by a paramedic.

14.171 At 23:39, Patrick Ennis placed a label on Lisa Lees identifying that she was dead. This was the first time Lisa Lees had been assessed by a paramedic.

14.172 At 23:39, Patrick Ennis attached a label to Angelika Klis identifying that she was dead. One minute later, he attached a label to Marcin Klis
identifying that he was dead. 222 This was the first time either Angelika Klis or Marcin Klis were assessed by a paramedic.

14.173 At 23:44, Patrick Ennis attached a label to Wendy Fawell identifying that she was dead. 223 This was the first time Wendy Fawell was assessed by a paramedic.

14.174 At 23:45, Patrick Ennis lifted the covering which had been placed over Kelly Brewster. He attached a label to Kelly Brewster identifying that she was dead. 224

14.175 At 23:45, Patrick Ennis lifted the covering which had been placed on Olivia Campbell-Hardy. He attached a label to Olivia Campbell-Hardy identifying that she was dead. 225 This was the first time Olivia Campbell-Hardy was assessed by a paramedic.

14.176 At 23:47, Patrick Ennis lifted the covering which had been placed over Jane Tweddle. He attached a label identifying that Jane Tweddle was dead. 226 This was the first time Jane Tweddle was assessed by a paramedic.

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222 150/109/16-110/4
223 152/20/19-25
224 154/22/1-4
225 151/17/18-24
226 151/34/5-12
14.177 At 00:32, Patrick Ennis assessed Michelle Kiss.\textsuperscript{227} This was the first time Michelle Kiss was assessed by a paramedic.

14.178 At 00:36, Patrick Ennis checked the label he had earlier attached to Lisa Lees.\textsuperscript{228}

### Covering people

14.179 The NWAS Major Incident Response Plan advises NWAS personnel not to cover people who have died. The exception to this is if the person is in public view. In these circumstances, it is advised that consideration be given to covering the person in order to maintain patient dignity.\textsuperscript{229}

14.180 On 22\textsuperscript{nd} May 2017, many of those who died were covered before they were verified as deceased by a person with the clinical qualification to do so, such as a paramedic. The process of verifying death is a process which is separate to the certification of death, which can only be done by a medical doctor.\textsuperscript{230}

14.181 Members of the public, Emergency Training UK (ETUK) staff and police officers covered individuals whom they believed to be dead. On some occasions, this occurred after Patrick Ennis

\textsuperscript{227} 151/25/4-8  
\textsuperscript{228} 152/6/25-7/2  
\textsuperscript{229} INQ012913/37  
\textsuperscript{230} 110/28/1-24
had indicated that no further help could be given. The items used to cover people included T-shirts and posters.

14.182 Fifteen of those who died had been covered in some way by the time Patrick Ennis started triage at 23:05.231 Once Patrick Ennis began to triage casualties, he was not able to attach a label marking anyone as dead. This was because, as explained above at paragraph 14.111, he did not have any SMART Triage Tags with him. During the period before the HART operatives entered the City Room at 23:15, four further people believed to have died were covered.232

14.183 In the case of each of them, this was after Patrick Ennis had said that no further help could be given to them.

14.184 This is a difficult and sensitive issue. I well understand the wish to preserve the dignity of the person who had died. There may also be thought to be a potential benefit to the response overall: any person who has been marked as being dead will not further occupy responders who are trying to save other lives.

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232 153/17/23-18/7, 153/77/18-22, 154/15/4-8
14.185 The difficulty with this approach is demonstrated by the case of one of those who survived, Eve Hibbert. She was covered.\textsuperscript{233} She was not dead. It is possible that she might have received treatment sooner had she not been covered. The fact that she was covered gave rise to the risk that she would not be treated, when her life could still be saved. Fortunately, her life was saved due to the intervention of her father, Martin Hibbert.\textsuperscript{234}

14.186 Covering people who have not been verified to be dead, by a qualified person, is capable of leading to the loss of saveable life.

14.187 DHSC and NARU should provide guidance for all emergency services on whether to cover someone they believe has died, before they have been assessed by a person with appropriate clinical expertise. Those subject to the Protect Duty should also receive training and information to this effect. This information should be included in the guidance and training received by event healthcare providers.

14.188 One important aspect of the guidance will be alerting all of the above to the fact that members of the public will instinctively want to cover people whom they believe to be dead. The guidance

\textsuperscript{233} 138/11/8-13/12
\textsuperscript{234} 138/13/21-14/8
should extend to the general public but should also include training for emergency services staff and event staff in how to give clear instructions to the public as to what they should do.

Ambulance A344 on Trinity Way

14.189 Saffie-Rose Roussos was evacuated from the City Room on a makeshift stretcher at 22:57. A member of the public and police officers carried her out onto Trinity Way via the Trinity Way link tunnel. Accompanying them was an off-duty nurse. Saffie-Rose Roussos arrived on Trinity Way at 22:58.235

14.190 At 23:00, Ambulance A344 pulled up on Trinity Way. At 23:02, NWAS Control was informed that Ambulance A344 had been flagged down and was dealing with an eight-year-old with multiple injuries.236

14.191 At 23:06, Saffie-Rose Roussos was placed into the back of Ambulance A344. Ambulance A344 departed for the Royal Manchester Children’s Hospital 11 minutes later.237

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235 174/30/8-39/8
236 174/47/13-15, 174/50/11-21, INQ015101T
237 174/65/6-16, 174/74/4-6, 174/89/5-8
Operational command

Journey to and arrival at Victoria Exchange Complex and initial command decisions

14.192 Daniel Smith held a senior position within NWAS. He was Lead Paramedic for Greater Manchester and a Consultant Paramedic. He was experienced and well trained.

14.193 Daniel Smith travelled to the Victoria Exchange Complex in an unmarked vehicle on blue lights and sirens. He did not live far away at the time, and, as a result, he entered the railway station via the War Memorial entrance just before 23:00. He was in uniform and carrying two clinical response bags along with a tabard on the back of which was written “Ambulance Commander”. On assuming the role of Operational Commander, following his arrival at the scene, Daniel Smith put on this tabard. This was good practice. He was the only emergency services commander at the scene who did this. If all commanders had done so, it would have made it easier for them to identify each other.

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238 110/78/3-8
239 110/83/1-5, 110/92/21-93/19
240 INQ035612/172, 110/88/8-25, INQ035612/194
241 112/48/19-49/9, 114/49/15-50/14
14.194 Daniel Smith’s evidence was that, by the time he entered the Victoria Exchange Complex, his understanding was that a terrorist incident had occurred and that this had taken the form of a bomb attack, as opposed to a firearms attack or a bomb and firearms attack. A number of factors led to this understanding.

14.195 First, in his discussion with NWAS Control at 22:50, he had been told that Patrick Ennis had “confirmed it’s a nail bomb”.242 Second, on his journey on foot from where he parked his vehicle to the railway station, Daniel Smith had seen members of the public whose clothing suggested to him that there had been an explosion as opposed to a firearms attack. Third, Daniel Smith asked a police officer whether there had been a shooting. He was told that there was believed to have been a suicide bombing.243

Assuming the role of Operational Commander

14.196 Within seconds of Daniel Smith’s arrival at the railway station, three NWAS staff arrived in that same area. They were paramedics Martyn Nealon and Callum Gill and student paramedic Leigh-Sa Smith. At 23:00:50, they can all be seen in conversation by the War Memorial.244 By 23:01:24, that conversation was over. Martyn

242 INQ015056T
243 110/91/11-92/20
244 INQ035612/178-179, INQ035612/182
Nealon, Callum Gill and Leigh-Sa Smith walked towards the War Memorial entrance. Daniel Smith had deployed them to Trinity Way in order to deal with a single patient, albeit one he believed to be seriously injured.245

14.197 At the time of this deployment, there were six members of NWAS staff available to Daniel Smith in the Victoria Exchange Complex. By deploying three of those six to Trinity Way, Daniel Smith significantly depleted the resources immediately available to him. This was the wrong decision. This was a second command decision that Daniel Smith made before he had assumed the role of Operational Commander. At paragraphs 14.51 to 14.60, I set out his first intervention, which occurred at 22:50. The decision to deploy resources to Trinity Way was made without clear situational awareness about the City Room and without consultation with anyone else.

14.198 Almost immediately after Martyn Nealon, Callum Gill and Leigh-Sa Smith departed for Trinity Way, Patrick Ennis arrived at the War Memorial. He had walked there directly from the City Room. A discussion then took place between Patrick Ennis and Daniel Smith in the presence of Derek Poland and Dr Daley. Patrick Ennis’s involvement

245 110/96/13-97/21
in the conversation lasted for no more than 90 seconds.\textsuperscript{246}

14.199 Daniel Smith explained in evidence that it was in this conversation that he assumed the role of Operational Commander. He had only a general recollection of the conversation. He was unable to remember the detail but was able to confirm that by its conclusion he was aware that the City Room was the seat of the explosion and that there were a number of dead. He also knew that there were other casualties in that location in need of urgent medical treatment. Daniel Smith acknowledged that it was his responsibility as Operational Commander to make sure that those people received treatment as soon as possible.\textsuperscript{247}

14.200 It was a significant conversation. It was Daniel Smith’s first opportunity to obtain situational awareness and to seek the views and advice of the paramedic on the ground about how the casualties should receive the treatment they urgently needed. The conversation was over very quickly. This was not because of efficiency of expression and understanding, but because important matters that should have been discussed were not discussed, or at least not adequately discussed.
14.201 In considering the actions of Patrick Ennis earlier in this Part at paragraphs 14.131 to 14.149, I identified the inadequacies in this conversation. I will not repeat all of my findings but will summarise them.

14.202 First, Daniel Smith failed to ascertain from Patrick Ennis, a highly experienced paramedic with a senior role, that in his view the City Room was a safe place to work. 248

14.203 Second, when Patrick Ennis returned to the City Room following the discussion, the working assumption of Daniel Smith was that Patrick Ennis would be the only paramedic in the City Room. Daniel Smith must have known that a single paramedic would be inadequate to carry out effective triage in the City Room, let alone carry out life-saving interventions. However, beyond a briefly discussed suggestion that the casualties would need to be moved, Daniel Smith did not discuss with Patrick Ennis how this situation was to be resolved. 249

14.204 Daniel Smith bears principal responsibility for failing to ensure that the conversation with Patrick Ennis provided him with the information he needed to make important decisions. By this stage, he was the Operational Commander. In

248 110/14/19-15/4, 110/147/4-19, 110/153/11-154/2
249 110/129/17-136/18
that role, he had the main responsibility for achieving effective treatment for the casualties in the City Room.

Daniel Smith’s approach to zoning of the City Room

14.205 Daniel Smith’s understanding from an early stage that a bomb attack, not a firearms incident, had occurred was important. It was highly relevant to how the seat of the explosion should be zoned under Operation Plato and the Major Incident Response Plan. That, in turn, was capable of affecting decisions around deployment of non-specialists into the City Room. In Part 12, I considered the issue of NWAS commander discretion in relation to Operation Plato and Major Incident zoning.

14.206 The overall effect of the evidence of Daniel Smith was that he seemed to treat the City Room as an Operation Plato warm zone. In evidence, he stated:

“I think my view on scene around the armed police is that they were very present very quickly in numbers and that the potential for danger from … again, at the time, a lot of training around marauding terrorists with firearms. I felt relatively quickly comfortable around the threat of firearms, but not around the threat of further devices and not around
the … risk of detonation having occurred in the room and the subsequent damage that will have caused …

I think … I knew the terrorist had been in that room and detonated a device in that room, my view is that the policies aren’t ambiguous on that and that is a warm zone … I didn’t know which way the terrorist had been in, so by very definition I could have said downstairs was cold because I didn’t know which way he walked in. But for me, it was a warmish zone downstairs, but I’d have to call it warm upstairs, I’m sorry.”

14.207 Later in his evidence, Daniel Smith stated: “[T]he zoning would be from the JOPs [Joint Operating Principles].” He had a rigid view of what this meant as a matter of procedure, namely that it meant that only specialist resources could enter the City Room.

14.208 Daniel Smith was supported in his position by NWAS. In its closing statement, NWAS submitted that I should find that Daniel Smith “properly concluded that it [the City Room] was a warm zone”. In that closing statement, NWAS also invited me to note that: “[T]here was no discretion
for non-specialist paramedics to enter a warm zone.”

14.209 I will set out below what I consider to have been Daniel Smith’s failure to take steps to establish whether his zoning decision was correct. I will also consider whether, on the basis of his zoning decision, Daniel Smith’s view of the options available to him was correct.

14.210 One of the striking aspects of Daniel Smith’s evidence was that he felt he had no discretion to commit non-specialist assets into the City Room. Indeed, as he walked away from the railway station at 05:30 on 23rd May 2017, what Daniel Smith thought he would be criticised for was not that he failed to get paramedics in numbers into the City Room, but that he allowed Patrick Ennis to stay in that location. This explains why Daniel Smith did not speak to Patrick Ennis about the deployment of further non-specialist assets forward. He thought that the applicable procedures simply did not allow that to occur, so there was no point talking about it.

14.211 If GMP had given proper thought to the Operation Plato zones, the City Room should have been declared a cold zone by the time Daniel Smith
was in a position to deploy paramedics. Even if it was an Operation Plato warm zone, Daniel Smith still had a discretion, although this was not understood by him at the time. Either way, the risks that Daniel Smith was rightly focused on were not Operation Plato risks. As I set out in Part 11, properly understood, JOPs 3, in full *Responding to a Marauding Terrorist Firearms Attack and Terrorist Siege: Joint Operating Principles for the Emergency Services*, was concerned with the threat from a marauding gunman. Daniel Smith had correctly assessed the risk of this to be low. The risks Daniel Smith was concerned about were from a secondary device or structural collapse.257 These should have been considered under a robust risk assessment and zoning applied in accordance with the NWAS Major Incident Response Plan.

14.212 Even in an Operation Plato situation, a risk assessment of threats to safety outside of Operation Plato was required. The fact that an area is an Operation Plato cold zone does not automatically mean it is safe for everyone to operate in. There may be a gas leak; there may be a risk of fire. What this demonstrates is the importance of Daniel Smith gaining as much information as he could about the potential hazards in the City Room. He should then have

257 110/147/4-148/17, 110/163/25-164/19
shared that with the GMP Operational/Bronze Commander and jointly assessed risk.

14.213 In any event, Daniel Smith did not know Operation Plato had been declared.\(^{258}\) His decision-making falls to be judged by the system he thought he was operating under. I judge his decision-making by reference to the City Room being an inner cordon in accordance with NWAS’s Major Incident Response Plan. I accept that he was acting to protect NWAS personnel. However, he was too cautious. This was the result of inadequate information and inadequate efforts to obtain information.

14.214 As I set out in Part 12, NWAS Operational Commanders had a discretion, following a robust risk assessment, to send non-specialist paramedics into the inner cordon. It is important that commanders should understand that exercising such a discretion may save lives and that they should feel supported if they choose to do so. NWAS should review its training to ensure that commanders are not left with a false impression.

14.215 When he walked away from Patrick Ennis at 23:02, Daniel Smith knew that Patrick Ennis was returning to the City Room and knew that he would be the only paramedic in there. Daniel

\(^{258}\) 110/147/4-25, 110/215/4-6, 110/221/1-15
Smith would have known that the paramedic numbers in that location were inadequate. 259

14.216 Daniel Smith was just two minutes’ walk from the City Room throughout this period. He should have visited the City Room. That would have enabled him to make his own assessment of the number and nature of casualties, the number and skills of those assisting the paramedics, the difficulty of the route for extraction and the equipment available for carrying out those extractions. Daniel Smith did not at any stage visit the City Room. 260 Because there was no City Room Sector Commander, that was a mistake. It deprived him of an important opportunity, namely jointly to assess the risk with Inspector Michael Smith of operating in the City Room.

14.217 A proper assessment of the risk in light of the need to provide life-saving care would have led to the conclusion that it was safe enough to deploy non-specialists into the City Room. 261 When they were deployed would have depended on the availability of resources.

14.218 If Daniel Smith had not deployed Martyn Nealon and Callum Gill at 23:01 to treat a patient on

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259 110/130/11-131/9, 110/132/6-133/1
260 110/123/21-24
261 115/64/7-23
Trinity Way, they would have been available to help Patrick Ennis triage in the City Room. The delay in mobilising ambulances at Manchester Central Fire Station resulted in Daniel Smith having fewer resources available to him than ought to have been the case, at the point at which he should have been considering sending non-specialist paramedics into the City Room.

Allocation of the Operational Commander role

14.219 Derek Poland was present when Daniel Smith and Patrick Ennis had their discussion and confirmed that, at the end of it, he understood that there were many people requiring urgent medical treatment.262

14.220 Derek Poland had more than 20 years’ experience as a paramedic. He was Special Operations Response Team (SORT) and Ambulance Intervention Team trained. He was also a trained Operational Commander, having held that position for five years at the date of the Attack.263 He had a balanced and well-informed understanding of the approach that ought to be adopted to the deployment of NWAS assets into different zones. He was also one of the two NWAS on-call Operational Commanders that night.264 He would have been a more obvious
choice for the role of Operational Commander than Daniel Smith, whose training in operational command was years out of date.265

14.221 Daniel Smith’s position in evidence was that he assumed the role of Operational Commander because he arrived a short time before Derek Poland266 and that, in the briefest of subsequent discussions, Derek Poland communicated that he was content that Daniel Smith assumed that role.267 The time of arrival does not seem to me to be relevant to the issue, given that Daniel Smith was clear that he only assumed the role once Derek Poland was present at the scene.

14.222 Derek Poland’s recollection was different from that of Daniel Smith. His memory is that Daniel Smith, while holding the tabard, said that he would take the Operational Commander role unless Derek Poland wanted it, and, knowing Daniel Smith’s “background and experience”, Derek Poland declined.268 Derek Poland stated that he had no issue with Daniel Smith taking the Operational Commander role and that Daniel Smith was a very competent commander.269

265 110/191/25-193/15
266 110/89/5-90/23
267 110/102/14-103/16
268 112/108/11-110/12
269 112/24/5-9, 112/108/10-111/2
14.223 What had happened was that a senior figure within the NWAS hierarchy attended the scene because of an informal arrangement with another senior figure. Once there, he assumed the position of Operational Commander notwithstanding that the on-call Operational Commander, who had more recent training in that role, was present. That is not how command roles should be allocated in the response to an emergency.

14.224 There needed to be a good reason why Derek Poland did not assume the role of Operational Commander. There was none. I have no doubt that Daniel Smith’s actions were well intentioned, however, and that he believed he was well-equipped through ability and experience to perform the role of Operational Commander.

14.225 Derek Poland volunteered to go to the City Room in order to support Patrick Ennis. In evidence, he stated that one paramedic “wouldn’t be able to cope” on their own.270 This would have been a good use of Derek Poland at this stage. Before becoming an Operations Manager in 2011, he was a Senior Paramedic.271 He had maintained his clinical skills. He was a trained Operational Commander, a member of the Ambulance
Intervention Team and a member of SORT.\(^{272}\) He was prepared to work in the City Room.

14.226 Derek Poland could have been deployed forward as either the City Room Sector Commander or in a clinical capacity. Instead, Daniel Smith instructed that he should remain downstairs to help set up the command and control structures there.\(^ {273}\) In due course, Derek Poland was allocated the role of Parking Officer, which was an important functional role.\(^ {274}\)

**Events after Daniel Smith became Operational Commander**

14.227 By 23:03:54, Daniel Smith was on Station Approach wearing the Ambulance Commander’s tabard.\(^ {275}\) He remained on Station Approach or in the area of the War Memorial until 23:57, when he handed over the Ambulance Commander’s tabard to Stephen Hynes.\(^ {276}\)

14.228 During that 54-minute period, Daniel Smith worked hard to deal with what was happening in the area that became the Casualty Clearing Station. He showed compassion and resourcefulness in those efforts. However, I consider that Daniel Smith became focused on

\(^{272}\) INQ035612/420

\(^{273}\) INQ035612/194

\(^{274}\) 110/11/13-12/5, 112/120/18-121/17, INQ013422/12, 144/184/23-185/11

\(^{275}\) 112/1/12-3/20

\(^{276}\) 112/26/4-31/20
that area to the detriment of what was happening in the City Room. Because patients were arriving regularly in the Casualty Clearing Station, he assumed that systems were in place and working properly. In fact, the paramedics, police and others in the City Room were under intolerable pressure, and the way in which casualties were being transported to the Casualty Clearing Station was unsatisfactory.\textsuperscript{277} Daniel Smith did not realise this.\textsuperscript{278}

14.229 Daniel Smith made other significant errors in the discharge of his role as Operational Commander.\textsuperscript{279}

14.230 First, while Daniel Smith correctly sanctioned the deployment of HART paramedics Lea Vaughan and Christopher Hargreaves forward into the City Room, he did not ensure that the remaining members of the GM HART crew were deployed into the City Room. Instead, they were tasked with setting up what they considered to be a Casualty Collection Point.\textsuperscript{280} I will consider this issue in further detail below at paragraphs 14.384 to 14.401, but in summary it is my view that Daniel Smith played a significant part in the confusion that developed around this issue,

\begin{itemize}
\item \textsuperscript{277} 110/172/9-174/24, 110/237/12-25
\item \textsuperscript{278} 110/173/10-174/6
\item \textsuperscript{279} 110/103/17-126/3
\item \textsuperscript{280} 77/30/20-31/11, 110/208/1-209/23
\end{itemize}
which in turn prevented additional, much-needed HART members deploying to the City Room.

14.231 Second, contrary to the requirements of the Major Incident Response Plan, Daniel Smith failed to take steps to establish the location of a Forward Command Post (FCP). GMP had primary responsibility for establishing an FCP, but it was for Daniel Smith to find out where it was.

14.232 Daniel Smith did not liaise with either of the two GMP Operational/Bronze Commanders nor with anyone in a command role from BTP. He was not even aware that Inspector Michael Smith, the GMP unarmed Operational/Bronze Commander, was present in the City Room throughout the period when Daniel Smith was Operational Commander. In evidence, Daniel Smith acknowledged that liaison with Inspector Michael Smith would have brought a number of benefits, in particular an understanding of his desire that more paramedics came to the City Room. All Daniel Smith needed to do to understand that was walk to the City Room and speak to Inspector Michael Smith or take other steps to arrange to speak to him. He should have done so.
14.233 Third, it was Daniel Smith’s responsibility as Operational Commander to appoint a number of people to roles within the command structure. While he did fill some roles, others he did not. Most notably, he did not appoint a Safety Officer. The role of the Safety Officer includes ensuring that the environment and working practices of all ambulance and medical personnel involved with the incident do not pose an undue risk. In my view, such a person would have been likely to have ascertained the true situation in the City Room and communicated that to Daniel Smith. Daniel Smith candidly acknowledged that there was a role for a Safety Officer at the scene and that he had made a mistake in not appointing one. He did not appoint an Equipment Officer or Forward Doctor either. I will discuss the failure to appoint an Equipment Officer further at paragraphs 14.248 and 14.487.

14.234 Fourth, while dealing with the period in which Daniel Smith made decisions about arrangement of the scene, it is relevant to note that at 23:22:53, Daniel Smith transmitted a METHANE message to Control. This was a sensible step
to take. He followed the METHANE acronym precisely and in clear terms.

14.235 The final ‘E’ stands for “[E]mergency services present and those required.” What Daniel Smith said of this was: “Currently we’ve got a large number of emergency services on scene.” He did not refer to the fact that no member of GMFRS was present. That is because he had not noticed that was the case. He was unaware of their absence until Stephen Hynes arrived at the scene and pointed it out to him.

14.236 I do not regard this to be a personal failure by Daniel Smith. Others who were present in important roles were similarly oblivious, including Inspector Michael Smith and Patrick Ennis. This seems to me to demonstrate a lack of realisation of the value the fire and rescue services bring to a mass casualty incident. As I have previously observed, it is very important that each emergency service has a clear understanding of the capabilities of each of the others.

14.237 Finally and significantly, Daniel Smith failed to come up with an adequate plan to evacuate the City Room. I will address that as a topic on its own.
Evacuation plan

14.238 The Casualty Clearing Station was based on the station concourse. A total of 38 people were treated in the Casualty Clearing Station. Of those, 30 people were moved there. A wheelchair was used for three. Two people were carried on a purpose-made stretcher. The other 25 people were moved on makeshift stretchers.\\(^{294}\)

14.239 Daniel Smith’s plan involved deploying only some of the GM HART crew beyond the bottom of the staircase. In the event, only two members of HART went beyond this point. All the other available paramedics were deployed to the area at the bottom of the staircase and out onto Station Approach.\\(^{295}\) The only exception to this was Patrick Ennis, who volunteered to go back into the City Room.\\(^{296}\)

14.240 Patrick Ennis’s and the HART operatives’ joint role was to carry out triage in the City Room. It was not to transport patients down to the Casualty Clearing Station. Their role included providing life-saving treatment when required. This gave rise to the obvious issue of how the triaged patients would travel from the City Room, along the raised walkway, down the staircase and
onto the station concourse to the Casualty Clearing Station.

14.241 In his conversation with Daniel Smith at approximately 23:01, Patrick Ennis informed Daniel Smith that there were seriously injured people in the City Room. It should have occurred to Daniel Smith that many of those people required safe transportation to the Casualty Clearing Station. The first patient was carried into the Casualty Clearing Station on a makeshift stretcher at 23:07.

14.242 Between 23:01 and 23:07 Daniel Smith did not know what was already available by way of items in the City Room and the Arena that might be used to transport immobilised casualties. He should have identified the need for the stretchers carried by the ambulances to be made available for use in the City Room.

14.243 During this period, there was only one ambulance available to Daniel Smith at the scene: the vehicle in which Martyn Nealon arrived. Having dispatched Martyn Nealon and his colleagues to Trinity Way, I accept that Daniel Smith may not have thought he had any stretchers immediately available. This does not mean that Daniel...
Smith could not have issued the instruction that all arriving paramedics should bring their stretchers with them. He should have given this instruction.

14.244 In the event, had Daniel Smith considered that non-specialist paramedics were not able, or not available, to move those stretchers to the point of need, he could have asked for the assistance of the police in this. This is exactly the sort of conversation that should have taken place at a co-location of Operational/Bronze Commanders.

14.245 At 23:07, Daniel Smith was able to see for himself that there were insufficient stretchers readily available to those in the City Room. In fact, at that time there was only one. This should have prompted him to realise that the stretchers on the ambulances ought to be used. Daniel Smith’s evidence on this point was as follows:

“So the process of moving patients on makeshift stretchers started … as the first … ambulances started to arrive with me … I didn’t see the struggles of people happening … It seemed to me on the night that things were working, they were working efficiently, they were working well, and patients were being moved quickly to where we wanted them to be. The use of scoops stretchers from the ambulances, again, being totally open,
I did not consider on the night, and I didn’t consider because I just did not notice the problems that people were having.”

14.246 I am grateful to Daniel Smith for the candid way in which he answered this question. I accept his explanation. It does not follow that I regard his approach to stretchers as an acceptable state of affairs. On the contrary, it is clear that the failure to make stretchers available for the City Room delayed the evacuation.

14.247 Daniel Smith could have no idea of the extent to which makeshift materials would continue to be available for evacuating people because this was never information he was given. Nor could he be satisfied that whatever makeshift materials people were using provided a safe way of moving critically injured people down a substantial staircase. Both of these should have been obvious to him as more and more people were carried into the Casualty Clearing Station by improvised means.

14.248 On the issue of stretchers, Daniel Smith’s failure to appoint an Equipment Officer becomes more significant. Having a person whose role it was to consider the NWAS response by reference to what equipment was required may have resulted in a more satisfactory approach to evacuation.
being identified and addressed. The Equipment Officer could also have organised a more efficient distribution of blankets. Blankets are an important part of the management of severely injured casualties, as blood loss greatly increases the risk of hypothermia.

14.249 Two examples of the consequences of the lack of stretchers in the City Room arise from the evidence relating to two of those who died: John Atkinson and Georgina Callander.

John Atkinson’s evacuation from the City Room

14.250 At 23:16, police officers retrieved an advertising board to use as a makeshift stretcher for John Atkinson. A few seconds later, they carried the advertising board from the merchandise stall to where John Atkinson was. The advertising board was slid under him. At 23:17, John Atkinson was dragged on the advertising board by police officers and Ian Parry, of ETUK. John Atkinson held on to the board as he was dragged.302

14.251 By 23:18, John Atkinson was on the raised walkway. Those helping him continued to drag him using the advertising board. He continued to grip the board. The advertising board began to break. A police officer ran on ahead to see if they
could use the lift to transport him down to the concourse level.  

14.252 At 23:19, those assisting John Atkinson began to drag him to the lift. They realised the advertising board would not fit. At about the same time, two police officers went back to the City Room. They returned two minutes later with a metal barrier.

14.253 By 23:22, efforts were being made to lift John Atkinson onto the metal barrier. The advertising board he was on gave way. The effect of this was that he fell a short distance onto the metal barrier. Given his injury burden at the time, this must have been very painful for him.

14.254 By 23:23, John Atkinson was being carried on the metal barrier towards the staircase. He was then carried down the stairs. It took approximately two minutes to carry him down to the station concourse. He entered the Casualty Clearing Station area at 23:23:54.

14.255 While John Atkinson was on the raised walkway at 23:20, two GMP officers who had been with him went down to the station concourse to ask paramedics for assistance. They found Daniel Smith. One of those police officers, PC Leon

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303 158/41/16-44/6
304 158/44/14-50/13
305 158/50/8-21
306 158/52/8-54/13
McLaughlin, spoke to Daniel Smith, saying: “[E]xcuse me, I know you’re busy, we’ve got someone stuck on the first ground two fractures to his legs we just can’t move him.” Not all of what Daniel Smith said in reply is audible on the body-worn video, but this was captured: “[J]ust leave him there for now … blanket him up and leave him there.” To this, PC McLaughlin responded: “[Y]es, no problem, is there any blankets anywhere?”

14.256 In evidence, Daniel Smith stated he had no independent memory of this conversation. He went on to state:

“I think the only conclusion I can give you in terms of why that was my response was because at that point I think I was becoming comfortable … that a system had been created in terms of moving patients and that if a patient had become stuck … there were systems in place to assist that.”

14.257 An appropriate response from Daniel Smith would have been to enquire whether the casualty was being transported on a stretcher, and, if not, he could have instructed the police officers that
they could find one in the ambulances. In my view, this is what he should have said.

14.258 Daniel Smith’s failure to implement an adequate plan in relation to stretchers is not the only reason for the delay in John Atkinson’s evacuation from the City Room. However, the circumstances of John Atkinson’s evacuation provide a clear illustration of why stretchers were needed in the City Room.

Georgina Callander’s evacuation from the City Room

14.259 At 23:06, Patrick Ennis assessed Georgina Callander and said: “We just need to keep her in this position for now and we’ll get her moved as soon as we possibly can.”\(^{311}\) In a witness statement, Patrick Ennis recalled that he considered Georgina Callander to be the most urgent P1 casualty in the City Room at that time. Conversations then took place between police officers about the urgency of moving her.\(^{312}\)

14.260 At 23:09, PC Owen Whittell went looking for something on which to carry Georgina Callander. He found a table, and one minute later he and a colleague carried it back to where Georgina Callander was. The police officers then
concluded that they would need to speak to Patrick Ennis before moving her.\textsuperscript{313}

14.261 At 23:15, another police officer approached PC Whittell and asked if the table was being used. PC Whittell said it was not and the table was used for another casualty.\textsuperscript{314}

14.262 At 23:17, Georgina Callander was assessed by Lea Vaughan and Christopher Hargreaves. She was assessed to be a P1 casualty, and a label was tied to her.\textsuperscript{315}

14.263 Three minutes later, Bethany Crook approached Georgina Callander. Bethany Crook was an off-duty nurse. She had just finished helping with the evacuation of Saffie-Rose Roussos. Bethany Crook began to help Georgina Callander. At 23:21, Patrick Ennis told those helping Georgina Callander that she was the highest priority casualty.\textsuperscript{316}

14.264 At 23:24, police officers began to prepare a board on which to evacuate Georgina Callander. A minute later they succeeded in moving Georgina Callander on the makeshift stretcher. One minute after that, Georgina Callander was carried out of the City Room.\textsuperscript{317}
14.265 Georgina Callander arrived in the Casualty Clearing Station at 23:28. This was approximately two minutes after she had been carried out of the City Room.318

14.266 There was a delay of 20 minutes between Georgina Callander being identified by Patrick Ennis as the highest priority casualty in the City Room and Georgina Callander being carried out of the City Room on a makeshift stretcher. In that time, a table was identified by police officers as a possible means of carrying her out. When concerns developed about whether it was safe to move her, that table was used for someone else. A different means of carrying Georgina Callander out was subsequently identified.

14.267 The absence of a safe and appropriate way of transporting Georgina Callander out of the City Room caused avoidable delay in getting her from the City Room to the Casualty Clearing Station.

replacement as operational commander

14.268 By 23:51, Stephen Hynes had arrived at the railway station.319 He was the NWAS Deputy Director of Operations and therefore significantly senior to Daniel Smith. Daniel Smith and Stephen Hynes spoke. At 23:57, Daniel Smith handed
over his tabard to Stephen Hynes. He had been replaced as Operational Commander. Daniel Smith’s perception was that this had happened because the senior management of NWAS was unhappy with his command.

14.269 Stephen Hynes stated in evidence that he had not replaced Daniel Smith for this reason but instead because: “I was able to enhance the role with the training, education, experience and knowledge in terms of undertaking that role for the complex incident that we were dealing with at that time.” Whether Stephen Hynes’ view amounts to the same as Daniel Smith’s perception is not an issue that it is necessary for me to resolve.

14.270 Daniel Smith is a good and committed paramedic. He acted with the best of intentions on the night of the Attack, but he did make mistakes, some of them serious. He gave his evidence with candour, accepting many of his mistakes. It was plain to me that he wishes NWAS and the emergency services more generally to learn the lessons of what went wrong.

320 INQ035612/420
321 110/184/4-184/15
322 113/105/1-106/10
Hazardous Area Response Team

GM HART crew Team Leader

14.271 The post of Team Leader on the GM HART crew was not occupied on 22nd May 2017. The second in command of the GM HART crew was not working that night. In these circumstances, it was expected that a member of the team would volunteer to act as Team Leader for the shift. On the night of the Attack, Simon Beswick had volunteered to act up as Team Leader.323

14.272 Simon Beswick qualified as a paramedic in 2006 and joined HART in 2015.324 There were five other HART operatives on the GM HART crew on 22nd May 2017.325 Four of those five had been members of HART longer than Simon Beswick.326

14.273 The role of HART Team Leader in NWAS did not require any set qualifications. Prior to May 2017, NARU had produced an action card for the Team Leader of HART. It had not been adopted by NWAS.327 Simon Beswick had never had any training in the use of the Team Leader action card produced by NARU.328

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323 INQ006618/1
324 INQ006618/2, 76/155/23-156/7
325 76/204/15-206/11
326 77/83/17-84/3
327 140/10/20-12/10
328 76/180/22-25
14.274 Simon Beswick had not received any training in relation to the issue of whether all available HART resources should be deployed or whether some should be held back.329

14.275 In my view, the system operated by NWAS in relation to the position of HART Team Leader was unsatisfactory for a number of reasons. First, it was not appropriate to have a replacement for such an important role undertaken on a volunteer basis. The volunteer system undermines the need for a clear and established hierarchy where the person in the Team Leader role is appointed on merit grounds. The volunteer system meant that the best person for the role may be receiving orders, rather than giving them.

14.276 Second, the lack of any required formal training specific to the role of Team Leader meant that there was no safeguard to ensure that the person who volunteered to undertake the role was, in fact, qualified to do it.

14.277 Third, the lack of an action card meant that the person who undertook the role did not have a list of prompts to work from. There was a clear need for an action card given the importance of the role and the lack of other safeguards due to the system operated by NWAS. Simon Beswick’s evidence was that it would have been helpful to

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329 76/174/24-175/11
have had a prompt to remind him of his key tasks.\textsuperscript{330} I agree.

14.278 Simon Beswick was an experienced paramedic. But he had been a member of HART for only two years prior to the Attack. By contrast, three of the GM HART crew that night had six years’ or more experience as members of HART.\textsuperscript{331}

14.279 When giving evidence, Simon Beswick stated that he did not think he was adequately qualified to act as HART Team Leader.\textsuperscript{332} I agree. Responsibility for this unacceptable state of affairs lies with NWAS. Simon Beswick made a number of mistakes during the response to the Attack. In my view, NWAS is responsible for those mistakes. Simon Beswick did his best in extraordinary circumstances, but he should not have been put in the position in which he found himself.

Mobilisation of GM HART crew (22:40)

14.280 At 21:53, five of the GM HART crew were assigned to a fire at Unity Mills in Woodley, near Stockport. That crew comprised: Simon Beswick, Christopher Hargreaves, Lea Vaughan, Nicholas Priest and Stephen English. The sixth GM HART
crew operative, Ian Devine, was responding to a different incident.333

14.281 Simon Beswick, Christopher Hargreaves and Lea Vaughan arrived at the fire ground near Stockport in two vehicles shortly before 22:30. Upon arrival, it became apparent that HART was not required.334 It was a misfortune that the GM HART crew were deployed to an incident away from Manchester City Centre for which they were not needed. The effect of this was that the GM HART crew had much further to travel than would have been the case if they had been at their headquarters in Manchester.335

14.282 I recommend that NWAS consider this issue with great care. The HART resource is a scarce one. It is one thing for it to have been deployed to an incident at which its particular skill set was required. It is another for it to be taken away from Manchester only to discover it was not required. I recognise that the issue is a complex one, which is why I am not critical of anyone for it occurring. For example, I recognise that taking the view that it is better to mobilise HART early to a fire in case it is needed is capable of saving lives.

333 77/110/11-112/6
334 77/78/5-17, 79/20/19-21/1
335 77/79/17-22
14.283 I was told that HART is frequently deployed but not required.\(^{336}\) While it is fortunate in each of those circumstances that HART was not needed, it risks creating the situation that in fact occurred on 22\(^{nd}\) May 2017, namely that HART is taken away from where it is needed. One solution to this problem is to increase the number of HART crews on duty. I will address this further in Part 20 in Volume 2-II.

14.284 At 22:40, NWAS Control contacted Christopher Hargreaves and informed him of “\textit{a large-scale incident in the city centre}”.\(^{337}\) NWAS Control asked if the GM HART crew could be redirected to that incident.\(^{338}\) One minute later, Simon Beswick contacted NWAS Control. He was informed of the Attack.\(^{339}\) He spoke to the incident commander from the fire and rescue service to explain that he was leaving the fire ground.\(^{340}\) At 22:42, Simon Beswick contacted NWAS Control to say that he and his team were able to attend the incident in Manchester City Centre.\(^{341}\)

14.285 Nicholas Priest and Stephen English travelled to the fire near Stockport in a Public Support Unit

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\(^{336}\) 77/80/4-13
\(^{337}\) INQ015082T/1
\(^{338}\) INQ015082T/1
\(^{339}\) INQ015039T/1, 77/4/6-25
\(^{340}\) 77/5/5-8
\(^{341}\) INQ015103T
vehicle. They were still on the M60 at the point at which Simon Beswick spoke to NWAS Control at 22:42. Following that call, Simon Beswick contacted Nicholas Priest and Stephen English and instructed them to drive back to HART headquarters. Simon Beswick instructed them to pick up an additional vehicle and deploy to the Manchester City Centre incident.\textsuperscript{342}

14.286 Shortly after Simon Beswick had left the fire near Stockport, NWAS Control informed him that the RVP was Manchester Central Fire Station. This was confirmed at 22:49. However, at 22:54 Simon Beswick was told that the RVP had been changed to “Hunts Bank Bridge”.\textsuperscript{343}

14.287 At 22:58, the sixth member of the GM HART crew, Ian Devine, was allocated to respond to the Attack. Ian Devine had been “loaned” to the GM HART crew from Merseyside for that shift. By the time he was allocated to respond to the Attack, he had finished attending to the patient he was with and had started to make his way back to HART headquarters for a break.\textsuperscript{344}

14.288 Ian Devine should have been allocated to respond as soon as he was finished with the patient, which was, as he told me, earlier than

\textsuperscript{342} 76/205/7-206/7, 77/5/22-6/24
\textsuperscript{343} INQ015071T, INQ034282, INQ015041T, 77/18/10-18
\textsuperscript{344} 79/81/3-83/5
At the point of allocation, he was only 16 minutes away from the Victoria Exchange Complex. When he was allocated, he diverted from the course he was on in order to go to the Arena. It is likely that if Ian Devine had been allocated sooner than 22:58, he would have arrived before 23:10. This may have resulted in him going into the City Room as he would have been present when Simon Beswick asked for volunteers.

Arrival of first GM HART crew operatives on Hunts Bank (23:06)

Very shortly after 23:00, Simon Beswick, Christopher Hargreaves and Lea Vaughan arrived on Trinity Way. Simon Beswick informed NWAS Control: “It’s absolute chaos, we can’t get through, traffic’s blocked, we’re currently just outside … I cannot get to the rendezvous point because the traffic is completely blocked.”

Once on Trinity Way, they encountered Martyn Nealon. The HART operatives gave Martyn Nealon a lift back to Hunts Bank. This caused a slight delay to the progress of Simon Beswick, Christopher Hargreaves and Lea Vaughan.
towards Hunts Bank. Martyn Nealon informed Simon Beswick that Daniel Smith was the Operational Commander.\textsuperscript{350} At 23:03, Simon Beswick radioed NWAS Control. He informed NWAS Control that Daniel Smith was “already inside the Arena actioning clinical aid”.\textsuperscript{351}

14.291 The first HART operative to arrive on Hunts Bank was Lea Vaughan. Her single-crewed vehicle pulled up at 23:06. Less than a minute later, the double-crewed vehicle containing Simon Beswick and Christopher Hargreaves arrived and parked.\textsuperscript{352}

**GM HART operatives’ deployment to the City Room (23:11)**

14.292 Simon Beswick made his way to the area outside the War Memorial entrance. By 23:10, he was speaking to Derek Poland on Station Approach. Seconds later, the two men were joined by Daniel Smith. As Simon Beswick was speaking to these two colleagues, Lea Vaughan and Christopher Hargreaves were preparing their equipment. At 23:11, Christopher Hargreaves and Lea Vaughan joined the group.\textsuperscript{353}
14.293 In the course of his conversation with Daniel Smith, Simon Beswick was told that there had been an explosion in the City Room. Daniel Smith informed him that Patrick Ennis “was embedded in the scene and that the scene hadn’t been declared safe”. Simon Beswick interpreted this as meaning that the City Room was within a Major Incident “inner cordon”.354

14.294 At the point of this conversation with Daniel Smith, there were only three HART operatives available for immediate deployment: Lea Vaughan, Christopher Hargreaves and Simon Beswick. Nicholas Priest and Stephen English were still more than five minutes away. At this point, Simon Beswick did not know where Ian Devine was.355

14.295 Daniel Smith said to Simon Beswick that HART personnel were required to move forward into the City Room to assist Patrick Ennis with primary triage and treatment.356 Simon Beswick characterised it as a joint decision with Daniel Smith for Lea Vaughan and Christopher Hargreaves to be deployed into the City Room.357
14.296 Simon Beswick spoke to Christopher Hargreaves and Lea Vaughan. He informed them that there had been an explosion causing mass casualties and mass fatalities. He said that a secondary device had not been ruled out and that there were unconfirmed reports of shootings. He told Christopher Hargreaves and Lea Vaughan that it was not known if the building was safe. He asked if they had the equipment they needed. He concluded by asking if they were “happy to deploy”. Christopher Hargreaves and Lea Vaughan said that they were.358

14.297 In order to save time, neither Christopher Hargreaves nor Lea Vaughan had put on their ballistic protection.359 Having received the briefing, it was a brave decision by both of them to unhesitatingly agree to go to the City Room without protective equipment which was available to them.

14.298 When they deployed to the City Room, Christopher Hargreaves and Lea Vaughan had four “MTFA [Marauding Terrorist Firearms Attack] bags” between them. These contained tourniquets, haemostatic dressings and blast dressings, among other items.360 They also each took SMART Triage Tags as a means to identify
patients as P1, P2, P3 or deceased once they had been triaged.  

**Deployment of remainder of GM HART crew**

14.299 Simon Beswick did not go forward to the City Room. Daniel Smith tasked him to operate on Station Approach. While he and other HART operatives had relevant skills for supporting a Major Incident response outside the hazard area, the principal attribute of HART operatives is working in hazardous areas. I shall return to the issue of what Simon Beswick was tasked to do by Daniel Smith at paragraph 14.340.

14.300 By 23:21, the remaining members of the GM HART crew had mustered on Station Approach with Simon Beswick: Ian Devine had arrived at 23:14 and put on his ballistic kit; Nicholas Priest arrived at 23:18; and Stephen English arrived at approximately the same time as Nicholas Priest.

14.301 Daniel Smith stated in evidence that he deployed only two HART operatives into the City Room because Simon Beswick only “provided me with two”. He stated that he was not told of the arrival

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361  79/33/19-34/9  
362  77/30/2-24  
363  77/34/7-13  
364  INQ040616/5
of the other HART operatives. He stated that he would not have directed the additional HART operatives to set up a Casualty Collection Point, but that it was “very much likely that I would have said ‘Assist with the establishment of the CCS [Casualty Clearing Station] now that you’re here.’” Later in his evidence, Daniel Smith stated he could not recall being told that any further HART operatives were ready to deploy. His evidence was that he “thought the operational plan was working and if any more resources were needed, then they would have been requested”.

14.302 Simon Beswick’s evidence was that it was Daniel Smith’s “command decision”, which he supported, for the remainder of the GM HART crew to remain on Station Approach.

14.303 I find that when Daniel Smith became aware of the arrival of three more members of the GM HART crew, he directed that they stay on Station Approach. This was a decision with which Simon Beswick agreed. Both were wrong. The better decision was to deploy all of the GM HART crew to the City Room. I shall turn to this in more detail shortly.

365  110/185/16-187/10
366  110/206/1-13
367  110/209/12-23
368  77/44/4-22
While the responsibility for making this decision lay with Daniel Smith, he did not have the support in his decision-making that he should have had from Simon Beswick. This lack of support was principally the responsibility of NWAS, for the reasons I gave above at paragraphs 14.271 to 14.279, when considering Simon Beswick’s suitability for the role of HART Team Leader.

Specialist Response Team

Both HART and GMFRS’s Specialist Response Team train together. Simon Beswick knew of the Specialist Response Team’s capabilities. He knew that they had training on performing immediate life-saving interventions. He knew that they had the training and experience to move casualties safely and efficiently.369

As he made his initial assessment of the scene and considered deployment, Simon Beswick should have been asking himself where GMFRS was. In evidence, he stated that he was aware that GMFRS was not at the scene, but: “[W]e were quite busy managing patients and the actual response.”370

I recognise that Simon Beswick and his team were confronted with an extremely stressful situation, and it was important that the immediate

369 77/61/8-64/14
370 77/61/8-17
needs of casualties were addressed. However, for good reason, JESIP expects communication, co-location and co-ordination. The fact that Simon Beswick did not pause for a moment to consider whether the way his team operated might be enhanced by a co-ordinated approach with his counterpart team at GMFRS demonstrates that Simon Beswick was not thinking in JESIP terms. Instead, he was focused solely on NWAS’s response.

14.308 Simon Beswick should have contacted NWAS Control or the Tactical Advisor/NILO and asked for GMFRS to be informed that he was on Station Approach and that the Specialist Response Team should co-locate with him there. Had he done so, it is possible that GMFRS personnel would have arrived substantially sooner than they did. That arrival may have been in time to assist in the removal of casualties from the City Room.

14.309 In his evidence, Simon Beswick stated that he thought “action cards, visual prompts” would be beneficial to a response, “especially in stressful situations with a lot of challenges”. I agree.

GM HART operatives in the City Room (23:15)

14.310 The only HART operatives deployed to the City Room during the critical period of the response
were Lea Vaughan and Christopher Hargreaves. They walked through the War Memorial entrance to the railway station at 23:13. At 23:15, they entered the City Room. They immediately spoke to Patrick Ennis.

14.311 I have explained the two types of triage required in the Major Incident Response Plan in Part 12. Lea Vaughan and Christopher Hargreaves commenced primary triage at 23:16. They carried this out in a clockwise direction. Christopher Hargreaves stated that they had completed primary triage of all the patients in the City Room by 23:27. Having triaged the patients once, they spoke to Patrick Ennis again. They then started on secondary triage.

14.312 During her evidence, Lea Vaughan was asked whether it was good enough that only three paramedics were in the City Room treating those who needed treatment. Her answer was that she did not believe that further paramedics would have been of any help “at that point”. In a media interview she gave after her evidence, however, Lea Vaughan stated: “I definitely think more HART paramedics should have been sent
in … I did think more HART paramedics would have turned up. Only three paramedics went in. Yes, I am sorry that isn’t enough. I know it isn’t enough. Every person knows that isn’t enough.”

14.313 Following that media interview, Lea Vaughan provided a further statement to the Inquiry in which she stated she stood by her evidence. She stated that by the time the other HART paramedics arrived, she and Christopher Hargreaves had already completed “a large part” of the triaging and stabilisation.

14.314 Christopher Hargreaves’ evidence was that at no point while in the City Room did he think that further paramedics were required. However, he went on to say: “Ultimately, I think if we would have had extra personnel there, it would have helped.” He stated: “I don’t want to make it sound like we were struggling there or anything like that, because I don’t honestly believe at any point we were, but ultimately more medics in there would have helped.”

14.315 During the questioning, it was suggested to Christopher Hargreaves that the treatment which

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377 ‘Manchester Arena attack paramedic “let down” by North West Ambulance Service’, ITV Worlds Collide interview, 16/04/2022

378 INQ042742

379 112/168/7-8

380 112/168/18-21
was given in the City Room would have occurred earlier had there been more trained paramedics in the City Room. He replied: “Yes. I can’t argue with that.”

14.316 Simon Beswick made the point that neither Lea Vaughan nor Christopher Hargreaves requested additional resources in the City Room. His evidence was that, although he had not briefed Lea Vaughan and Christopher Hargreaves to request further members of HART: “I’m aware of my colleagues’ traits and I know if they’d needed extra assistance, they’d have contacted us.”

Simon Beswick stated he believed that Patrick Ennis “would act in a sort of forward operating role”. He accepted that he should have made direct contact with Patrick Ennis to establish the parameters of his role. In my view, Simon Beswick was wrong to rely on Lea Vaughan or Christopher Hargreaves to inform him if further HART operatives were required in the City Room. I am critical of Daniel Smith as well for adopting the same approach.

14.317 First, there was a real risk that Lea Vaughan and Christopher Hargreaves could become completely focused on their task and not take a step back. Simon Beswick accepted that there
was a risk of this occurring. I agree with Christopher Hargreaves when he stated: “[I]t’s always good to have … a forward incident commander … [or] a sector commander, [who] would have been able to see [the] big picture because you are quite focused on what you are doing at the time.”

14.318 What happened on the night of the Attack demonstrates why a Sector Commander, such as the HART Team Leader, was required in the City Room. Christopher Hargreaves’ belief at the time was that he and Lea Vaughan were coping. He now recognises that more HART operatives would have improved the care given to those in the City Room. I make it clear that I am not critical of Christopher Hargreaves for either his approach at the time or his subsequent evidence.

14.319 What Christopher Hargreaves’ evidence demonstrated was the need for someone in the City Room who was not focused on coping with the task of triage and life-saving treatment, but whose role it was to assess how the best outcome could be achieved. That was the role of a Sector Commander. Simon Beswick accepted during his evidence that he “could have been more effective moving forward”. I agree.

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384 77/52/1-5
385 112/169/21-170/10
386 77/42/15-24
14.320 Second, there was a risk that an assumption might be made by Christopher Hargreaves or Lea Vaughan that the other members of HART would follow upon arrival. Simon Beswick accepted this. In fact, Lea Vaughan made this assumption when she went into the City Room. She stated that her expectation was that the rest of the GM HART crew would follow them into the City Room upon arrival.

14.321 Third, Simon Beswick had only one radio. After Lea Vaughan and Christopher Hargreaves were deployed to the City Room, Simon Beswick switched radio channel from the HART channel to the NWAS Major Incident channel. The effect of this was to cut himself off from direct radio messages from Lea Vaughan and Christopher Hargreaves. There were other ways in which a message could have reached Simon Beswick. However, given that he was relying upon Lea Vaughan and Christopher Hargreaves to tell him if further HART operatives were required, this was a less than ideal state of affairs.

14.322 Simon Beswick should not have left it to Lea Vaughan and Christopher Hargreaves to tell him that further HART operatives were required in the City Room. He should have informed Daniel
Smith that the HART Team Leader needed to deploy to the City Room. With Daniel Smith’s approval, he should then have accompanied Lea Vaughan and Christopher Hargreaves into the City Room. He should have informed the rest of the GM HART crew that they should follow.

14.323 As an alternative, I would not have been critical of Simon Beswick or Daniel Smith if Simon Beswick had waited for the balance of GM HART crew to arrive and had accompanied them, provided he was confident that their arrival would be imminent. Either way, with the approval of Daniel Smith, Simon Beswick should have been deployed to the City Room, as should the balance of the GM HART crew. They are trained to work in very difficult conditions. That training should have been put to proper use when it was needed.

14.324 Daniel Smith should have deployed all members of the GM HART crew forward. The immediate threat to life necessitated as many paramedics in the City Room as could safely go in. By this point, Daniel Smith had reasoned himself into a position that he could not deploy non-specialists forward. That meant that only HART operatives could provide life-saving interventions to the standard of a paramedic to those in the City Room.

390 77/54/16-55/14
391 77/33/18-23, 77/42/15-24
14.325 HART operatives train as a team and operate most effectively as a team. Daniel Smith’s decision had the effect of splitting the team up for an important period in the emergency response.

14.326 More HART operatives in the City Room from 23:25 would have made a difference to the casualties in there at that time. The final casualty was not evacuated from the City Room until 23:39. If the remainder of the GM HART crew had deployed forward, on arrival, there would have been a total of six paramedics operating, under the supervision of Simon Beswick, in the City Room between 23:25 and 23:39. While it is now known that this could not have saved any lives that night, it would have increased the speed of the triage that was being carried out, provided a greater opportunity for critical clinical interventions where needed by those in the City Room, and resulted in a faster evacuation down to the Casualty Clearing Station.

Involvement with those who died

14.327 At 23:17, Lea Vaughan and Christopher Hargreaves assessed Georgina Callander. One minute later, they placed a red label on Georgina Callander to identify her as a P1 casualty. They moved on shortly after that.  

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392 77/170/10-14, 79/31/18-22
393 155/16/24-17/2
Georgina Callander was moved out of the City Room on a makeshift stretcher by others at 23:26.\textsuperscript{394} I shall return to Georgina Callander’s treatment and the treatment she received in the Casualty Clearing Station shortly.

14.328 At 23:40, Lea Vaughan and Christopher Hargreaves approached Chloe Rutherford. They lifted the covering which had been placed over her by that time. Lea Vaughan attached a label to Chloe Rutherford identifying that she was dead. Shortly after, Lea Vaughan attached a label to Liam Curry identifying that he was dead.\textsuperscript{395} This was the first time either Chloe Rutherford or Liam Curry were assessed by a paramedic.

14.329 At 23:41, Lea Vaughan attached a label to Nell Jones identifying that she was dead.\textsuperscript{396} This was the first time Nell Jones was assessed by a paramedic.

14.330 At 23:42, Lea Vaughan and Christopher Hargreaves assessed Martyn Hett. This was the first time Martyn Hett had been assessed by a paramedic. Two minutes later, Christopher Hargreaves attached a label to Martyn Hett identifying that he was dead.\textsuperscript{397}

\begin{footnotesize}
\begin{enumerate}
\item 155/22/6-13
\item 154/99/25-100/15
\item 152/27/20-22
\item 156/11/21-12/11
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14.331 At 23:45, Lea Vaughan attached a label to Eilidh MacLeod identifying that she was dead.\textsuperscript{398} This was the first time that Eilidh MacLeod was assessed by a paramedic.

14.332 At 23:45, Christopher Hargreaves lifted the covering which had been placed on Elaine McIver. He attached a label identifying that she was dead.\textsuperscript{399}

14.333 At 23:46, Lea Vaughan attached a label to Sorrell Leczkowski identifying that she was dead.\textsuperscript{400}

14.334 At 23:47, Lea Vaughan knelt beside Alison Howe. She briefly held Alison Howe’s right arm before standing up and moving away.\textsuperscript{401}

**GM HART operatives on Station Approach**

14.335 There was some confusion within the evidence as to whether the members of the GM HART crew who did not deploy to the City Room were tasked with setting up the Casualty Clearing Station or a Casualty Collection Point. The distinction may be thought to be an inconsequential one. It is not. The functions of a Casualty Clearing Station and a Casualty Collection Point are different.
14.336 As I set out in Part 12, the NWAS Major Incident Response Plan stated that a Casualty Collection Point is “designed to provide basic care for life threatening injuries prior to a casualty being moved to the CCS [Casualty Clearing Station] or direct to hospital. Equipment to establish the CCP [Casualty Collection Point] is carried by the Hazardous Area Response Team.” A Casualty Clearing Station aims to provide a treatment place to stabilise a casualty with a view to getting them to a definitive point of care “as soon as possible”. Once a Casualty Clearing Station has been established: “[A]ll casualties must be directed/transferred from the site or CCP to the facility for further triage.”

14.337 The staging of the two at a Major Incident is important. Any misunderstanding around this indicates a misunderstanding of the correct way to structure a Major Incident response.

14.338 Daniel Smith stated in evidence that he had used the terms “CCP” and “CCS” interchangeably in his witness statement. He stated that what he had sought to establish was a Casualty Clearing Station. He stated that there was no Casualty Collection Point. He stated:

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402 INQ012913/41
403 INQ012913/42
404 INQ012913/42
405 110/159/18-160/15
“I just wouldn’t ask somebody to set up a CCP outside of a CCS. If I’ve given that instruction of that nature, then it may be a mis-communication on my part, or both. I am fairly confident it would have been … to set up or assist within the CCS … it would just make no sense to have a CCP outside.”

14.339 I agree that in the circumstances of 22nd May 2017 it would make no sense to have a Casualty Collection Point on Station Approach. This does not explain why Daniel Smith used “CCP” and “CCS” interchangeably in his witness statement. Indeed, it begs the question why he did.

14.340 Simon Beswick’s evidence was: “I was tasked by Mr [Daniel] Smith to establish a CCP and support him in his response.” Setting up a Casualty Collection Point was something in which Simon Beswick had received training. He agreed that a Casualty Collection Point should sit between the incident and the Casualty Clearing Station. He agreed that the Casualty Clearing Station should then feed into the ambulance loading point.

14.341 When asked whether the Casualty Collection Point was being set up in the area of the
ambulance loading point, Simon Beswick replied: “It evolved into that, yes. My initial thought process because the scene safety hadn’t been declared was, in discussion, we attempted to get everyone away from the concourse through the Victoria Station doors … to try to give us a barrier, a buffer … a safety zone.”

He went on to say that this area “did progress to a casualty clearing station”.

14.342 GM HART crew member Ian Devine’s recollection when he gave evidence was that he was asked to set up a Casualty Collection Point by Simon Beswick when they spoke at 23:21. Setting up a Casualty Collection Point was something that HART had practised during exercises. He stated: “[A]s the incident progressed … [it] then became apparent that where we were actually set up was not a casualty collection point but was a casualty clearing station.” He stated: “[I]f I’d had a knowledge of the scene at that time … the CCP could have been positioned closer.” He agreed that there would not have been room between the area they were working in and the ambulance loading area for there to be a Casualty Clearing Station.
14.343 Both Nicholas Priest and Stephen English stated that they were asked to set up a Casualty Collection Point.\textsuperscript{415} In a presentation she gave on 16\textsuperscript{th} January 2018 about her involvement in the response to the Attack, Lea Vaughan identified Nicholas Priest, Stephen English and Ian Devine as “CCP”. She described the area on Station Approach outside the War Memorial entrance as “\textit{HART CCP/CCS}”.\textsuperscript{416}

14.344 The evidence of Helen Mottram, who acted as a triage officer on the station concourse, was that she was working in the Casualty Clearing Station, “\textit{but the casualty collection point appeared to be on the pavement outside Victoria, where some of the HART team were operating}”.\textsuperscript{417}

14.345 I am satisfied that the instruction given by Daniel Smith at 23:10 was for Simon Beswick to set up a Casualty Collection Point on Station Approach. Whether Daniel Smith meant Casualty Clearing Station and made a mistake, or whether he intended at that time to say Casualty Collection Point, I am not able to say. Either way, I am satisfied that he said Casualty Collection Point. Simon Beswick relayed this instruction to his colleagues in the GM HART crew at 23:21.

\textsuperscript{415} INQ006559/3, INQ004979/3
\textsuperscript{416} INQ022850/3, INQ022850/5, INQ022850/6
\textsuperscript{417} 81/36/19-37/8
14.346 Station Approach was not an appropriate place for a Casualty Collection Point. It was too far from the scene to discharge the function of a Casualty Collection Point. HART operatives were well qualified to set up a Casualty Collection Point due to a Casualty Collection Point ordinarily being located close to a hazardous area. As a result of their lack of situational awareness, the GM HART crew on Station Approach followed the instruction they had been given. It very quickly became apparent to those who were setting it up that the Casualty Clearing Station was better located on the station concourse between the bottom of the staircase to the raised walkway and the War Memorial entrance. By 23:17, there were a number of casualties on the station concourse.418

14.347 Two things arise from Daniel Smith’s instruction to set up a Casualty Collection Point on Station Approach. First, by saying “CCP”, Daniel Smith instructed Simon Beswick to do something he had expected to do as a result of his training. The Major Incident Response Plan made clear that HART operatives are Casualty Collection Point specialists.419 As a result, there was no reason for Simon Beswick to suggest that he was engaging in an activity which HART would not
ordinarily be expected to carry out. If Simon Beswick had been instructed to set up a Casualty Clearing Station, I consider it likely that he would have challenged that decision: he certainly should have done. This may have led to a discussion about deploying HART further forward.

14.348 Second, Daniel Smith told Simon Beswick when he arrived that nowhere within the Victoria Exchange Complex had been declared safe. As a result, Simon Beswick accepted the area of Station Approach as an appropriate location for a Casualty Collection Point. If Simon Beswick had better situational awareness, it is likely that he would have queried the choice of Station Approach as a location for the Casualty Collection Point. He did not have good situational awareness. Obtaining situational awareness was a reason for Simon Beswick to have gone forward into the Victoria Exchange Complex at an early stage.

14.349 Both of these factors are relevant to the issue of why the whole GM HART crew did not go into the City Room. They demonstrate part of the breakdown in communication and decision-making which led to a situation where four HART

420 77/39/1-7
421 77/30/20-34/6, 77/36/20-37/12, 77/57/8-58/9
422 77/38/1-4
operatives were working further from any potential hazard than the non-specialist paramedics.

14.350 During the critical period of the response, at around 23:30, Simon Beswick briefly entered the Victoria Exchange Complex. While on the station concourse, he noticed the staircase. The challenge the staircase might present to P1 and P2 casualties did not strike him at the time. He stated this was because, at that time, he “had limited information on the number of casualties in the City Room”. By this stage, the Casualty Clearing Station was well established on the station concourse.

14.351 Simon Beswick candidly stated that more training would have been helpful to him at the point at which he was discussing with Daniel Smith the setting up of the Casualty Collection Point. I agree. Principal responsibility for the shortcomings in Simon Beswick’s approach lies with NWAS. NWAS failed to ensure that an appropriately qualified person was leading the GM HART crew.

14.352 The GM HART operatives who did not go up to the City Room contributed to the emergency
response in a positive way. I have no reason to think they did other than discharge the role they had been given as well as they could. My concern around their contribution is that they could have been better used than they were.

Further deployment of GM HART operative to City Room (23:40)

14.353 Shortly before 23:40, Simon Beswick deployed Ian Devine to the City Room.\(^{426}\) Ian Devine entered the City Room at 23:40.\(^{427}\) By the point at which Ian Devine entered the City Room, the last casualty who was capable of being helped had been removed.\(^{428}\)

14.354 Simon Beswick deployed Ian Devine to provide SMART Triage Tags to Lea Vaughan and Christopher Hargreaves. These cards were to be used to identify those left in the City Room who had died.\(^{429}\)

C&M HART crew

14.355 The Team Leader of the C&M HART crew on duty on 22\(^{nd}\) May 2017 was Ronald Schanck. He became aware of an incident in Manchester City Centre, via social media, at around 22:55. At that time, he was at HART headquarters in

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\(^{426}\) 77/59/9-60/6
\(^{427}\) INQ035612/374
\(^{428}\) INQ035612/373
\(^{429}\) 77/59/17-60/6
Merseyside, approximately 30 miles from the Arena. He immediately notified the rest of the C&M HART crew to ready themselves. At about 23:06, he spoke to NWAS Control. It was agreed that the C&M HART crew would mobilise to Manchester. Ronald Schanck was formally allocated to respond to the Attack at 23:14. By this stage, he and his team were already on the road.

14.356 Ronald Schanck’s evidence was that he would have expected to have been notified by NWAS Control of the incident earlier than he was. In my view, Ronald Schanck was correct to have this expectation. There was an unacceptable delay by NWAS Control to notify the C&M HART crew. In the NWAS closing statement to the Inquiry, NWAS accepted this.

14.357 I have already criticised NWAS Control for the time it took to mobilise the GM HART crew. The mobilisation occurred as a result of a conversation with Annemarie Rooney at 22:39. At that stage, there was no good reason not to mobilise the C&M HART crew towards the Victoria Exchange Complex. Ronald Schanck’s evidence was that he would have expected

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430 81/115/18-118/9
431 81/115/15-118/6
432 81/118/10-119/5
433 INQ0425544/26 at paragraph 58
notification to be given to his team within ten minutes of the explosion.\textsuperscript{434} Again, I agree with his evidence.

14.358 If NWAS Control had notified the C&M HART crew at the same time as the GM HART crew, members of the C&M HART crew could have been on Hunts Bank by 23:15 or just after.\textsuperscript{435} Had this occurred, based on their travel times from Merseyside, there would have been at least three members of the C&M HART crew available to Daniel Smith at around this time: Ronald Schanck, Ciaran Martin and Garry Blyton.\textsuperscript{436} It is highly likely in these circumstances that more HART operatives would have been deployed into the City Room. These may have been from the GM HART crew and/or the C&M HART crew.

14.359 It was argued on NWAS’s behalf that sending the C&M HART crew straight to the scene at 22:40 would not have been reasonable.\textsuperscript{437} The evidence of the Ambulance Service Experts was cited in support, namely: “There’s a risk … particularly with a terrorist attack, that you don’t know if it’s going to be multi-sited so there needs
to be a caution about sending all specialist assets to a single location."

14.360 I accept that particular caution was required at 22:40 for the reason given by the Ambulance Service Experts: fewer than ten minutes had passed since the detonation. However, as time passed, the risk of a further attack diminished. By 23:15, over 40 minutes had passed since the explosion without any clear evidence of a further attack. Balanced against that risk was the fact that Daniel Smith had made the decision that only HART operatives could provide assistance to the people in the City Room.

14.361 In my view, by the stage at which the C&M HART crew would have been nearing the RVP at Manchester Central Fire Station and the Victoria Exchange Complex, there was a clear justification for deploying them straight to the scene so that they could help casualties. If Daniel Smith had directed non-specialists into the City Room, then I recognise that holding the C&M HART crew back at this stage would have been justified.

14.362 A decision to deploy both HART crews to the scene at 23:15 would have required thought to be given to ensuring that some of the HART operatives at the scene were able to deploy to
another scene quickly should they be needed.\(^{439}\) In the circumstances, as far as they were capable of being known, at 23:15 on 22\(^{nd}\) May 2017, I do not accept that it would have been reasonable to withhold badly needed help from casualties in the City Room on the basis of the risk of a further attack.

14.363 The mitigation for such a risk was to ensure that the HART crews in Yorkshire and the East Midlands Ambulance Services were alerted at the same time as the NWAS HART crews so that they could be ready to provide support to NWAS if required.

14.364 As it was, the C&M HART crew were directed to attend Manchester Central Fire Station. Ronald Schanck arrived at 23:43 in the same vehicle as a second member of his team.\(^ {440}\) Other members of his team arrived in the minutes that followed. The final members of the team arrived just after midnight.\(^ {441}\) Ronald Schanck explained that he and his C&M HART crew were frustrated that they had been mobilised to an RVP rather than to the scene.\(^ {442}\) He stated: "\(\text{[B]}\)ut it’s not unreasonable for the command structure to be a bit cautious because in my mind, as HART team
leader, I was concerned this could be … the start of something big, as in attacks across the north west.”

14.365 Ronald Schanck was correct to recognise that the decision as to whether to deploy the second HART crew to the scene required consideration of the risk that they may be required elsewhere as part of an unfolding attack. His evidence echoed that of the Ambulance Service Experts as I set out above at paragraph 14.359.

14.366 Just as he was arriving at Manchester Central Fire Station, Ronald Schanck spoke to Daniel Smith to notify him of his location. Daniel Smith informed Ronald Schanck that he was “probably going to move [him] forward” but that he needed to clear the roads a little.

14.367 At 23:50, Ronald Schanck contacted the NWAS Merseyside Control Room from Manchester Central Fire Station. He said: “We’ve got a HART team at the RVP now and we’re looking at possibly backing our colleagues up from Manchester HART, closer to where the incident is.”

14.368 At 23:54, the NWAS Merseyside Control Room spoke to Ronald Schanck. He repeated that he
wanted to know if NWAS Control wanted him to back up his colleagues on scene. The reply he received was: “[I]t might have to come from Manchester.” This was a reference to the NWAS Control Room in Greater Manchester. The NWAS Merseyside Control Room said: “[W]e are just trying to get hold of Manchester but we can’t get any reply from them at the moment, it’s obviously chaos there.”

14.369 At 00:13, the C&M HART crew were deployed from the RVP to Hunts Bank. They arrived on Hunts Bank at 00:19.

14.370 It is not completely clear to me from the evidence why it took 30 minutes for this to occur. What is clear is that Daniel Smith was in favour of the C&M HART crew coming to the scene. It is also clear that delay was caused as the Merseyside-based part of NWAS Control sought to contact the Manchester-based part of NWAS Control.

14.371 If there was a deliberate decision to hold the C&M HART crew back, one relevant consideration was the risk of further attacks. A second relevant consideration was whether or not there was a particular need for HART’s specialist skill set.
14.372 As to the first consideration, by 23:43 more than an hour had passed since the detonation. While GMP had investigated other potential threats, there was no clear evidence of a further attack.\(^{448}\) The risk of a further attack was diminishing as every minute passed. As to the second consideration, by 23:43 all casualties who could be helped had been evacuated from the City Room and were in the Casualty Clearing Station.\(^{449}\)

14.373 On the available evidence, it is likely that there was no deliberate decision to hold the C&M HART crew back. Indeed, as the C&M HART crew were arriving just under a mile away from Hunts Bank, Daniel Smith was saying to Ronald Schanck that it was only congestion that was stopping him calling the C&M HART crew forward.\(^{450}\)

14.374 Consequently, it is unnecessary for me to resolve whether a deliberate decision to hold the C&M HART crew back was justified. A combination of congestion at the scene and communication breakdown within NWAS Control appears to be the explanation for this delay. Both are likely to happen to some degree during a Major Incident response. However, in my view, half an hour to

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\(^{448}\) 101/101/2-115/16

\(^{449}\) INQ041266

\(^{450}\) 81/128/2-16
resolve this combination of factors at that stage in the incident is an unacceptably long period of time. I make clear that the delay was not the fault of Ronald Schanck. He took appropriate steps to convey to NWAS Control that he was eager to move forward and support his colleagues.

14.375 It is fortunate that Ronald Schanck put his time at Manchester Central Fire Station to constructive use, acting as a Parking Officer there.\(^{451}\) It is also fortunate that the urgent need for paramedics who were able to operate in the area Daniel Smith had decided to keep non-specialist paramedics away from had also passed by this time. Nevertheless, it should not have happened that the specialist resource of the C&M HART crew was delayed in arriving at the scene for the time it was. In the closing statement made on its behalf, NWAS accepted this.\(^{452}\)

Casualty Clearing Station before midnight

Prioritisation for transfer to the Casualty Clearing Station

14.376 The first two casualties treated in the Casualty Clearing Station arrived on the station concourse at 23:07. One was assisted down from the City Room and treated as a P1 casualty in the Casualty Clearing Station. The other was carried...
from the City Room on a makeshift stretcher and treated as a P2/3 casualty in the Casualty Clearing Station. By this point, Saffie-Rose Roussos had been evacuated from the City Room to Trinity Way.

14.377 The immediate issue arising from these facts is that a makeshift stretcher was used at a very early stage of the evacuation to carry down a person who was not a P1 casualty. I have no doubt that this person was in pain and in need of treatment in the Casualty Clearing Station. However, the reality of a mass casualty situation is that the most seriously injured should be identified and prioritised during the first triage process. At the point at which that P2/3 casualty arrived in the Casualty Clearing Station, there were 16 P1 casualties in the City Room and one on the raised walkway.

14.378 From 23:15, Patrick Ennis received support from two members of the GM HART crew, Lea Vaughan and Christopher Hargreaves. By this point, one P1 casualty had been carried into the Casualty Clearing Station on a makeshift stretcher. Two more P2 casualties had been

453 INQ041266
454 174/38/22-39/8
455 110/19/10-20/15
456 INQ041266
457 INQ035612/259
carried into the Casualty Clearing Station on makeshift stretchers. A number of P1 and P2 casualties had also reached the Casualty Clearing Station without needing to be carried.458

14.379 By 23:31, there were 25 casualties in the Casualty Clearing Station. Six were P2 casualties who had been carried out on makeshift stretchers. At that time, there were still four P1 casualties who needed to be carried out of the City Room to the Casualty Clearing Station.459

14.380 I recognise that in circumstances as difficult as this, it is likely to be impossible to achieve a situation where every P1 casualty is given priority over the P2 casualties for transportation to a Casualty Clearing Station. However, the triage system should have worked better than it did.

14.381 I have covered the extent of my criticism of Patrick Ennis for this in paragraph 14.182. It is confined to the fact that he did not ensure he had ‘cruciform cards’ with him as he conducted his triage.460 It is very difficult to conduct triage of a large number of casualties without triage cards of some sort. I am not critical of the two GM HART operatives for their involvement with triage. They were overstretched and doing their best.

458 INQ041266
459 INQ041266
460 109/178/11-181/15
14.382 Had more non-specialists been deployed to the City Room, the triage system is likely to have worked better than it did. If the whole GM HART crew had been deployed to the City Room upon their arrival, this would also have improved the triage in the City Room. If there had been stretchers used in the City Room, it would have been much easier to arrange a proper order of priority for removal.

14.383 In my view, Daniel Smith and NWAS as an organisation share responsibility for the triage system in the City Room not working as well as it should have. There should have been more paramedics, including an NWAS commander, deployed to the City Room to help co-ordinate the prioritisation of casualties with the police, ETUK and members of the public.

Allocation of resources to the incident

14.384 NWAS provided data for its fleet of vehicles. At 22:32, there were 319 vehicles in operation across the region covered by NWAS.⁴⁶¹ Of these, six were available for immediate mobilisation to a new incident.⁴⁶² The Ambulance Service Experts described this as “pretty typical”.⁴⁶³
14.385 In the period from 22:32 to 22:46, NWAS Control allocated five ambulances to respond to the Attack.\(^{464}\) Patrick Ennis had also been allocated. He travelled in an Emergency Rapid Response Vehicle. A second Emergency Rapid Response Vehicle was also allocated. The second Emergency Rapid Response Vehicle was at Blackpool Victoria Hospital at the time of allocation and understandably took nearly an hour to arrive at Hunts Bank.\(^{465}\)

14.386 At 22:46, Patrick Ennis sent a message just before he entered the Victoria Exchange Complex. Based on what he could see, he told NWAS Control that there were “apparently between six and eight casualties, all appear to be walking wounded”.\(^{466}\) He requested “at least four emergency ambulances”.\(^{467}\)

14.387 At 22:54, Patrick Ennis sent a METHANE message from the City Room to NWAS Control. In it, he said: “[W]e’ve got at least 40 casualties approximately 10 er appear to be deceased on scene we’ve got at least a dozen priority 1.”\(^{468}\)

14.388 At 22:56, Nicola Pratt, a duty Manager at NWAS Control, informed Annemarie Rooney that Patrick

\(^{464}\) INQ015140T/3, INQ042544/67-68 at paragraph 141

\(^{465}\) INQ040368/1, INQ040368/2

\(^{466}\) INQ015047T/1

\(^{467}\) INQ015047T

\(^{468}\) INQ015070T/1
Ennis had reported “only ... six casualties, but that the police are saying there are up to 60.” Nicola Pratt said that there were nine vehicles allocated to the incident. Annemarie Rooney instructed Nicola Pratt to “aim to get a dozen ... and then we’ll review”.

14.389 At 22:57, the Chief Executive Officer of NWAS, Derek Cartwright, telephoned NWAS Control. He asked: “So we’ve no sign, we don’t have any casualties yet?” In reply, he was told: “[I]t started off with reports of 30, then 40, then 60, so it’s getting on towards mass casualty.” NWAS Control went on to inform Derek Cartwright that the casualty numbers came from the police. This provides a snapshot of NWAS Control’s understanding of the scale of the incident at 22:57. It is not necessarily the case that all casualties would require transportation to hospital by ambulance.

14.390 At 23:06, Derek Poland sent a radio transmission from the scene to NWAS Control saying: “[W]e’re going to need at least 20 vehicles for this ... if we can ... I’ll give you better updates once I know, there’s quite a few P1’s and quite a few
fatalities.” NWAS Control replied that it was understood that “you need 20 vehicles”. The reply continued that Nicola Pratt would be spoken to about how many vehicles had been allocated by that time. Derek Poland concluded the exchange by asking what the arrival time for HART was estimated to be. He was told that NWAS Control would get back to him.

14.391 Derek Poland’s recollection is that he gave the instruction relating to “at least 20 vehicles” on his own initiative rather than by reason of a request or order from Daniel Smith.

14.392 The position by the time Derek Poland gave his instruction at 23:06 was that NWAS Control had allocated 14 ambulances to respond to the Attack.

14.393 Following Derek Poland’s instruction, NWAS Control continued to allocate resources to the response. By 23:23, a further 13 ambulances had been allocated, bringing the total to 27.

14.394 At 23:23, Daniel Smith sent a METHANE message. He said: “Number of casualties so far, we have confirmed at least 15, one five, priority
one patients.”\textsuperscript{480} At the time he sent this message, there were 16 casualties in the Casualty Clearing Station.\textsuperscript{481} Given Daniel Smith’s later use of the term P1 at 23:34, 15 must have been a reference to the people in the Casualty Clearing Station, not the total number of patients requiring ambulances at the scene.\textsuperscript{482} His figure took no account at all of the other 22 casualties in the City Room or on the raised walkway who were later to be brought down to the Casualty Clearing Station. This was because of Daniel Smith’s lack of situational awareness of the City Room.\textsuperscript{483}

14.395 Between 23:23 and 23:34, NWAS Control allocated another four ambulances to the response. This brought the total at 23:34 to 31 allocated ambulances.\textsuperscript{484}

14.396 At 23:34, Daniel Smith made a radio call to Annemarie Rooney, in which he said:

“So currently estimating and it is an estimate of around forty, 40, P1 patients, that’s 40 P1 patients and multiple walking wounded. We are going to have to start moving them as we’ve got some very critical on scene so we
will have to start moving some of the patients soon.”

14.397 By this time, there were 29 patients in the Casualty Clearing Station. Daniel Smith was correct to have now recognised that there were seriously injured people who had not yet reached the station concourse.

14.398 In a further radio call to Annemarie Rooney between 23:44 and 23:46, Daniel Smith said: “We need to start moving vehicles down from the RVP to the casualty clearing station. I need to know how many vehicles are at the RVP, how many I’ve got available and so we can start making some decisions on movement of patients.” He went on: “[W]e’ve a difficult scene, we’ve kind of got 3 places where casualties are lining up … we may have less than we first thought but at the moment let’s just stick with the numbers we know about.”

14.399 At 23:47, Daniel Smith informed NWAS Control:

“The RVP is where I want crews being sent to, they should not be coming here without us asking them to come down. At the moment, I haven’t the foggiest how many of these here
to be honest as they are spread out all around the area. So, from now on, crews to go to an RVP at Thompson Street [Manchester Central Fire Station] and then mobilised into Hunts Bank off Corporation Street … make ambulance 40, at least, we have got multiple casualties down here, we are going to need at least 40 vehicles."489

14.400 Ambulances continued to be allocated from 23:34 onwards, albeit at a slower rate. At 23:54, a 39th ambulance was allocated to the incident.490 At this point, there were the same number of ambulances responding to the incident as there were patients requiring transportation by ambulance from either the Casualty Clearing Station or, in Saffie-Rose Roussos’s case, Trinity Way.

14.401 Ambulances were not the only resources that were allocated by NWAS Control in the period prior to midnight. A total of 11 Emergency Rapid Response Vehicles containing non-specialist paramedics were allocated.491 Two Urgent Care Vehicles and an Intermediate Care Vehicle were allocated. The GM HART crew and the C&M HART crew were allocated. A number of other

489  INQ034316/1
490  INQ040368/13
491  INQ040368
individuals, including Daniel Smith and Derek Poland, attended in unmarked vehicles. 492

**Allocation of available ambulances**

14.402 I have considered the evidence provided by NWAS in relation to the ambulances that were allocated to respond. I am grateful to NWAS for providing me with this evidence in the form it did. Many of the ambulances were allocated shortly after they are recorded as “clear”. This evidence suggests that in the case of many ambulances allocated to respond to the Attack, NWAS Control staff were mobilising them to respond as quickly as they were registering as available. 493

14.403 However, that is not universally the case. During the period before midnight, there were a number of ambulances that were allocated over five minutes after they are shown as being clear by this evidence. I readily accepted that there may be a good reason for some or all of these. My investigation did not extend to examining each of these cases. 494

14.404 This is something that NWAS should examine so as to satisfy itself that the system for allocating available ambulances worked as well as it could. The fact that I am recommending this
investigation take place should not be understood as implied criticism of NWAS. I did not receive sufficient evidence on this issue to make any finding.

**NWAS resources at Victoria Exchange Complex before midnight**

14.405 The first ambulance arrived on Hunts Bank at 23:00. At 23:06, the six ambulances at Manchester Central Fire Station set off in convoy for Hunts Bank. The first of them arrived at 23:08. By 23:11, there were eight ambulances on Hunts Bank.

14.406 In addition to the ambulance crews who arrived on the ambulances, at 23:11 Daniel Smith also had immediately available to him, in the Victoria Exchange Complex: Senior Paramedic Derek Poland; Advanced Paramedic Patrick Ennis; Dr Daley; and three members of the GM HART crew.

14.407 As I set out at paragraph 14.190, a ninth ambulance, A344, was on Trinity Way between 23:00 and 23:15 having been flagged down by those assisting Saffie-Rose Roussos. It acted independently of the arrangements Daniel Smith was putting in place.

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495 INQ040368/1, INQ040368/2-4
496 174/50/7-24
14.408 During the next 49 minutes, more ambulances and staff arrived. I will address those staff who were given a functional role below at paragraphs 14.430 to 14.443.

14.409 By 23:20, there were 14 ambulances at the Victoria Exchange Complex. At 23:30, as the golden hour ended, the total number of ambulances at the scene had risen to 17. As I have explained in Part 10, the golden hour refers to the first hour of the emergency response.

14.410 The first ambulance to depart from Station Approach left at 23:40. That ambulance transported Georgina Callander to Manchester Royal Infirmary. By that point, there were 22 ambulances at the Victoria Exchange Complex. Thirty-seven people remained in the Casualty Clearing Station requiring transfer to hospital. At midnight, a second ambulance left, transporting John Atkinson to Manchester Royal Infirmary.

14.411 At midnight, there were 36 patients in the Casualty Clearing Station. There were 20 ambulances at the Victoria Exchange Complex.

497 INQ041992/1
498 155/34/11-35/25
499 INQ041266, INQ041992/1
500 INQ041266
Adequacy of number of ambulances

14.412 A key question for Daniel Smith was how many people required transportation to hospital. This was something that could have been accurately estimated before 23:20. An NWAS commander located in the City Room could have provided that figure to him. If Daniel Smith had deployed Derek Poland forward to the City Room when Derek Poland offered to go, it may have been possible for this figure to have been provided by 23:10. If Daniel Smith had deployed Simon Beswick forward to the City Room with Lea Vaughan and Christopher Hargreaves, it would have been possible for this figure to have been provided around 23:20, before Daniel Smith’s METHANE message at 23:23.

14.413 I have seen no evidence of an accurate number being identified by anyone at the scene before 23:34. It should have been. Identifying the number of casualties requiring transportation to hospital at the earliest possible stage is essential due to the delay that may be caused by how far an available ambulance has to travel.

14.414 It is not simply a case of one ambulance for one casualty. The evidence of the Ambulance Loading Officer, Matthew Calderbank, was instructive on this point. During his evidence, he was asked
why he thought it took as long as it did to transfer all casualties to hospital. He stated:

“To move all of those people … with a degree of haste, more so than we did, would have required that 19 ambulances at least to provide clinical care and then subsequent ambulances were moving patients.”501

14.415 Matthew Calderbank’s reference to 19 ambulances was based on the assumption that there were two crew in each ambulance, each of which could then be allocated to one of the 38 casualties in the Casualty Clearing Station.502 The position on the night of 22nd May 2017 was more complex than this, as there were other NWAS personnel who attended who did not arrive by ambulance.

14.416 The substance of the point Matthew Calderbank was making was that a number of the NWAS personnel arriving in ambulances would not be immediately available to transport patients as their crews would be assisting patients.503 This only serves to emphasise the need for a greater number of ambulances than there were casualties in the Casualty Clearing Station, and for those ambulances to be allocated as soon as

501 114/187/13-188/3
502 114/182/22-185/3
503 114/185/4-186/16
possible. This can only be achieved once it is known how many patients there are who need transportation by ambulance. This number was not identified at the scene and communicated to NWAS Control until 23:34.  

James Birchenough was allocated the role of Casualty Clearing Officer. He was asked in evidence about the time it took to transport casualties to hospital. He explained:

“A combination of resources, of treatment for those patients. I’m not sure at the time that the detail about the casualty plan came through we – I don’t know how much resource we had on scene, whether we had enough people initially for every patient, so initially they were involved in treatment rather than transportation. Some of the treatments that patients got were quite extensive to make them stable enough to be transported.”

His reference to the “casualty plan” was to 23:39, when Annemarie Rooney provided the numbers for each hospital’s capacity. At 23:40, there were 22 ambulances at the scene. There were 43 paramedics and Emergency Medical Technicians not in functional or command roles. There were
four members of the GM HART crew on Station Approach, one of whom was a Team Leader. There were also a number of student paramedics who had been directed to help P3 casualties. Additionally, there were at least five doctors.507

14.419 I accept the thrust of what James Birchenough was saying: there needs to be a minimum number of NWAS personnel in a mass casualty situation before transportation to hospital can occur.508 I also accept that some patients will need to be stabilised before they are transported. This may require more than one member of NWAS staff.

14.420 All of this makes it all the more important to establish at the earliest possible stage how many seriously injured casualties there are.

14.421 Even allowing for the fact that an ambulance may transport more than one patient to hospital over the course of the response, it ought not have taken until 23:54 for the same number of ambulances that were required to transport those who needed them to be allocated to the incident. As Matthew Calderbank and James Birchenough explained, more ambulances than there were patients were required for transportation to occur.

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507 INQ040368/1, INQ040368/2-9, 81/33/7-34/4, INQ035612/268
508 114/85/5-18
quickly. However, the limits of my investigation mean that I cannot say whether or not there were ambulances available to be allocated faster than they were.

14.422 Requiring more ambulances at the scene than there are casualties needing transportation is an approach which I consider should be reviewed. I recommend that NARU take the lead in investigating this. I consider this issue further when I deal with the Care Gap in Part 20 in Volume 2-II.

14.423 What I can say is that earlier identification of the number of patients requiring ambulances and/or the number of ambulances required should have occurred. That is because it will inevitably take time for an ambulance that has been allocated to reach the scene. Given the number of ambulances that were required, there was substantial travelling time for some. Responsibility for ensuring that the extent of required resources was identified as early as possible lay with Daniel Smith, as Operational Commander.

**Location of Casualty Clearing Station**

14.424 Derek Poland recalled having a conversation with Daniel Smith after Patrick Ennis had returned to
the City Room at 23:02. In that conversation, Derek Poland and Daniel Smith discussed casualties being “placed within the concourse of the train station” and being treated there. Also discussed was the fact that no one was to go up the staircase.

14.425 At 23:05, Daniel Smith approached GMP PC David Shott. Daniel Smith pointed to the area of the War Memorial entrance and said: “Casualty clearing is there.” Daniel Smith stated in evidence that he was indicating the area just inside the entrance. He explained:

“[W]hen we do major incident exercises we tend to keep priority 1s on one side of the tent, or whatever we are using, and priority 2s on the other. In my mind, I thought we’d do that at the war memorial entrance and we’d have two nice, neat rows. Clearly it doesn’t work like that in reality, something I learned on the night and obviously that war memorial entrance wasn’t going to be big enough to house the patients we had.”

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510 112/42/15-43/1
511 112/42/15-43/10
512 110/155/3-16
513 110/155/3-156/3
14.426 Daniel Smith’s choice of area reveals his lack of appreciation of the number of P1 and P2 casualties there were. This lack of appreciation was a product of the limited situational awareness he had at this time. A clearer understanding on his part of the scale of the incident would likely have caused him to start the Casualty Clearing Station on the station concourse.

14.427 As the number of casualties managed in the Casualty Clearing Station increased, the Casualty Clearing Station area grew, almost to the bottom of the staircase, and out onto Station Approach.  

14.428 Figure 38 depicts the area of the Casualty Clearing Station. The approximate location of each casualty’s arrival, and the timing of their arrival, is marked.
Figure 38: Drawing of the Casualty Clearing Station showing casualties’ locations and arrival times\textsuperscript{515}
14.429 Derek Poland’s evidence was that he recalled it being Daniel Smith’s intention to have a Casualty Collection Point at the bottom of the staircase, with the Casualty Clearing Station further towards the War Memorial entrance. He stated that, ultimately, there was never a Casualty Collection Point at the bottom of the staircase, as this area became part of the Casualty Clearing Station.

Functional roles in Casualty Clearing Station

14.430 In a radio message at 23:31, Daniel Smith informed Stephen Taylor: “[W]e are just trying to establish functional roles, about to get patients moving. I’ve asked for a tactical decision on hospital destinations because we’ve got multiple casualties obviously with penetrating trauma so we are going to have to activate the Greater Manchester Mass Casualty situation.” Daniel Smith began the process of allocating functional roles before this message.

14.431 Senior Paramedic Joanne Hedges arrived at the Victoria Exchange Complex as part of the convoy of ambulances that set off from Manchester Central Fire Station at 23:06. She arrived on
Hunts Bank at 23:10. She was given an initial briefing by Daniel Smith.\textsuperscript{521}

14.432 In evidence, Joanne Hedges recalled being told that treatment and triage would take place at the bottom of the stairs. She was told not to go up the stairs.\textsuperscript{522} She was not formally allocated a role. She viewed herself as Secondary Triage Officer. She considered the HART operatives to be acting as Primary Triage Officers.\textsuperscript{523}

14.433 She stated that, when she “went forward”, the area at the bottom of the stairs where she worked was a Casualty Collection Point.\textsuperscript{524} She also stated that once patients started being laid on the station concourse, the area she was working in became the Casualty Clearing Station.\textsuperscript{525}

14.434 Also undertaking triage was paramedic Helen Mottram. Helen Mottram was part of the group who came from Manchester Central Fire Station. She arrived on Hunts Bank at 23:09.\textsuperscript{526}

14.435 On arrival, Helen Mottram recalled being spoken to by Derek Poland. In evidence, she stated he said something along the lines of: “I don’t know if

\textsuperscript{521} 80/34/14-35/15
\textsuperscript{522} 80/35/20-39/6
\textsuperscript{523} 80/40/19-42/1
\textsuperscript{524} 80/44/23-45/17
\textsuperscript{525} 80/44/23-45/25
\textsuperscript{526} 81/28/4-23
it’s safe inside.” She stated that he asked for volunteers and that she put her hand “straight up”.

14.436 Helen Mottram was told that she was to undertake the role of “Triage Officer”. In this role she was expected to conduct an initial triage of the casualties. She entered the Victoria Exchange Complex by the War Memorial entrance at 23:17. She regarded herself as working in the Casualty Clearing Station, but the layout of the arrangements was not explained to her.

14.437 James Birchenough was contacted by NWAS Control at 22:50. At the time, he was at a hospital managing a queue of ambulances. He was told by NWAS Control that there were reports of shootings at the Arena. He was not asked to mobilise to the Arena.

14.438 Following his contact with NWAS Control, James Birchenough spoke to a police officer who was nearby. He was told there had been an explosion. Immediately, he informed staff at the hospital that they needed to clear the queue of ambulances in

527 INQ022542/5
528 81/30/20
529 81/30/24-31/10
530 81/33/7-16, 81/35/18-21
531 81/30/7-37/8, 81/40/18-41/3
532 114/8/5-12/2
533 INQ015397T/1-2
the next five minutes. At 22:58, he contacted NWAS Control. He was asked to respond to the Attack. He was told to go to Hunts Bank. He arrived on Hunts Bank in an Emergency Rapid Response Vehicle at 23:11.

14.439 James Birchenough spoke to Daniel Smith on arrival. Daniel Smith asked James Birchenough to undertake the role of Casualty Clearing Officer. James Birchenough understood from the conversation that the Casualty Clearing Station was on the station concourse and that he was not to go up the staircase to the raised walkway.

14.440 The role of Casualty Clearing Officer gave James Birchenough primary responsibility for the management of all activities within the Casualty Clearing Station, including: triage and treatment; liaison with the Casualty Clearing Station medical lead; and liaison with the Ambulance Loading Officer to ensure casualties were dispatched to hospital appropriate to their priority.

14.441 The Ambulance Loading Officer on the night of the Attack was Matthew Calderbank.
Matthew Calderbank was one of the two on-call Operational Commanders contacted by NWAS Control on the night of 22\textsuperscript{nd} May 2017. He was notified of the Attack at 22:42.\textsuperscript{541} He arrived on Hunts Bank at 23:28.\textsuperscript{542}

14.442 Matthew Calderbank met with Derek Poland and Daniel Smith on Station Approach. Daniel Smith briefed Matthew Calderbank and allocated him the role of Ambulance Loading Officer.\textsuperscript{543} An Ambulance Loading Officer’s duties included: liaising with the Casualty Clearing Officer; and taking responsibility for ensuring the appropriate and effective loading of casualties from the Casualty Clearing Station onto the next available, appropriate vehicle.\textsuperscript{544} The loading point was chosen to be Station Approach, opposite the War Memorial entrance.\textsuperscript{545}

14.443 As I have said, the role of Parking Officer was allocated to Derek Poland.\textsuperscript{546} This role included requiring him: to establish an appropriate safe location to park further resources likely to arrive at the incident; to liaise with police officers to ensure that the parking location was secure and that access and egress were maintained; to
manage the arrival and safe parking of incoming vehicles; and to brief ambulance crews on any specific routes to and from the Casualty Clearing Station.\(^{547}\)

**Treatment of Georgina Callander in Casualty Clearing Station**

14.444 Georgina Callander arrived in the Casualty Clearing Station at 23:28.\(^{548}\) She had been carried out of the City Room two minutes earlier. During her time in the Casualty Clearing Station, Georgina Callander was assessed and treated by Paramedic Adam Williams, Emergency Medical Technician Lucy Favill and an off-duty doctor, Dr Jesse Compton.\(^{549}\)

14.445 Georgina Callander was placed into the back of Ambulance A347 at 23:39.\(^{550}\) She was driven to Manchester Royal Infirmary by Emergency Medical Technician Sian Edmunds.\(^{551}\) A347 left Station Approach at 23:40. Accompanying her in A347 were Paramedic John Buchanan, Adam Williams and Georgina Callander’s mother, Lesley Callander.\(^{552}\) Georgina Callander was the
first casualty to be taken by ambulance from the Casualty Clearing Station. 553

Treatment of John Atkinson in Casualty Clearing Station

14.446 John Atkinson was carried into the Casualty Clearing Station on a makeshift stretcher at 23:24. 554 He had been removed from the City Room at 23:17. 555 He had spent a period of time on the raised walkway due to the inadequacy of the means by which he was being carried. He was conscious and in terrible pain throughout this period. 556

14.447 He was first assessed by a paramedic when he arrived at the Casualty Clearing Station. 557 A total of 53 minutes had elapsed since the explosion. That delay was unacceptable and should have been avoided by NWAS. He should have been triaged before then.

14.448 At 23:29, a P1 casualty label was attached to John Atkinson. 558 During his time in the Casualty Clearing Station, John Atkinson was assessed and treated by Senior Paramedic Philip Keogh, Senior Paramedic Michael Ruffles, Emergency

553 INQ041266
554 158/54/9-16
555 158/41/16-42/1
556 158/40/11-54/16
557 158/55/9-57/5
558 158/57/11-13
Medical Technician Laura Worrall and Dr Daley.559

14.449 At 23:47, John Atkinson went into cardiac arrest. At 23:50, John Atkinson was placed into Ambulance A368. John Atkinson was the second casualty to be taken by ambulance from the Casualty Clearing Station.560 At 00:00, A368 set off for Manchester Royal Infirmary. John Atkinson arrived at Manchester Royal Infirmary at 00:06.561

Tactical command

14.450 Annemarie Rooney was the on-call Tactical Commander for the Greater Manchester region.562 She qualified as an on-call Tactical Commander in June 2014.563

14.451 Annemarie Rooney was not able to give oral evidence.564 She was able to provide a second witness statement in which she answered a series of detailed questions from the Inquiry Legal Team.565 I have had firmly in mind that I did not hear from Annemarie Rooney from the witness box, but I have had no alternative other

559 158/57/2-21, 159/6/24-7/2
560 INQ041266
561 159/16/18-20/3, 159/29/8-30/12
562 115/114/8-20
563 INQ025679/2, INQ041728/5
564 115/108/17-25
565 INQ041728
than to resolve any relevant factual dispute on the basis of the evidence before me. While I have taken fully into account her statements, there is always a risk that evidence given in person will have more impact. I have borne this in mind and done my best to make allowance for it.

14.452 Annemarie Rooney was notified of the Attack by NWAS Control at 22:38.566 I have already observed that it was during this call that the deployment of HART was raised by Annemarie Rooney. While she was right to do so, Annemarie Rooney should have made clear that it was not just the GM HART crew that needed to be mobilised, but also the C&M HART crew. As Tactical Commander, she had responsibility for ensuring that adequate resources were put in place to support NWAS’s response to the incident.567

Decision to go to GMP HQ

14.453 At 22:41, Annemarie Rooney spoke to Daniel Smith. During this call, Annemarie Rooney informed him that she would be travelling to GMP HQ. This was in accordance with NWAS’s plan for the Tactical Commander.568
14.454 Following her contact with Daniel Smith, Annemarie Rooney had three more important conversations before she arrived at GMP HQ. First, she spoke to Neil Barnes, NWAS Strategic Commander. Second, she spoke to Stephen Taylor, one of the on-call Tactical Advisors/NILOs. Stephen Taylor informed her that Jonathan Butler, another on-call Tactical Advisor/NILO, was travelling from his home to the scene. Annemarie Rooney confirmed that Stephen Taylor should remain at home. Third, at 22:56, she had a further call with NWAS Control in which she said: “I’m going to go towards Central Park as that’s where the TCG [Tactical Co-ordinating Group] is set up.”

14.455 I can see a benefit to there being a Tactical Commander at the scene in response to an incident as complex and large as occurred on 22nd May 2017. That commander would be able to perform the JESIP role of co-locating with commanders from other emergency services, allowing the Operational Commander to continue to direct NWAS personnel.

14.456 I recognise that there is also a benefit in having a Tactical Commander away from the scene
co-located with other Tactical Commanders, particularly in the event of a multi-sited incident.

14.457 I recommend that DHSC and NARU review and issue guidance on the most appropriate location(s) for ambulance Tactical Commanders in a Major Incident. This review should consider the actions of Stephen Hynes on the night of the Attack, as he carried out Tactical Commander functions as well as Operational Commander functions from the scene. DHSC and NARU should also liaise with other emergency services to ensure that the guidance is consistent.

National Capability Mass Casualty Equipment Vehicle

14.458 During the call with NWAS Control at 22:56, Annemarie Rooney was informed: “[T]he police are saying there are up to 60 [casualties], but hopefully most are walking wounded.”

14.459 The Greater Manchester Resilience Forum Mass Casualty Plan defined a mass casualty incident as: “A disastrous or simultaneous event(s) or other circumstances where the normal major incident response of Category 1 organisations must be augmented by extraordinary measures in order to maintain an effective, suitable and sustainable response.” The plan
anticipated that once a mass casualty incident was confirmed, the National Capability Mass Casualty Equipment Vehicle would be deployed.\textsuperscript{575}

14.460 The National Capability Mass Casualty Equipment Vehicle was not deployed to the Victoria Exchange Complex on 22\textsuperscript{nd} May 2017.\textsuperscript{576} In her second witness statement, Annemarie Rooney stated that deployment of the National Capability Mass Casualty Equipment Vehicle was within the action cards for NWAS Control. She stated deployment of that vehicle “\textit{did not cross my mind}”.\textsuperscript{577} She stated that at no stage did anyone tell her that there was a shortage of equipment at the scene.\textsuperscript{578}

14.461 The National Capability Mass Casualty Equipment Vehicle would not have assisted with the use of stretchers during the response. Not only is this because it is unlikely to have arrived during the critical period, but National Capability Mass Casualty Equipment Vehicles did not carry stretchers.\textsuperscript{579} The Ambulance Service Experts invited me to consider recommending the inclusion of stretchers on National Capability

\begin{flushleft}
\textsuperscript{575} INQ008123/19  \\
\textsuperscript{576} 144/147/2-19, 140/23/11-24/1  \\
\textsuperscript{577} INQ041728/14  \\
\textsuperscript{578} INQ041728/14  \\
\textsuperscript{579} 144/151/16-152/1, INQ042544/11 at paragraph 24
\end{flushleft}
Mass Casualty Equipment Vehicles.\textsuperscript{580} In my view, this is a sensible idea. I recommend that DHSC and NARU review whether National Capability Mass Casualty Equipment Vehicles should carry stretchers.

14.462 The Ambulance Service Experts pointed out that the absence of the National Capability Mass Casualty Equipment Vehicle was mitigated in part by how well equipped NWAS was in terms of additional support vehicles. However, they stated that the National Capability Mass Casualty Equipment Vehicle held equipment which may have assisted the casualties in the Casualty Clearing Station.\textsuperscript{581} I agree. The National Capability Mass Casualty Equipment Vehicle was intended for use at situations of the scale of the Attack. Its presence would have ensured that there was no risk of equipment shortage in the Casualty Clearing Station.

14.463 Annemarie Rooney should have directed that the National Capability Mass Casualty Equipment Vehicle was deployed when she was told at 22:56 how many casualties the police were saying had resulted from the detonation of the bomb. It was her responsibility to ensure that there were adequate resources at the scene. There was a contractual agreement that the

\textsuperscript{580} 144/151/16-152/1
\textsuperscript{581} 144/149/1-151/15
National Capability Mass Casualty Equipment Vehicle would be on scene within 60 minutes of mobilisation. Given the potential time it would take to get the vehicle to the scene, it needed to be deployed early. It is not appropriate to wait for an equipment shortage to become apparent before mobilising it.

14.464 It was accepted on NWAS’s behalf that insufficient consideration was given to the deployment of the National Capability Mass Casualty Equipment Vehicle. I agree. While Annemarie Rooney as Tactical Commander bears particular responsibility for the failure to deploy the vehicle, I consider that NWAS bears overall responsibility for this failure. The time of 22:56 is the point at which Annemarie Rooney should have identified the need for the National Capability Mass Casualty Equipment Vehicle. Others within NWAS Control had the relevant information earlier than this. However, none of those involved in the response from NWAS thought to suggest that this vehicle was mobilised. This demonstrates a failure to embed the use of this vehicle at an organisational level.
Briefing from GMP

14.465 Annemarie Rooney arrived at GMP HQ at 23:12. She made her way to the Silver Control Room. When she arrived, Temporary Superintendent Arif Nawaz and Assistant Chief Constable (ACC) Deborah Ford were both present. Annemarie Rooney was briefed by Temporary Superintendent Nawaz, the GMP Tactical/Silver Commander. He informed her that a suicide bomber was responsible for the Attack. He told her that there were 20 fatalities at that time, including the bomber. Annemarie Rooney asked Temporary Superintendent Nawaz and ACC Ford whether there was “a shooter” present. Annemarie Rooney was told that it was not a shooting incident.586

14.466 Annemarie Rooney did not pass this important information on to Daniel Smith.587 In the early stages of the incident, there were concerns circulating that there may be an active shooter.588 Annemarie Rooney established that GMP’s assessment was that this was not the case.589 She should have relayed this to Daniel Smith, as it was capable of informing his risk assessment at the scene.
14.467 Fortunately, and without reference to Annemarie Rooney, Daniel Smith had reached his own view at an early stage of being at the scene that it was unlikely to be a firearms attack.\textsuperscript{590} However, that does not mean Annemarie Rooney should not have passed this information on. There was no evidence that Annemarie Rooney knew at the time she was given this information that Daniel Smith held the view he did.\textsuperscript{591} Sharing information of this importance was central to establishing good communication.

14.468 Annemarie Rooney did not pass on the information she received from Temporary Superintendent Nawaz to NWAS Control.\textsuperscript{592} By this stage, Annemarie Rooney had discussed Operation Plato with NWAS Control. It had been agreed that the Major Incident action card would be followed.\textsuperscript{593} However, it would have been a simple matter to inform NWAS Control that the GMP Tactical/Silver Commander had confirmed that this was not a shooting incident. As she has accepted in her second witness statement, Annemarie Rooney should have done this.\textsuperscript{594} In doing so, she would have ensured that NWAS
Control did not repeat the earlier concerns that it might be a shooting incident.

14.469 During her briefing from Temporary Superintendent Nawaz, Annemarie Rooney was not told that GMP had declared Operation Plato approximately 30 minutes earlier.\textsuperscript{595} Annemarie Rooney was not told that GMP had declared Operation Plato until 00:18. She learned of the declaration from Temporary Superintendent Christopher Hill.\textsuperscript{596}

14.470 I have no doubt that Temporary Superintendent Nawaz’s failure to inform Annemarie Rooney of the Operation Plato declaration was as a result of his own lack of understanding of what that declaration meant, for which both he and GMP bear responsibility.\textsuperscript{597} Regardless of his own ignorance, he should have informed Annemarie Rooney of the Operation Plato declaration when he briefed her shortly after 23:15.

14.471 What is striking about the discussion between Temporary Superintendent Nawaz and Annemarie Rooney is the fact that it did not reveal the difference in approach which was being taken by GMP and NWAS towards the issue of the risk in the City Room.\textsuperscript{598} JESIP

\textsuperscript{595} INQ041728/33-34 at paragraph 89, 115/122/6-124/9
\textsuperscript{596} 104/57/4-11, 115/133/24-134/20
\textsuperscript{597} 104/18/5-22
\textsuperscript{598} 104/66/19-68/17
expects that risk will be jointly assessed. While commanders at a scene will be best placed to carry out this risk assessment, understanding the extent of any unsafe areas, and the number of casualties who might be in them, is important for a Tactical Commander.

14.472 GMP had assessed at 22:50 that the City Room was “safe enough” for all of its personnel to operate in. That assessment extended to BTP officers, members of the public and a non-specialist paramedic, Patrick Ennis. By contrast, shortly after 23:00, NWAS assessed that only the specialist members of HART could be deployed to the City Room. Adequate communication between Tactical/Silver Commanders at around 23:15 should have identified this divergence in approach.

14.473 The discussion between Annemarie Rooney and Temporary Superintendent Nawaz did not include any mention of an FCP. An FCP is key to ensuring the co-location of commanders at the scene. Both Tactical Commanders finished their conversation without any realisation that their respective Operational Commanders had

599 INQ004542/5
600 104/68/15-69/3
601 104/68/3-69/3
602 110/141/9-143/3
603 104/56/14-24
604 INQ004542/6, 104/186/9-18
not spoken by this point and had each located themselves in different parts of the Victoria Exchange Complex. 605

14.474 At a fundamental level, the discussion between Temporary Superintendent Nawaz and Annemarie Rooney was not focused where it should have been. The focus should have been on co-ordinating the efforts of the emergency services. 606 It was not sufficient for Temporary Superintendent Nawaz to provide Annemarie Rooney with the latest information he had. They should have been working out how the emergency services could best assist each other to work together to save lives. Both Temporary Superintendent Nawaz and Annemarie Rooney bear responsibility for the inadequacies in their discussion at around 23:15.

Communication with GMFRS and BTP during critical period of response

14.475 Annemarie Rooney did not seek to make contact with her counterparts at GMFRS or BTP during the critical period of the response. 607 In her second witness statement, Annemarie Rooney stated: “I co-located at GMP and would have expected all the other key partners to be

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605 115/123/7-124/23, 104/54/12-57/20, 104/64/1-21, 104/66-19-68/17, 104/70/3-71/14
606 104/69/4-70/2, INQ041856/18, 144/79/24-80/8
607 INQ041728/13, INQ041728/21, INQ041728/41
there.” Her explanation for not communicating with GMFRS or BTP once she arrived at GMP HQ was: “The communication lines with GMFRS and BTP did not take place as they were not present at that time.”

14.476 This is not an adequate explanation for the failure to contact her counterparts at GMFRS and BTP during the critical period of the response. Communication at the Tactical/Silver Commander level is important. It is expected by JESIP. Annemarie Rooney should have tasked NWAS Control or a Tactical Advisor/NILO with finding out the relevant contact details once she realised that they were not at GMP HQ. Alternatively, she should have discussed with GMP the absence of Tactical/Silver Commanders from other services, and decided what action should have been taken.

Tactical plan

14.477 The entry in Annemarie Rooney’s decision log timed at 00:54 records: “John Butler assisted Annemarie Rooney with the NWAS tactical plan.” “John Butler” was a reference to Tactical Advisor/NILO Jonathan Butler, who had travelled to GMP HQ. I will return to his role on the night at paragraph 14.523.
In her second witness statement, regarding this entry, Annemarie Rooney stated:

“The general tactics were in place as soon as my response to the incident started. They are made up of CSCATTT, which is the prompt used as to how to form tactics and is something at the forefront of my mind when setting them. The details logged at 00:54 was referring to the pre-written template. The principles … of which are the same, it’s just the format is different.”

“CSCATTT” stands for Command and Control; Safety; Communications; Assessment; Triage; Treatment; Transport.

The “pre-written template” was a document dated January 2016, provided by Jonathan Butler to Annemarie Rooney for approval. It contained a generic tactical plan. It included, for example, the need to appoint a Safety Officer.

NWAS’s Major Incident Response Plan stated: “The Tactical Commander … works at the Tactical Level and has responsibility for developing the Tactical Plan … The Tactical Plan

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612 [INQ041728/12 at paragraph 18]
613 116/32/24-33/13
614 115/139/8-140/18, [INQ025533/2]
provides a framework for the Operational Commander to operate within.”

14.482 Annemarie Rooney’s communications with Daniel Smith do not reveal any occasion when she set out what her tactical plan was. Annemarie Rooney should have identified the headline points in her tactical plan and communicated them to Daniel Smith as part of her first conversation with him as Operational Commander. Had she done so, it might have highlighted the problems with moving the seriously injured from the City Room. As I shall set out, the action card for Annemarie Rooney’s role was capable of providing her with considerable support in this.

Action card

14.483 Annemarie Rooney’s first contact with Daniel Smith in his role as Operational Commander was after she spoke to Temporary Superintendent Nawaz. Annemarie Rooney had an important role to play once Daniel Smith had gained some situational awareness. It was her role to provide Daniel Smith with a tactical plan and to ensure that Daniel Smith did not overlook important actions.
In my view, it would have been better if Annemarie Rooney had spoken to Daniel Smith before she received her briefing from Temporary Superintendent Nawaz. In that way, she would have had greater situational awareness, which she could have provided to GMP during that discussion. It would have better placed her to participate in that conversation. It would also have meant that Annemarie Rooney gave direction at a tactical level to Daniel Smith in the early stages of him establishing structures at the scene.

The action card for Annemarie Rooney’s role would have assisted her in this. It contains a number of prompts, which she should have used in an early conversation with Daniel Smith. I will consider the most significant action prompts that Annemarie Rooney overlooked during the critical period of the response.

First, action prompt 3 expected Annemarie Rooney to “[o]btain a full briefing from the Operational Commander”. I do not consider that Annemarie Rooney did obtain such a briefing. At no point did Daniel Smith set out for Annemarie Rooney his plan for organisation of the scene by reference to its layout. There
was no discussion about major decisions that Daniel Smith was making: for example, his decision that non-specialist paramedics were not being deployed to the City Room, in circumstances where police officers were. It was Annemarie Rooney’s responsibility to obtain a full briefing from Daniel Smith as to the steps he was taking and for her to advise him on suitable tactics.

14.487 Second, action prompt 10 expected Annemarie Rooney to “[e]nsure that all Operational Command support roles have been allocated, and designate other roles”. Action prompt 11 expected Annemarie Rooney to “[m]onitor and ensure a safe working environment, so far as reasonably practicable in conjunction with the Operational Commander and Safety Officer”. Action prompt 22 expected Annemarie Rooney to “[l]iaise with Operational Commander to ensure functional roles are being undertaken”. As I set out at paragraph 14.233, Daniel Smith did not appoint a Safety Officer or an Equipment Officer. It was Annemarie Rooney’s responsibility to ensure that all functional roles,

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621 INQ041728/20 at paragraph 48, 115/130/16-24
622 INQ013422/24-25
623 INQ013422/24-25
624 INQ013422/24-25
625 110/121/18-122/20, 110/125/22-23
including a Safety Officer and an Equipment Officer, were appointed.

14.488 Third, action prompt 13 expected Annemarie Rooney to “consider the sectorisation of the incident, if required and ensure they match Police / Fire sectors. Allocate Sector Commanders via the Operational Commander.” In her second statement, Annemarie Rooney stated that she did not discuss with Daniel Smith the option of deploying the HART Team Leader as a Sector Commander in the City Room. She stated that she would have expected this to be “a consideration on his part in fulfilling his role [as Operational Commander]”.

14.489 This is not the approach expected by the action card. In my view, this is something that Annemarie Rooney should have discussed with Daniel Smith. Had she done so, he would have had to explain his rationale for holding back the HART Team Leader and a number of HART operatives in the Casualty Clearing Station. This may have led to a different decision being taken.

14.490 A conversation of this nature would have required Annemarie Rooney to have an understanding of

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626 INQ013422/24-25
627 INQ041728/20 at paragraph 48
628 INQ013422/24-25, INQ013422/6-7
the scene layout, which is why a full briefing was required as set out at paragraph 14.484.

14.491 Fourth, action prompt 16 expected Annemarie Rooney to “[c]onsider the need for other specialist assets eg BASICs [British Association for Immediate Care], SORT, Mass Casualty Vehicle, HART, MERIT [Medical Emergency Response Incident Team], Air Assets”. 629 As I set out at paragraph 14.462, this should have acted as a prompt to Annemarie Rooney to deploy the National Capability Mass Casualty Equipment Vehicle.

14.492 Fifth, action prompt 21 expected Annemarie Rooney to “[l]iaise with the Tactical Advisor to ensure that the Major Incident Plan is being followed”. 630 Annemarie Rooney spoke to Stephen Taylor, the Tactical Advisor/NILO, once during the critical period of the response. They did not discuss the Major Incident Response Plan. 631 As I shall set out in paragraphs 14.559 to 14.565, Stephen Taylor provided information in that call and no advice was sought or given.
‘GM Framework for Patient Dispersal in a Mass Casualty Event’

14.493 On 29th March 2017, NWAS tested a draft plan titled ‘GM Framework for Patient Dispersal in a Mass Casualty Event’ (the draft NWAS GM Patient Dispersal Plan).632 This plan included a casualty capability chart in relation to hospitals in and around the Greater Manchester area.633 This chart provided numbers of casualties over and under 12 years old that each of the local hospitals were able to manage during the first two hours of a mass casualty event.

14.494 A copy of the draft NWAS GM Patient Dispersal Plan was circulated by email on 2nd April 2017. The recipients included Annemarie Rooney and Daniel Smith. The text of the email stated:

“I have attached the draft Mass casualty distribution plan for GM area. Please note this is still in draft, but following 2 successful workshops and exercise Socrates last week … I am sharing this for your information.

The final sign off will come from LHRP [the Local Health Resilience Partnership] in the near future but should an incident happen
before that this should help inform your
decisions at the tactical level.”

14.495 This email was to prove prescient. The draft
NWAS GM Patient Dispersal Plan had not been
signed off by 22nd May 2017, but it was used that
night to inform command decisions.

14.496 At 23:32, Annemarie Rooney contacted NWAS
Control. In that call, she said: “I need to know …
about hospitals, … we are going to be activating
the Greater Manchester Mass Casualty Plan.”
She asked whether all the Greater Manchester
hospitals were aware of the incident. She went
on to observe that the hospitals had “at least a
good half an hour’s notice that we are at major
incident declared”. The call concluded with
NWAS Control informing Annemarie Rooney that
a check would be made that the hospitals were
aware.

14.497 At 23:34, Annemarie Rooney spoke to Daniel
Smith. In the course of the conversation, the
following exchange took place:

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634 INQ041728/7
635 115/126/7-129/15, INQ041728/15 at paragraph 31, INQ041728/17-18 at paragraph 40,
INQ041728/25 at paragraph 68, INQ041728/40 at paragraph 105, INQ041728/47 at
paragraph 120d(iii)
636 INQ025178T/1
637 INQ025178T/1
638 INQ025178T
“[Daniel Smith] We are going to have to start moving them as we’ve got some very critical on scene, so we will have to start moving some of the patients soon. So can you confirm that the major incident plan in terms of mass casualties is up and ready. If you can read that out over the air so the cas [casualty] clearing officer can hear he can start then allocating … casualties to hospitals.

[Annemarie Rooney] Sorry, yeah apologies, what is it you want me to read out?

[Daniel Smith] Sorry, just the mass casualty numbers, you know the mass casualty plan for Greater Manchester, just the numbers for each hospital.

[Annemarie Rooney] I shall come back to you with the … mass casualty numbers shortly.”
“[Annemarie Rooney] I’ve got details for you on the GM casualty capability chart in the mass casualty event.”

14.498 At 23:39, Annemarie Rooney read out to Daniel Smith the information contained in the draft NWAS GM Patient Dispersal Plan.

14.499 Based on the above exchange, it appears that at 23:32 Annemarie Rooney spoke to NWAS Control about activating the Greater Manchester Resilience Forum Mass Casualty Plan. Two minutes later, Daniel Smith raised with her the need for the chart contained within the draft NWAS GM Patient Dispersal Plan.

14.500 The casualty capability chart in the draft NWAS GM Patient Dispersal Plan was exactly what Daniel Smith needed. It was a simple, practical document, which set out the capacity of the local hospitals. It allowed informed decisions to be made as to where casualties should be transported by ambulances at the scene. It did not matter that this document was, strictly speaking, still in draft. It had been tested and simply awaited being formally adopted.
14.501 In her second witness statement, Annemarie Rooney stated: “The timing of the activation of the plan [draft GM Patient Dispersal Plan] itself did not delay processes in terms of patient transportation to hospital in my opinion.”

She pointed out that hospitals were expecting to receive patients following the Major Incident declaration. She stated that in a large mass casualty incident, it is not expected that patients will be transported immediately to hospital.

14.502 The Ambulance Service Experts considered the issue of the timing of the use of the draft GM Patient Dispersal Plan. They stated: “In terms of timings, we are of the opinion that it may have been possible to put the transfer and dispatch arrangements in place quicker but this appears to us to be marginal and is unlikely to have made any significant difference to clinical outcomes.”

14.503 In my view, first accessing the draft GM Patient Dispersal Plan 68 minutes after the explosion was later than should be expected. Annemarie Rooney should have had this essential information more readily to hand. Although the plan was in draft, Annemarie Rooney was sent a copy and instructed to use it in a mass casualty situation. The need for it should have been

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645 INQ041728/17-18 at paragraph 40
646 INQ041728/17-18 at paragraph 40
647 INQ041856/17-18
among her first thoughts when realising the scale of the incident.

14.504 However, there is no evidence that the transportation of any casualty in the Casualty Clearing Station was delayed because of a lack of certainty as to which hospital they should be taken to.  

648 Further, Daniel Smith requested the information in the casualty capability chart five minutes before being provided with it by Annemarie Rooney.  

14.505 Overall, I agree with the Ambulance Service Experts on this issue. I am satisfied that any delay that there may have been in relation to the transportation of casualties to hospitals from the Casualty Clearing Station was not caused by the timing of communication of the draft GM Patient Dispersal Plan.  

650 It is clear that the Major Incident notification had been communicated to all relevant hospitals at least half an hour before Annemarie Rooney provided the numbers in the casualty capability chart to Daniel Smith.  

Multi-agency control room communication

14.506 At 23:52, Annemarie Rooney spoke to Temporary Superintendent Nawaz. She asked for a multi-
agency control room talk group to be set up.\textsuperscript{652} Shortly after this, a message was sent by GMP from the Silver Control Room using the proposed multi-agency control room talk group which I examined in Part 12.\textsuperscript{653} NWFC responded to this broadcast. NWAS did not.\textsuperscript{654} This was because it was not until 00:05 that Annemarie Rooney was provided with the short dial code for this channel. Once she had it, she passed it on to NWAS Control at 00:08.\textsuperscript{655} This talk group was not used again that night by any of the emergency services’ control rooms.\textsuperscript{656}

14.507 This is just one of a number of examples of time being spent during the emergency response on 22\textsuperscript{nd} May 2017 seeking to establish a multi-agency control room talk group. On the night, this issue wasted precious time and diverted attention during a period when that time and attention could have been better spent on other things.

14.508 I am not critical of Annemarie Rooney for raising the need for a multi-agency control room talk group over an hour and 15 minutes after the Attack. However, the reality is that by this point in the response it was too late to make any...
difference.\textsuperscript{657} A multi-agency control room talk group should have been an embedded part of all control rooms’ practice before 22\textsuperscript{nd} May 2017.\textsuperscript{658} Responsibility for failing to ensure this lies with GMP, NWAS and GMFRS.

Role after midnight

14.509 Shortly before midnight, Stephen Hynes relieved Daniel Smith of his role as Operational Commander.\textsuperscript{659} At 00:02, Annemarie Rooney contacted Derek Poland to ask for confirmation of whether Stephen Hynes was now Operational Commander.\textsuperscript{660} This is an inversion of what should have happened. As Tactical Commander, it was Annemarie Rooney’s responsibility to decide whether or not the Operational Commander remained in role.\textsuperscript{661}

14.510 In fact, Stephen Hynes had asked if Daniel Smith minded being relieved of operational command. Daniel Smith had said he did not. At that point, operational command was transferred at the scene.\textsuperscript{662}

14.511 Six minutes after Annemarie Rooney had asked Derek Poland if Stephen Hynes had taken over

\textsuperscript{657} INQ012913/32-33 at paragraph 6.4
\textsuperscript{658} INQ008372/10-11 at paragraph 4.4, 63/93/10-20, 109/12/20-13/7
\textsuperscript{659} 110/78/23-79/12, 110/182/6-183/12, INQ035612/412, INQ035612/420
\textsuperscript{660} INQ023657T, 115/133/3-11
\textsuperscript{661} INQ013422/24-26, INQ041728/22-24 at paragraphs 55, 61-62
\textsuperscript{662} 113/104/17-25
the role of Operational Commander, Stephen Hynes contacted her and provided an update from the scene. In that conversation, Stephen Hynes “inform[ed]” Annemarie Rooney that he had taken operational command.663

14.512 Stephen Hynes was a senior figure within NWAS. He was senior to Annemarie Rooney.664 The Ambulance Service Experts commented:

“It is unusual for such a senior rank … to take over operational level command … Whilst it is right to say that major incident roles are assigned based on competence to do that role rather than rank or seniority, there is a serious risk that having an Operational Commander who holds significantly senior rank to the Tactical Commander compromises the Tactical Commander’s authority and function.”665

14.513 In evidence, Annemarie Rooney’s view was that there was “some compromise” in the command structure when Stephen Hynes took over as Operational Commander.666 She stated: “This was due to the way Steve Hynes operated in that role.”667 She further stated:

663 113/110/9-111/11, 115/133/3-11
664 113/122/11-20
665 INQ041856/13
666 INQ041728/20/23 at paragraphs 49 and 61
667 INQ041728/18 at paragraph 49
“[T]here were some decisions that should have come through the Tactical Commander that did not. Decisions were being made at scene and were only passed to me once completed and that was for information purpose only rather than asking me for a decision.”

14.514 Annemarie Rooney’s authority and function were compromised when Stephen Hynes relieved Daniel Smith of the role of Operational Commander. This should not have occurred, as any breakdown in the pre-arranged command structure creates a risk of miscommunication and a lack of co-ordinated effort.

14.515 However, these difficulties were not the effect of Stephen Hynes’ actions. In fact, Stephen Hynes was able to address some of the shortcomings in Daniel Smith’s command, as I shall set out at paragraphs 14.635 to 14.648. The priority must be making the response as effective as possible. That is what matters to the casualties who urgently need help.

14.516 Consequently, my criticism of Stephen Hynes in relation to the circumstances of him taking operational command is more technical than substantial. He should have contacted Annemarie Rooney and made clear that he was seeking her

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668 INQ041728/21-22 at paragraph 55
approval of him taking over as Operational Commander. He should have made clear that, despite his rank within NWAS, the command hierarchy was maintained. In these circumstances, I have no reason to think that Annemarie Rooney would not have agreed to Stephen Hynes becoming the Operational Commander.669

14.517 By describing my criticism of Stephen Hynes as more technical than substantial, I should not be understood to be encouraging others to do what he did. In other circumstances, it might have substantially diminished the effectiveness of the response.

Operation Plato

14.518 At 00:18, Annemarie Rooney spoke to Temporary Superintendent Nawaz’s replacement as GMP Tactical/Silver Commander, Temporary Superintendent Hill. In the course of the conversation, Temporary Superintendent Hill informed Annemarie Rooney that GMP had declared Operation Plato at 22:47.670 Annemarie Rooney did not inform Stephen Hynes of this declaration until 00:54.671
14.519 Annemarie Rooney stated in her second witness statement that when she was told of the Operation Plato declaration, she asked if anything had changed. She stated that she was told it had not. She accepted that she should have told Stephen Hynes sooner but suggested that the Operation Plato declaration did not make any difference to NWAS’s approach at that time.\(^{672}\)

14.520 In fact, the delay was not insignificant. At 00:39, Stephen Hynes spoke to Station Manager Andrew Berry. In the course of that conversation, he told Station Manager Berry that inside the Victoria Exchange Complex was a “warm zone”.\(^{673}\) He meant that it was an NWAS Major Incident warm zone, not an Operation Plato warm zone.\(^{674}\) Because Station Manager Berry did know about the Operation Plato declaration at this stage, he understood Stephen Hynes to be informing him that the inside of the Victoria Exchange Complex was an Operation Plato warm zone.\(^{675}\) This was an unsatisfactory state of affairs.

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672 INQ041728/34 at paragraph 90
673 113/162/5-163/7
674 113/148/4-149/18, 120/93/10-96/22
675 120/93/10-13, 120/160/2-19
14.521 If Annemarie Rooney had communicated to Stephen Hynes, shortly after she was told by Temporary Superintendent Hill that GMP had declared Operation Plato, this miscommunication about the risk would not have occurred. Annemarie Rooney should have informed Stephen Hynes that GMP had declared Operation Plato shortly after she was told.

14.522 When Annemarie Rooney was informed about the Operation Plato declaration, she did not ask about what zones had been imposed; Temporary Superintendent Hill did not discuss zoning until he spoke to Chief Inspector (CI) Mark Dexter at 00:50. Annemarie Rooney should have asked about zoning at 00:18. The whole purpose of Operation Plato is to ensure that emergency personnel can operate within acceptable risk parameters through the use of zones. What zones had been imposed was relevant information for Annemarie Rooney to pass on to Stephen Hynes. It is likely that if she had asked about zoning at 00:18, she would have prompted GMP to think more rigorously about the zoning of the Victoria Exchange Complex at that stage.

676 104/199/1-10
677 INQ008372/11
First Tactical Advisor/NILO

Mobilisation to the scene (22:49)

14.523 Jonathan Butler was on call as a Tactical Advisor/NILO on the night of 22nd May 2017. As the name suggests, there are two parts to this role. The Tactical Advisor role involves providing tactical advice to NWAS commanders. This advice is not limited to the Tactical Commander. Operational Commanders can use the Tactical Advisor, as can the control room. The NILO role faces outward from NWAS. This requires liaison with other emergency services.

14.524 The explanation for one person discharging both roles is that information received from outside agencies can have an impact on the advice that is given. NWAS operated an action card created by NARU for the Tactical Advisor/NILO role.

14.525 The NARU action card anticipates the difficulty which may be caused by having one person discharging both roles. The second action it prompts is: “Activate an additional Tactical Advisor as required.”
At 22:49, NWAS Control contacted Jonathan Butler. The purpose of the call was “to get you [Jonathan Butler] going” to the incident. Jonathan Butler informed NWAS Control that he would speak to Stephen Taylor, the other NWAS on-call Tactical Advisor/NILO.

After the call with NWAS Control, Jonathan Butler called Stephen Taylor. Jonathan Butler said that he was mobilising to the scene. He asked Stephen Taylor to perform the Tactical Advisor/NILO role from home. At the time he mobilised, Jonathan Butler considered that the fact he was an Ambulance Intervention Team Commander may have been relevant to NWAS Control’s direction that he attend the scene.

At 22:56, NWAS Control spoke to Jonathan Butler a second time. In that call, he was informed that NWAS had declared a Major Incident. He was also told that the RVP was “Hunts Bank”. NWAS Control told him that Annemarie Rooney was the Tactical Commander. Jonathan Butler concluded the call by saying: “I’m on my way … Steve [Taylor] will be able to assist you on the phone if you need anything.”
14.529 In that call, Jonathan Butler raised the issue of an NWAS Airwave talk group. In evidence, he stated: “Steve [Taylor] was going to be dealing with [the multi-agency talk group].”

Diversion to GMP HQ (23:47)

14.530 Jonathan Butler lived approximately 45 minutes’ drive from Manchester City Centre. He left his home shortly after 23:00. At approximately 23:47, Stephen Taylor contacted Jonathan Butler. Stephen Taylor informed Jonathan Butler that Annemarie Rooney wanted him to attend GMP HQ. At the time of the call, Jonathan Butler was approximately two minutes from the Victoria Exchange Complex. Jonathan Butler queried the decision, pointing out that he was an Ambulance Intervention Team Commander. He was told he was wanted at GMP HQ. As a result, he changed course and drove to GMP HQ.

14.531 At 23:49, Jonathan Butler made a radio broadcast to Annemarie Rooney informing her that he was in the city centre. He asked whether she wanted him at GMP HQ or “to assist down on scene”. Annemarie Rooney instructed him to
come to GMP HQ for a Tactical Co-ordinating Group meeting.  

14.532 Jonathan Butler’s evidence of his experience is highly relevant to the position of his counterpart at GMFRS that night, Station Manager Berry. Jonathan Butler stated: “[Y]ou can’t actually follow an action card while you are driving on blue lights … there’s nothing other than driving.” In Part 15, I will consider GMFRS’s response to the Attack. As I will explain, one of the problems Station Manager Berry encountered was trying to manage GMFRS’s response to the incident while simultaneously driving a significant distance at speed.

14.533 At approximately 00:10, Jonathan Butler arrived at the GMP Silver Control Room at GMP HQ. Once in the GMP Silver Control Room, he “overheard somebody mention Plato”. He spoke to Temporary Superintendent Hill, who told him that Operation Plato had been declared very shortly after the Attack had occurred.

14.534 Jonathan Butler said that Annemarie Rooney was “extremely busy going from one phone call to a
At approximately 00:25, he was briefed by Annemarie Rooney. He formed the impression that, at that stage, Annemarie Rooney “had a very good handle on the incident”.

In his reflection the day after the Attack, Jonathan Butler wrote: “Steve Hynes hampered the normal chain of command that had been agreed for this incident and Annemarie Rooney was always playing catch-up to the scene.” Stephen Hynes replaced Daniel Smith as Operational Commander at 23:57.

Jonathan Butler went on to explain during his evidence that he wrote this because Stephen Hynes took a lot of decisions at the scene. He stated that he did not believe that this hampered or affected any form of patient care. He went on to say that he believes “that NWAS should take a more pragmatic approach to scene management”. By this he meant that the NWAS Tactical Commander should also consider going to the scene to co-locate with other Tactical Commanders. Jonathan Butler went on to say that he thought that, on 22nd May 2017, GMP HQ
was the correct place for Annemarie Rooney to go because that was where the GMP Tactical/Silver Commander was.\textsuperscript{706}

14.537 I recommend that NWAS, in consultation with other emergency services in its area of operation, consider the issue of the location of the Tactical Commander, as this may be capable of improving outcomes at Major Incidents. It will, however, require a co-ordinated approach to this issue across emergency services.

14.538 Jonathan Butler’s final reflection was that he “felt like a spare part as advice was not needed in the TCG [Tactical Co-ordinating Group] due to decisions being made at the [scene]”.\textsuperscript{707} This is unfortunate. Jonathan Butler struck me as being a highly capable member of the NWAS response. It was clear to me that he was able to add a substantial amount to the quality of the NWAS response. In the event, his own view is that he did not.

14.539 While I am not prepared to go as far as he does and find that he was a “spare part”, it is clear to me that, through no fault of his own, Jonathan Butler was not able to contribute as much as he might have. This was the result of diverting him away from the scene.

\textsuperscript{706} 116/53/1-55/21
\textsuperscript{707} 116/58/9-59/7
14.540 I will consider the wisdom of the decision to divert Jonathan Butler once I have dealt with the second Tactical Advisor/NILO.

Second Tactical Advisor/NILO

Advice during the critical period of response

14.541 Stephen Taylor was notified of the incident by Jonathan Butler shortly after 22:49. Stephen Taylor lived closer to Manchester City Centre than Jonathan Butler. They both proceeded on the basis that Jonathan Butler would travel while Stephen Taylor would operate from his home, covering the period when Jonathan Butler was travelling. Because of his Ambulance Intervention Team Commander qualification, Jonathan Butler had an additional set of competencies relevant to the response. As a result, I am not critical of the fact that they did not reverse roles.

14.542 However, journey time for on-call staff is capable of building in substantial delay. I recommend that NWAS review its approach to Tactical Advisors/NILOs in light of this issue. NWAS should consider whether it is possible and practical to identify in advance of any shift which of its on-call NILOs is best placed to travel to a Major Incident

708 116/38/4-11, 116/125/24-126/7
709 116/154/7-156/13
710 116/2/21-4/25
should it occur and which of them should operate from home to provide cover for particular areas.

14.543 At some point after he agreed this approach with Jonathan Butler, Stephen Taylor spoke to the Tactical Commander, Annemarie Rooney. He informed her of the arrangement, which she ratified.711 I will return to this call at paragraphs 14.559 to 14.565.

14.544 At 23:07, Stephen Taylor contacted NWAS Control. In the course of the call, Stephen Taylor enquired about Operation Plato.712 He was told that Operation Plato had not been declared.713 Strictly, this was not correct, as Inspector Sexton had declared Operation Plato at 22:47.714 However, the inaccuracy was not the fault of NWAS Control. It was a further consequence of Inspector Sexton’s failure to notify NWAS of his declaration.715

14.545 Stephen Taylor was informed by NWAS Control that a Major Incident had been declared. He informed NWAS Control that he had tried to get through to GMP on a number of occasions and had been unsuccessful.716

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711 INQ015347T
712 115/118/13-24
713 INQ015347T
714 INQ024325/1, 97/163/21-164/2, 98/7/19-8/18
715 97/114/1-9
716 INQ015347T
14.546 At 23:22, Stephen Taylor called NWAS Control. He enquired whether NWAS Control had “done a hailing group call to GMP”.\textsuperscript{717} He explained he was “struggling to get hold of them”.\textsuperscript{718}

14.547 Nine minutes later, at 23:31, Stephen Taylor contacted Daniel Smith over the radio. The purpose of Stephen Taylor’s contact was because he was trying to establish where the NWAS Strategic Commander, Neil Barnes, should go. Daniel Smith told him, “I haven’t a clue,” and directed Stephen Taylor to contact the Tactical Commander.\textsuperscript{719} In the course of the conversation, Stephen Taylor enquired whether a METHANE message had been sent. Daniel Smith had broadcast a METHANE message eight minutes earlier.\textsuperscript{720}

Inter-agency liaison during the critical period of response

14.548 Between 22:50 and 23:33, Stephen Taylor made “numerous phone calls” to try to get through to the FDO. He was not successful during this period. On each occasion, the line he tried was engaged.\textsuperscript{721} Stephen Taylor’s experience was the same as more than one officer from GMFRS
who also tried unsuccessfully to get through to the FDO on a number of occasions during the critical period of the response. 722

14.549 At 23:33, Stephen Taylor was connected on the FDO telephone line. He spoke to David Myerscough, a police support staff officer. 723 Stephen Taylor enquired whether GMP wanted the NWAS Strategic Commander to go to GMP HQ, as well as the NWAS Tactical Commander. David Myerscough confirmed that the NWAS Strategic Commander should go to the Silver Control Room at GMP HQ. 724

14.550 Stephen Taylor asked: “Do you want to open up an inter-op channel with our control rooms …?” 725 A little later in the call, he said: “Is there any chance of opening that inter-op channel at all? Just to keep them abreast.” 726 Stephen Taylor suggested two channels. Neither of them was the proposed multi-agency control room talk group channel. Towards the end of the call, Stephen Taylor said: “But if we could open up a channel with our control room, that would be ideal really in terms of just sharing information.” 727
14.551 Stephen Taylor was correct to be raising the issue of a multi-agency control room talk group. I am not critical of him for suggesting the use of channels other than the proposed multi-agency control room talk group. However, this conversation further serves to demonstrate the consequences of the failure by all emergency services operating in the Greater Manchester area to agree the Standard Operating Procedure for the proposed multi-agency control room channel before the Attack.

14.552 The use of a multi-agency control room talk group should have been well established before 22nd May 2017. This would have led to far better communication between the emergency services. It would also have meant that Stephen Taylor and others did not have to occupy time talking about setting it up. It would have avoided the risk of confusion arising as to which talk group should be used.

14.553 At about the same time as Stephen Taylor was raising this issue with GMP, GMFRS and NWFC were discussing the same topic. The GMFRS and NWFC conversations focused on the use of the proposed multi-agency control room talk group. In due course, the proposed multi-agency control room talk group was used to the extent

728  INQ001186/1-2
that GMP checked who was listening. NWAS did not reply. This was because, as I set out above at paragraph 14.506, at the time at which GMP checked, NWAS had not been given the channel number.729

Communication failures during the critical period of response

14.554 Stephen Taylor raised the multi-agency hailing talk group with NWAS Control at 23:22. He accepted he should have raised this earlier than he did.730 He was correct to recognise this. His NILO role required that he communicate with emergency services partners. Having correctly identified that his first contact should be with GMP, he should have systematically worked his way through all means of reaching the FDO. Unlike his counterpart at GMFRS, by remaining at home Stephen Taylor had placed himself in the optimum environment to be able to think clearly and carry out the tasks he needed to.731 In these circumstances, not raising the multi-agency hailing talk group earlier was a failing on his part.

14.555 Stephen Taylor did not attempt to contact BTP. He explained that he did not think he had “a direct route to BTP on my phone”.732 This is not
an adequate explanation for him not trying. He could have asked NWAS Control to provide him with a number. He is not solely responsible for this failing. NWAS should have ensured that he had the relevant contact numbers for BTP.

14.556 Stephen Taylor made no attempt to contact NWFC or GMFRS before 01:00 on 23rd May 2017. He stated in evidence: “I think my expectation ... is that they would have responded. I was aware that they were aware of the call.”

Again, this was not an adequate explanation for this failure. Quite aside from the fact that Stephen Taylor’s expectation was wrong, JESIP required that there should be ongoing communication so that situational awareness could be shared, the risks could be jointly assessed and, most importantly, there was co-ordination between agencies. Stephen Taylor’s explanation suggests a fundamental misunderstanding of these important principles.

14.557 At 01:04 on 23rd May 2017, Stephen Taylor contacted NWFC. He began: “I just wondered have you got a NILO on this incident in Manchester at the moment or is he at scene, or ... have you got a liaison officer with you in control.”

It is extraordinary that, even by 01:04, Stephen Taylor did not know the identity of the
GMFRS NILO or have any contact details. Stephen Taylor’s role was an ‘inter-agency’ one.\textsuperscript{735}

14.558 The other side of Stephen Taylor’s role was to provide advice. He spoke to Daniel Smith, the NWAS Operational Commander, during the critical period of the response. He did not offer him any advice. He provided limited advice to NWAS Control during his two calls set out above at paragraphs 14.544 to 14.546.\textsuperscript{736}

14.559 Stephen Taylor stated in evidence that he did speak to Annemarie Rooney, the NWAS Tactical Commander, but he was not “100% sure” when.\textsuperscript{737} He stated that he thought it was before Annemarie Rooney’s conversation with Daniel Smith at 23:39.\textsuperscript{738} Stephen Taylor stated that in his call with Annemarie Rooney, he discussed the activation of the “\textit{Mass Casualty Distribution Plan}”. Stephen Taylor’s notes of his involvement indicate that this discussion may have occurred at 22:47, which was before he was even notified of the Attack.\textsuperscript{739} His witness statement, which was based upon his notes, records that he “\textit{recall[s] discussing the Mass Casualty}
Distribution Plan with Annemarie [Rooney]” in a call at 22:47.\footnote{740}

14.560 For reasons that I will explain below, I was not able to rely upon Stephen Taylor’s notes. Consequently, I have looked for other evidence on this issue.

14.561 Annemarie Rooney recorded in her first witness statement that she spoke to Stephen Taylor as she was travelling to GMP HQ.\footnote{741} She stated that, while she is unable to recall the specifics, she reached agreement with Stephen Taylor that he would remain at home while Jonathan Butler travelled. Annemarie Rooney makes no mention of any mass casualty plan being discussed in that conversation.\footnote{742}

14.562 Annemarie Rooney referred to the ‘Greater Manchester mass casualty distribution plan’ in her first statement. It is first referenced in the statement in a conversation “at approximately 23:35”.\footnote{743} That conversation was with Daniel Smith. Annemarie Rooney suggested in that statement that the plan she was referring to was “in draft”. I set out at paragraphs 14.496 to 14.502 that the plan that was being discussed with Daniel Smith was the draft NWAS GM
Patient Dispersal Plan. As I set out in Part 12, this draft plan was intended to complement the Greater Manchester Resilience Forum Mass Casualty Plan. When Annemarie Rooney referred in her statements to the ‘mass casualty distribution plan’, I understand her to be referring to the draft NWAS GM Patient Dispersal Plan.

14.563 Annemarie Rooney’s second witness statement responded to the question of whether she accepted that in her call with Stephen Taylor, as she was travelling to GMP HQ, he advised her to activate the mass casualty distribution plan. Her reply was: “No, I do not recall any conversation with Mr Taylor about the mass casualty distribution plan. I believe the first conversation about this plan was with Dan Smith at around 23:35 as per my log.”

14.564 Given the extent of Stephen Taylor’s timing inaccuracies and given the content of Annemarie Rooney’s witness statements, on the balance of probabilities, I find that Stephen Taylor did not give Annemarie Rooney advice about any mass casualty plan prior to her discussion with Daniel Smith between 23:34 and 23:39 about hospital casualty numbers. Stephen Taylor should have done.

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744 INQ041728/25 at paragraph 68
14.565 In light of all the evidence, I find that Stephen Taylor did not offer any advice to either the Operational Commander or the Tactical Commander during the critical period of the response.

Record-keeping

14.566 Stephen Taylor wrote notes of his involvement. He also completed an incident log. The incident log was written up during the 72 hours following the incident, in accordance with the requirement marked on the front page of the incident log. The incident log corresponded in substance with the content of the notes Stephen Taylor made. Stephen Taylor’s subsequent witness statement corresponded with the notes and the incident log.

14.567 During Stephen Taylor’s evidence, it became apparent that the notes and incident log he had written were inaccurate in a number of important respects. I accept that this was as a result of mistakes on his part.

14.568 Stephen Taylor’s evidence was that he tried to make notes as he went, but that he was “playing catch-up” while he was making and receiving

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745 INQ029154/1
746 116/122/21-23/6
747 116/146/17-147/21
calls. He stated that some notes were written up “a few hours into the evening”. Although he was concerned about the accuracy, he did not make any record to indicate this concern.

14.569 I am critical of Stephen Taylor for failing to make accurate notes as the incident unfolded, given the circumstances in which he was involved. I recognise that it would not have been easy for him. I also recognise that if he had had a Dictaphone this would have removed the need for him to make notes. However, the notes were so inaccurate, including recording things that were not said, it would have been better if Stephen Taylor had just recorded that he did not have a clear recollection of much of what he did.

14.570 The inaccurate entries risked creating confusion immediately after the incident and beyond. They led to an unsatisfactory situation in which another witness who gave evidence before Stephen Taylor was questioned on the basis that Stephen Taylor’s notes were accurate.

14.571 To illustrate the problem this caused, I take but one example of mis-recording. Stephen Taylor recorded that at 22:50 he spoke to “GMP (FDO),

748 116/123/12-24
749 116/147/7-8
750 116/146/17-147/21
751 116/153/8-154/6
752 115/79/5-81/13
Inspector Dale Sexton”.\textsuperscript{753} His record goes on, that at 22:51: “Confirmed with tactical commander (AMR) and strategic commander, Neil Barnes, that FDO requested presence at GMP command module – advised to attend.”\textsuperscript{754} At 22:52, he recorded: “[F]rom FDO at this stage no secondary devices or active shooting.”\textsuperscript{755}

14.572 In fact, at no stage did Stephen Taylor speak to the FDO, Inspector Sexton. His contact with GMP was nearly 45 minutes later than his notes suggest. At that stage, he spoke to David Myerscough, who had identified himself by name at the start of the call.\textsuperscript{756} By that stage, Annemarie Rooney was already at GMP HQ, as Stephen Taylor stated in the call. As such, it was not Stephen Taylor’s contact with GMP that led to Annemarie Rooney going to GMP. In fact, Annemarie Rooney decided to go to GMP HQ during her call with Daniel Smith at 22:41, nearly ten minutes before Stephen Taylor was informed of the Attack.\textsuperscript{757} Further, there was no discussion during Stephen Taylor’s call with GMP about secondary devices or active shooters.\textsuperscript{758}
14.573 Stephen Taylor’s witness statement did include this statement: “Having had an opportunity to reflect on my involvement with this incident, I know that not all of the calls I made have been recorded within my incident decision log.” The witness statement said nothing to indicate that the content of the statement was inaccurate in any other way. Indeed, it contained an attestation that the content was true to the best of his information, knowledge and belief.

14.574 Jonathan Butler suggested that increasing the Tactical Advisors/NILOs within NWAS may lead to overall improvement. Stephen Taylor said that a third Tactical Advisor/NILO on call “would have been ideal”. I recommend that NWAS review the number of Tactical Advisors/NILOs it has and whether the number of such specialists, both generally and on call, should be increased.

14.575 I will return to this issue of the importance of clear and accurate recording of involvement in Major Incidents in Part 19 in Volume 2-II.
Ambulance Intervention Team Commander

Mobilising an Ambulance Intervention Team Commander

14.576 Jonathan Butler was a qualified Ambulance Intervention Team Commander. During his evidence, he explained this role:

“The role of an AITC [Ambulance Intervention Team Commander] … when Ambulance Service staff are actually involved in a ballistic-type attack environment, would be to liaise with the police, agree the risk assessment, and then agree a way in which we can move forward to treat patients and bring them out of that area. It’s about deployment of staff … the AITC has actually undergone further training and liaison with the police to understand when … to commit staff and when not to commit staff.”

14.577 He went on to state that the role was:

“not only that [about communicating with the police where is safe], it’s all about getting commanders to the scene as well. So even if the role of an AITC wasn’t actually in play at that point in time, what the [Ambulance Intervention Team Commander] can bring to
the table is an extra commander to support the decision-making.”}

14.578 He stated that an Ambulance Intervention Team Commander would locate herself or himself at the FCP at the scene.

14.579 As I set out at paragraphs 14.22 to 14.24, at 22:38 Annemarie Rooney was contacted by NWAS Control. In the course of the call, Annemarie Rooney stated: “[W]e need to get HART, we need to find out who’s the AITC.”

Annemarie Rooney then said: “Identify your AIT on duty.”

14.580 In her call with NWAS Control at 22:56, Annemarie Rooney again brought up the issue of the Ambulance Intervention Team Commander. She asked: “[H]ave we identified an AITC?” This led to a discussion about who might be available to undertake this role. The call concluded with NWAS Control informing Annemarie Rooney: “I’ll find one, I’ll get one.”

14.581 At 23:10, the Greater Manchester Emergency Operations Centre within NWAS Control contacted the Regional Health Control Desk
within NWAS Control.\textsuperscript{771} The Manchester Control Room asked the Regional Health Control Desk to find an Ambulance Intervention Team Commander. The Regional Health Control Desk agreed to do this.\textsuperscript{772} It is not clear to me whether this happened or not.

14.582 It is unsatisfactory that, over 30 minutes after the Attack, NWAS Control had still not identified an Ambulance Intervention Team Commander who could be mobilised in that capacity. NWAS’s plan was that the Ambulance Intervention Team Commander would lead the specialist team responding to a Marauding Terrorist Firearms Attack.\textsuperscript{773} If there had been marauding gunmen, there would have been an even more urgent need than there was on 22\textsuperscript{nd} May 2017 for such a commander at the scene.

**Diversion of Jonathan Butler (23:47)**

14.583 Jonathan Butler could have been at the Victoria Exchange Complex by 23:50. He was on call that night, not as an Ambulance Intervention Team Commander, but as a Tactical Advisor/NILO. As I set out above at paragraphs 14.530 and 14.531, at 23:47 and 23:49 it was communicated to him

\begin{itemize}
\item \textsuperscript{771} INQ015367T
\item \textsuperscript{772} INQ015367T
\item \textsuperscript{773} INQ026738/13 at paragraphs 86–87, INQ026738/34 at paragraph 248
\end{itemize}
that Annemarie Rooney wanted him to go to GMP HQ rather than the scene.\textsuperscript{774}

14.584 In my view, Jonathan Butler would have been able to bring his skills both as a Tactical Advisor/NILO and as an Ambulance Intervention Team Commander to bear if he had completed his journey to the scene and operated from there, rather than from GMP HQ. His colleague Stephen Taylor was available on the telephone to provide Annemarie Rooney with tactical advice.

14.585 I am not critical of Annemarie Rooney for her decision to divert Jonathan Butler to GMP at 23:47. This is for a number of reasons. First, by 23:47 Annemarie Rooney had been at GMP HQ for over 30 minutes. She had spoken to the GMP Tactical/Silver Commander, but she had not been told that Operation Plato had been declared.\textsuperscript{775} She had received no information, since her arrival, that there were marauding gunmen. As such, Jonathan Butler’s Ambulance Intervention Team Commander qualification, while useful, was not essential at the scene.

14.586 Second, the most significant area in which an Ambulance Intervention Team Commander would have been able to assist on the night of the Attack was in relation to entry to the City Room.

\textsuperscript{774} INQ034311, 116/39/24-40/22, 116/44/2-45/21
\textsuperscript{775} 115/133/24-134/20
by paramedics. An Ambulance Intervention Team Commander would have been well placed to speak to the police on scene, to assess the risk to paramedics going forward and to support the command decisions around this.\textsuperscript{776} By 23:50, when Jonathan Butler would have arrived at the scene, had he not been diverted, all of the casualties who could be helped had already been removed from the City Room.

14.587 Third, around the time that Jonathan Butler could have arrived at the scene, another NWAS qualified Ambulance Intervention Team Commander had arrived: Stephen Hynes.\textsuperscript{777} Stephen Hynes pulled up on Hunts Bank at 23:50. At 23:57, he took up the role of Operational Commander from Daniel Smith.\textsuperscript{778}

14.588 Fourth, at the time she made the decision, Annemarie Rooney was not to know that Stephen Hynes was imminently to start making decisions without substantial recourse to her. Consequently, she was not to know that the contribution she could make as Tactical Commander would be lessened from this point.

14.589 In my view, it would have been a reasonable decision to permit Jonathan Butler to complete

\begin{itemize}
  \item \textsuperscript{776} 116/2/21-3/17
  \item \textsuperscript{777} 113/81/16-21
  \item \textsuperscript{778} INQ035612/405, INQ035612/420
\end{itemize}
his journey to the scene. However, Annemarie Rooney was well placed to decide if she needed a Tactical Advisor/NILO with her at GMP HQ. For the reasons I have given, I am not critical of her for deciding this was the best use of Jonathan Butler.

14.590 I will return to Stephen Hynes after I have addressed the role of the Strategic Commander on the night of the Attack.

**Strategic command**

**Initial notification**

14.591 Overnight on 22\textsuperscript{nd} May 2017 into 23\textsuperscript{rd} May 2017, Neil Barnes was the NWAS on-call Strategic Commander for Greater Manchester.\textsuperscript{779} At approximately 22:40, he missed a call from Annemarie Rooney. He telephoned her back. In the ensuing conversation, Annemarie Rooney informed him that there had been a suspected bombing at the Arena.\textsuperscript{780} She informed him that there were two on-call Operational Commanders on their way to the scene. She told him that she was going to deploy to the Tactical Co-ordinating Group at GMP HQ. Neil Barnes told her he approved of her doing this. He asked her to call him again with a METHANE message.\textsuperscript{781}

\begin{itemize}
\item \textsuperscript{779} 115/11/11-17/24
\item \textsuperscript{780} 115/11/11-17/24
\item \textsuperscript{781} 115/11/11-17/24
\end{itemize}
14.592 Neil Barnes’ impression was that Annemarie Rooney thought that the incident was serious, but he anticipated the possibility it might not be. He had previous experience of incidents that were successfully handled by the Tactical Commander and that did not require a Strategic Commander.\(^{782}\)

14.593 Neil Barnes’ approach to this initial notification was not adequate. A suspected bombing was likely to require a multi-agency response. It was highly likely that an NWAS Strategic Commander would be required. Doing nothing until he received a METHANE message from his Tactical Commander was unacceptably passive. NWAS’s Major Incident Response Plan stated: “\textit{Whilst it is not the responsibility of the Strategic Commander to make tactical decisions they still have responsibility for ensuring the tactics which are being employed are effective.}”\(^{783}\)

14.594 Neil Barnes should have taken a more proactive approach. He should have established with Annemarie Rooney what her tactical plan was. He should have made arrangements for their next contact, rather than making it contingent on her receiving and passing on a METHANE message.\(^{784}\)

\(^{782}\) 115/18/13-19/25  
\(^{783}\) INQ012913/15  
\(^{784}\) 115/11/11-17/24
14.595 Following his call with Annemarie Rooney, Neil Barnes switched on his television to see if he could learn anything more.\textsuperscript{785} He was able to learn very little beyond the fact that an incident involving several people had occurred. He began to get the equipment he might need together. He then continued watching the television while he waited for more information from Annemarie Rooney.\textsuperscript{786}

14.596 Neil Barnes’ decision to wait at home for more information from Annemarie Rooney was not an appropriate one. He should have actively sought out further information.\textsuperscript{787} Annemarie Rooney had told him that she was going to travel to GMP HQ. Accordingly, it was likely that a significant period of time would pass before she spoke to him again. I accept that at that initial stage Neil Barnes would not know that it would be essential for him to travel to GMP HQ. However, having prepared himself, the next obvious step for him was to contact NWAS Control to obtain an update. Relying entirely on the media for information while he waited for Annemarie Rooney to call him back was inadequate.\textsuperscript{788}

\textsuperscript{785} 115/22/1-27/6
\textsuperscript{786} 115/22/1-27/6
\textsuperscript{787} 115/22/1-27/6
\textsuperscript{788} 115/22/1-27/6
14.597 Had Neil Barnes telephoned NWAS Control a few minutes after he had spoken to Annemarie Rooney, he would have discovered that, at 22:46, NWAS declared a Major Incident. It is likely he would have been provided with information about the number of known casualties at that time. He would have realised that it was essential that he mobilise immediately. None of these things occurred because Neil Barnes did not contact NWAS Control.

Call from NWAS Chief Executive Officer (23:00)

14.598 At approximately 23:00, Neil Barnes received a telephone call from Derek Cartwright, the NWAS Chief Executive Officer. Derek Cartwright suggested that Neil Barnes should mobilise to GMP HQ. Following the call, Neil Barnes decided to remain at home.

14.599 Neil Barnes’ reasoning for this decision was that, although Derek Cartwright was the most senior person within NWAS, he was not “part of the command structure” that night. He stated: “I made the decision for the command structure to kick into play, to wait for a response from Annemarie [Rooney] or wait for a response from another area of the command and control structure, such as the NILO or the ROCC.”
[Regional Operational Co-ordination Centre within NWAS Control].”\(^{792}\)

14.600 I recognise that Derek Cartwright was not formally part of the command structure on the night of 22\(^{nd}\) May 2017. However, as Chief Executive Officer he was the most senior person in NWAS. While Derek Cartwright did not give a command, in my view there needed to be a very good reason for Neil Barnes not to follow his suggestion. No such reason existed.

14.601 Neil Barnes should have followed Derek Cartwright’s advice and immediately deployed to GMP HQ. Alternatively, he should have sought further information. This could have been from Annemarie Rooney, NWAS Control, a Tactical Advisor/NILO or his counterparts at the other emergency services. What was not an acceptable course for Neil Barnes was simply remaining at home waiting for information to come to him. However, that was what Neil Barnes did.

Call from NWAS Control (23:20)

14.602 At approximately 23:20, NWAS Control called Neil Barnes.\(^{793}\) In the course of this call, Neil Barnes was informed that NWAS Control was receiving offers of staff to come on duty. Neil Barnes stated: “Right, well we don’t know the

\(^{792}\) 115/38/10-39/2

\(^{793}\) INQ034628T
situation yet do we? I haven’t had a full SITREP [situation report] yet … I am waiting for the Silver Commander to get back to me.” 794 In response, NWAS Control asked Neil Barnes when he had last had an update. He replied: “I spoke to her briefly about 10 minutes ago, why have you got one?” 795

14.603 NWAS Control provided Neil Barnes with an update. He was told that there were reports of shots fired. He was told that there were at least 18 fatalities. He was told that the police had asked NWAS to send as many vehicles as possible. He was told that the RVP was Hunts Bank. 796

14.604 Neil Barnes asked: “[H]ave they opened a gold?” 797 This was a reference to GMP opening the Gold Control Room at GMP HQ. He was told that NWAS Control had been unable to get through to find out. The call concluded with Neil Barnes providing the following instruction: “We need to wait until our bronze commander makes decisions in terms of resourcing rather than listening to the police at this stage.” 798 By “this stage”, GMP had had resources at the scene for 40 minutes.
14.605 There are a number of unsatisfactory elements to this conversation. First, Neil Barnes failed to ask when the incident had occurred. Establishing how long had elapsed since the start of the incident by this point was important information.

14.606 Second, Neil Barnes failed to enquire whether a Major Incident had been declared. This was an obvious question to ask. The Major Incident Response Plan stated: “The nature of the incident will determine whether all levels of command are required. Most large or major incidents will require a multi-agency approach to command and control.”

14.607 Third, Neil Barnes failed to enquire whether Operation Plato had been declared. Having been informed that there were reports of shots fired and 18 fatalities, the possibility of an Operation Plato declaration should have been obvious.

14.608 Fourth, although he was told about the number of fatalities, he failed to ask how many casualties there were. This was also an obvious question to ask.

14.609 Fifth, the only direction Neil Barnes gave NWAS Control was to ignore the police’s request for
support. He did so on the basis that NWAS Control needed “to wait” for the Operational Commander’s decision. This was an inappropriate instruction to give.

14.610 The emergency services must trust each other. If the police request as many vehicles as are available, steps should immediately be taken to comply unless there is a compelling reason not to. Neil Barnes had no idea at this point where the Operational Commander was or how long NWAS might have to wait for that person to identify the resources that were needed. He took no steps to find out this information before he gave the instruction he did. He did not even find out if there were any paramedics at the scene.

14.611 As I have set out above, I am critical of Neil Barnes for his approach to this conversation. The obvious deficiencies in it are aggravated by the fact that up until this point Neil Barnes had remained at home waiting for information to come to him.

14.612 Having received this call and learned that there were at least 18 fatalities, Neil Barnes should have sought to contact Annemarie Rooney, a Tactical Advisor/NILO and/or his counterparts at GMP, BTP and GMFRS. He did not do any of
these things. He continued to wait at home for Annemarie Rooney to call.⑧⁰⁴

Call from Tactical Advisor/NILO (23:40)

14.613 During his evidence, Neil Barnes was asked if he would have stayed at home if, during his conversation with Derek Cartwright at 23:00, he had learned that NWAS was responding to a mass casualty incident. He answered that he would not have stayed at home.⑧⁰⁵ I am unable to accept this evidence. When Neil Barnes was told at 23:20 that there were 18 fatalities, he decided to continue waiting at home.⑧⁰⁶

14.614 It was not until Stephen Taylor called Neil Barnes at approximately 23:40, to notify him that a Strategic Co-ordinating Group would be required, that Neil Barnes decided to leave his house.⑧⁰⁷ Neil Barnes should have left his home to travel to GMP HQ following his call with NWAS Control at 23:20. At that point, it was a certainty that a Strategic Co-ordinating Group would be required. At that stage, Neil Barnes knew that the emergency services were responding to a terrorist incident which had caused 18 fatalities.

⑧⁰⁴ 115/35/1-36/3
⑧⁰⁵ 115/37/6-12
⑧⁰⁶ INQ034628T
⑧⁰⁷ 115/40/18-42/23
14.615 Again, Neil Barnes’ approach was not proactive enough. Rather than seize the initiative and start his journey, his approach until 23:40 was to wait to be told that he was required to leave his home.\(^{808}\)

**Silver Control Room at GMP HQ (00:30)**

14.616 The journey time from Neil Barnes’ house to GMP HQ was approximately 30 minutes. He drove in a vehicle equipped with blue lights and sirens but chose not to use them. He stated in evidence that this was because it takes concentration to drive with blue lights and sirens on. He stated that his journey may have been quicker if he had driven with the blue lights and sirens on.\(^ {809}\)

14.617 In the course of his journey, Neil Barnes had further conversations with NWAS Control. At 23:52, he called NWAS Control to obtain the postcode of GMP HQ.\(^ {810}\) Given the time he had before this call, it is surprising that Neil Barnes had not obtained the postcode before his departure. At 00:17, he called NWAS Control because he thought the address he had been provided with was wrong.\(^ {811}\) At around 00:30,
Neil Barnes entered the Silver Control Room at GMP HQ. 812

14.618 In evidence, Neil Barnes was asked whether it would have been better if he had arrived at GMP HQ sooner than he did. He answered that he did not think so. He stated that his only role before the meeting of the Strategic Co-ordinating Group was to provide support to Annemarie Rooney, which he could do over the telephone. He conceded that once present he was able to bring his influence to bear to encourage a Strategic Co-ordinating Group meeting to take place. 813 For the reasons I have given above, my view is that Neil Barnes should have set off much sooner than he did.

14.619 Also arriving at GMP HQ at the same time as Neil Barnes was an NWAS loggist. As the name suggests, this person’s function was to sit alongside a commander and make a record of decision-making. 814 The first entry in the NWAS Strategic Commander’s log is timed at 00:35. 815 In evidence, Neil Barnes stated that at this point he formulated a strategic plan. He stated he did not write that strategic plan down in the log. He accepted he should have. He stated that before

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812 115/42/24-43/25
813 115/47/21-49/22
814 115/55/1-56/4
815 INQ014784/4
00:35 he was relying on a generic strategic plan.\textsuperscript{816}

14.620 The Major Incident Response Plan states the following of the role of Strategic Commander:

"\textit{NWAS major incident action card 22 outlines the Strategic Commander’s key responsibilities. The action card must be used during the management of the incident.}

\textit{The Strategic Commander has overall responsibility for the command, response and recovery for any major incident for their organisation. They will set the trust’s strategic aims – ie develop a strategic plan. This provides a framework for Tactical Commander(s) to work within. A generic Strategy can be found at Appendix D. This should be adapted by the Strategic Commander as necessary.}\textsuperscript{817}

14.621 Neil Barnes should have formulated an incident-specific strategic plan substantially earlier than 00:35. This would have required him to have a much better understanding than he had prior to his arrival at GMP HQ. He should have written the plan down. He should have communicated it to Annemarie Rooney."
14.622 The action card that the Strategic Commander is required by the Major Incident Response Plan to follow directed Neil Barnes to do a number of important things he did not do during the first two hours of the emergency response. First, action card 22 directed: “[O]n notification of the incident start an incident log.” There was no good reason for Neil Barnes not to do this: he was at home during the critical period of the response.

14.623 Second, action card 22 expected Neil Barnes to “[g]ain assurance from the Ambulance Incident Commander [Tactical Commander] that risk assessments have been carried out as appropriate”. He failed to do this. The issue of the assessment of risk was extremely important on the night of 22nd May 2017. Contrary to the requirements of JESIP, the NWAS risk assessment was conducted by the NWAS Operational Commander without reference to other emergency services. It produced a different conclusion to that conducted by the GMP Operational/Bronze Commander in terms of where unprotected, non-specialist responders could work.

14.624 Third, action card 22 expected Neil Barnes to attend the Strategic Co-ordinating Group, if
established, or to “consider the need to request that an SCG [a Strategic Co-ordinating Group] is set up”. Having attended GMP HQ in expectation of a Strategic Co-ordinating Group meeting, he only did so when he was advised to do so by Stephen Taylor. I have concluded that Neil Barnes failed to consider the need to request that a Strategic Co-ordinating Group be set up.

14.625 Fourth, action card 22 expected Neil Barnes to “confirm the strategy for the incident and ensure that this is disseminated to the Ambulance Incident Commander [Tactical Commander]. Ensure the strategy is documented within the incident log.” He failed to do any of these things during the first two hours of the response, despite being in a position to address these requirements.

14.626 Fifth, action card 22 expected Neil Barnes to “[e]nsure inter service liaison at the appropriate strategic level”. It was not until after he arrived at GMP HQ that Neil Barnes spoke to any other Strategic Commander. As I have set out above, he should have sought to do this sooner.

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821  INQ013422/44
822  115/40/18-42/23
823  INQ013422/44
824  115/49/3-22
825  INQ013422/45
Strategic Co-ordinating Group meeting  
(04:15 on 23rd May 2017)

14.627 I have dealt with the timing of the Strategic Co-ordinating Group meeting in the section in which I consider GMP’s response to the Attack, in Part 13. It is only necessary to mention it again at this stage of my Report because Neil Barnes did not attend it.

14.628 Neil Barnes had a pre-booked flight to take him on holiday at midday on 23rd May 2017. Before he came on call on 22nd May 2017, he had arranged that his period on call would end at 06:00 rather 08:00 on 23rd May 2017 because of this booking. As a result of his holiday, Neil Barnes asked Derek Cartwright if he could be relieved as NWAS Strategic Commander so he could catch his flight later that day. At 04:08 on 23rd May 2017, a replacement Strategic Commander arrived at GMP HQ. Neil Barnes briefed his replacement for a period of six to eight minutes and left GMP HQ.

Role of Strategic Commander on 22nd May 2017

14.629 Neil Barnes agreed, during his evidence, that prior to 00:30 he “provided no leadership” and
“made no decision during that period that made any difference to the response on the ground”\textsuperscript{828}

14.630 The Ambulance Service Experts summarised their opinion of Neil Barnes’ contribution as follows:

“A number of strategic obligations set out in the NWAS plan and the Strategic Commander Action Card were not satisfactorily completed by Mr Barnes.

His delay in obtaining information and responding was unacceptable.

He was in a unique position to take steps to confirm JESIP was being effectively applied and that there was an effective joint response. Had he taken such steps, he should have realised that JESIP was not being effectively applied at the Operational and Tactical level …

…

It is our opinion that there was a significant lack of decisive and effective leadership at the Strategic Command level.

From the evidence it appears that Mr Barnes … made no significant or meaningful
contribution [from the time he responded to the time he left].”

For the reasons I have given above, I agree with the opinion of the Ambulance Service Experts.

Casualty Clearing Station after midnight

At 00:00, the ambulance transporting John Atkinson to hospital left the Casualty Clearing Station. At the same time as that ambulance was leaving, Patrick Ennis radioed Daniel Smith from the City Room. Patrick Ennis said: “We’ve got one – eight, 18, confirmed dead. We have no … priority one, two or three patients here, all patients have been moved down to you or other locations.”

Daniel Smith replied to Patrick Ennis’s report from the City Room: “Just to confirm then, you’ll stay inside … and you will re-triage to see if there’s any more … can you just shout up on this channel once you are aware … that you are complete inside. Steve Hynes is here now as incident commander.”

At no stage have I lost sight of the fact that many people were badly affected by the Attack. However, the terms of reference require me to

829 INQ041856/19-20
830 INQ040615/5
831 INQ040615/6
focus upon those who died in the Attack. The 36 casualties who remained in the Casualty Clearing Station at the point of John Atkinson’s departure for hospital survived. In these circumstances, it is not for me to subject the period after midnight to the same level of scrutiny as the period before midnight.

Replacement Operational Commander

14.635 Stephen Hynes self-deployed to the scene. He arrived at 23:51. As set out at paragraph 14.268, he discussed taking over the role of Operational Commander with Daniel Smith. At 23:57, Stephen Hynes is captured on CCTV wearing the Operational Commander’s tabard. At the point he took over as Operational Commander, Stephen Hynes was not aware of GMP’s Operation Plato declaration.

14.636 From his handover with Daniel Smith, Stephen Hynes understood that Station Approach had been assessed as a Major Incident cold zone and the station concourse was a Major Incident warm zone. He assumed that the site of the explosion was a Major Incident hot zone.
14.637 At 00:10, Stephen Hynes telephoned Annemarie Rooney. The purpose of this call was to inform her that he had taken up the role of Operational Commander.836

14.638 At 00:12, Stephen Hynes received a telephone call from the GMFRS Chief Fire Officer Peter O’Reilly.837 I will deal with this call in detail when I consider GMFRS’s response to the Attack, in Part 15.

14.639 At 00:16, Stephen Hynes spoke to CI Dexter.838 Stephen Hynes asked: “[Is it safe at present?” CI Dexter replied: “I’d say warm … I’ll border on cold but I will stick with warm [inaudible].” A little later in the conversation, CI Dexter stated: “I would declare this cold now.”839 This was a reference to the area of the Casualty Clearing Station. The difficulty for Stephen Hynes was that he did not know about the declaration of Operation Plato at this time. Consequently, he did not appreciate that CI Dexter was talking about Operation Plato zones as opposed to Major Incident zones.840

14.640 This miscommunication was not Stephen Hynes’ or CI Dexter’s fault. It was the result of the use of

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836 113/110/13-111/1
837 113/112/5-113/11
838 INQ035612/436
839 INQ040657/33-34
840 113/130/20-136/12
the same terminology within NWAS for Major Incidents as was used for Operation Plato.

14.641 Following this conversation, Stephen Hynes spoke to NWAS Control. NWAS Control then called NWFC and communicated the request for GMFRS officers at the scene.\textsuperscript{841} I shall return to this in the sections dealing with NWFC and GMFRS’s responses in Part 15.

14.642 At 00:36, the same issue in relation to terminology recurred. Zoning was discussed again by CI Dexter and Stephen Hynes. CI Dexter made clear that the “cold” zone was not the whole Victoria Exchange Complex, but only outside it.\textsuperscript{842}

14.643 At 00:39, GMFRS officer Station Manager Berry approached Stephen Hynes. Stephen Hynes informed Station Manager Berry that inside the station was a “warm zone”.\textsuperscript{843} By this, Stephen Hynes was intending to communicate that it was a Major Incident warm zone. Stephen Hynes was not intending to say anything about Operation Plato zoning as he did not know at this point that Operation Plato had been declared.\textsuperscript{844}

\textsuperscript{841} INQ001149
\textsuperscript{842} INQ040657/53
\textsuperscript{843} 113/148/4-149/18, 113/161/17-162/21
\textsuperscript{844} 113/130/20-136/12, 113/147/18-155/5
14.644 By contrast, Station Manager Berry now knew of the Operation Plato declaration. Consequently, he interpreted what Stephen Hynes was saying as meaning that inside the station was an Operation Plato warm zone. This was capable of having implications relating to which GMFRS personnel were able to operate in that area.845

14.645 In the course of this conversation, Stephen Hynes asked Station Manager Berry to arrange for blankets to be collected and for firefighters to help P3 casualties who had been directed to the area across the road from the War Memorial entrance on Station Approach.846

14.646 At some point shortly after 00:50, Stephen Hynes spoke to Annemarie Rooney. In the course of that call, Annemarie Rooney informed Stephen Hynes that GMP had declared Operation Plato. By this point, Stephen Hynes had been on scene for approximately one hour. It was the first time he was made aware of the Operation Plato declaration.847

14.647 At 00:54, the first tri-service discussion took place at the scene.848 This took place immediately after Stephen Hynes had spoken to Annemarie

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845 113/147/18-155/5
846 120/82/9-83/17
847 113/153/9-25
848 INQ035612/522
Rooney. The participants were Stephen Hynes for NWAS, CI Dexter for GMP and Station Manager Berry for GMFRS. Chief Fire Officer O’Reilly participated in part of the conversation via telephone. The content of some of that discussion was captured on CI Dexter’s Dictaphone. I set out, in detail, what was said in the section relating to GMFRS’s response to the Attack in Part 15.

In terms of the chronology of Stephen Hynes’ involvement, it is not necessary for me to go beyond 01:00. He continued in his role as Operational Commander until after the last casualty was removed from the Casualty Clearing Station and all the ambulances had left. While I have identified areas in which he should have done better than he did, overall it is important I acknowledge that Stephen Hynes did address a number of the JESIP failings that had occurred during the first hour and a half of NWAS’s response.

**Resources allocated**

By midnight, 41 ambulances had been allocated to the response. Within the following 30 minutes, another seven ambulances were allocated by

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849 113/155/6-9
850 INQ035612/522
851 INQ040657/67-70
852 113/157/14-16
NWAS Control. Nine more were allocated in the period between 00:30 and 00:50, although two of those were stood down.853

14.650 As at 01:00 on 23rd May 2017, 55 ambulances had been allocated to respond to the Attack.854

Resources at scene

14.651 By midnight, a number of ambulances allocated to respond were being held at Manchester Central Fire Station. This meant they were available to be called forward if and when required.855

14.652 After the departure of the ambulance transporting John Atkinson to Manchester Royal Infirmary, there were 20 ambulances remaining on Hunts Bank. This number fluctuated over the following hour as ambulances departed to transport casualties to hospital and other ambulances arrived.856

14.653 At 01:00 on 23rd May 2017, there were 23 ambulances at the scene and 26 patients in the Casualty Clearing Station.857

853 INQ040368/1-17
854 INQ040368/1-17
856 INQ041992/1
857 INQ041992/1, INQ041266
14.654 The high point in terms of number of ambulances at the scene came at 01:30 on 23rd May 2017, when there were 32 ambulances in attendance. \(^{858}\)

14.655 When the final casualty left the Casualty Clearing Station in an ambulance, there were 16 ambulances at the scene. \(^{859}\)

**Contribution of GMFRS**

14.656 At 00:37, GMFRS personnel arrived on Station Approach. \(^{860}\) I shall deal with the circumstances in which this occurred when I address GMFRS’s response to the Attack in Part 15.

14.657 At 00:43, a firefighter was captured on CCTV carrying an oxygen bottle into the Victoria Exchange Complex. \(^{861}\) Having spoken to Patrick Ennis on Station Approach, at 00:44 firefighters began to move trolleys and other equipment from ambulances into the Victoria Exchange Complex. \(^{862}\)

14.658 Even at that relatively late stage, GMFRS was able to provide meaningful support to the NWAS response. This evidence only serves to highlight the importance of GMFRS’s arriving two hours earlier.

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858 INQ041992/1
859 INQ041992/1
860 INQ035612/470
861 INQ035612/495
862 INQ035612/499, INQ035612/504, INQ035612/507
Transportation of P1 and P2 casualties to hospital

14.659 Table 4 shows how many casualties remained in the Casualty Clearing Station during the period after midnight.

<table>
<thead>
<tr>
<th>Time (by)</th>
<th>Total casualties transported from Casualty Clearing Station</th>
<th>Total casualties remaining in Casualty Clearing Station</th>
<th>P1s remaining in Casualty Clearing Station</th>
<th>P2s remaining in Casualty Clearing Station</th>
</tr>
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<tr>
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<td>2</td>
<td>36</td>
<td>18</td>
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</tr>
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</tr>
</tbody>
</table>

Table 4: Casualty Clearing Station after 00:00 on 23rd May 2017

14.660 During the period from 00:01 to 01:01 on 23rd May 2017, 12 of the remaining 36 casualties in the Casualty Clearing Station were taken by ambulance to hospital. They were all P1 casualties.

14.661 During the period from 01:01 to 02:01 on 23rd May 2017, 10 of the remaining 24 casualties
in the Casualty Clearing Station were taken by ambulance to hospital.  

By 02:01, there was one P1 casualty remaining in the Casualty Clearing Station.

14.662 During the period from 02:01 to 02:51 on 23rd May 2017, the remaining 14 casualties in the Casualty Clearing Station were taken by ambulance to hospital.

14.663 The fact that only P1 casualties were transported during the period up to 01:01 indicates that the triage system had become more effective in terms of the identification of priority.

14.664 I do not have sufficient evidence to determine whether, within the P1 category of casualties, there were any of greater need who were delayed. I accept as a general proposition the evidence of the Casualty Clearing Officer, James Birchenough, that a patient would need to be stabilised sufficiently to be able to travel safely to hospital.

Conclusions on triage, treatment and transfer of P1 and P2 casualties

14.665 It was beyond the Inquiry’s terms of reference for me to carry out a detailed examination of the circumstances of each of those who survived.

865 INQ041266/1
866 114/84/11-85/18
As such, I reach no conclusions in relation to the adequacy of care of any individual who survived the Attack.

14.666 As part of my assessment of the overall adequacy of the response, the evidence I heard enables me to reach some overarching conclusions about the running of the Casualty Clearing Station.

14.667 The Ambulance Service Experts’ opinion on triage was:

“Triage was accurate, followed NaSMED [sic: National Ambulance Service Medical Directors] requirements and patient distribution was excellent. Proper consideration was given to the allocation of patients to ambulances with appropriately qualified staff, destination, facilities, capabilities and capacity at hospitals and the elimination, as far as possible, of secondary transfers between hospitals.”

14.668 The evidence bears this opinion out: speaking generally, P1 casualties were prioritised for transport to hospital from the Casualty Clearing Station. However, I do not have sufficient evidence to comment on any particular case.

867 INQ041856/17
14.669 The Ambulance Service Experts’ opinion on treatment and management of casualties was:

“The approach to care outside the City Room was generally in keeping with expectations. There was a good mix of highly skilled paramedical and medical staff present. Paramedics were on scene in numbers from around 23:08 …

However there were areas that could have been improved.

…

Organisation (logistics / non-clinical management) of patients within the CCS [Casualty Clearing Station]

…

Comfort of patients within the CCS (on floor).”

14.670 It was accepted on NWAS’s behalf “that some patients were not always given information as to the process”.

14.671 The evidence I received from survivors about their experience in the Casualty Clearing Station supports a conclusion that some were not adequately informed about the way it was
intended that they would be managed and when they would be transported to hospital.\textsuperscript{870}

14.672 In relation to the treatment and management in the Casualty Clearing Station of those who survived, I do not have sufficient evidence to justify criticism beyond the Ambulance Service Experts' opinion. In saying that, I should not be understood to be commenting one way or the other on any other aspect of the adequacy of the care of those patients. If there was any inadequacy, it does not appear to me to have been as a result of a lack of suitably qualified people in the Casualty Clearing Station or their desire to help.

14.673 The Ambulance Service Experts’ opinion in relation to transfer to hospital was:

“\textit{Given proximity to designated hospitals, patient distribution although effective could have been faster in some cases …}

\textit{The dispatch of casualties from the CCS [Casualty Clearing Station] to hospital was effective and followed the patient dispersal plan.}

…”

\textsuperscript{870} 89/40/20-47/25, 138/16/5-19/8, INQ041856/17
The CCS and dispatch process appears to have been well organised.

In terms of timings, we are of the opinion that it may have been possible to put the transfer and dispatch arrangements in place quicker but this appears to us to be marginal and is unlikely to have made any significant difference to clinical outcomes.”

14.674 In its closing statement, NWAS accepted this evidence.

14.675 At 02:00, there were 28 ambulances at the scene. There were 13 P2 and one P1 casualties left to transport to hospital. It took a further 50 minutes for the final casualty to depart the Casualty Clearing Station for hospital.

In the cases of P2 casualties, their categorisation as P2 reveals that the need to stabilise them was less than in the case of casualties categorised as P1. There was no shortage of means to transport those patients.

14.676 On the face of it, there may have been undue delay by NWAS. However, I am not in a position to make a finding to this effect. I reach no conclusion about the clinical treatment or
outcomes in the case of any of those who survived the Attack. I do not have a complete evidential picture about how they were managed or the transportation phase. However, I have sufficient concern that I invite NWAS to take a careful, objective look at whether things could have been done better. There was concern among a number of those treated in the Casualty Clearing Station that there was undue delay. As part of any review, I encourage NWAS to reflect carefully on the experiences of those people. In any event, in my view, steps should be taken by NWAS to try to bring such timings down in readiness for any future mass casualty situation that may occur.

Management of P3 casualties

14.677 Casualties categorised as P3 have less-immediate clinical needs during a mass casualty situation than those in the P1 or P2 categories. Nevertheless, those in the P3 category can be in significant pain. P3 casualties require treatment. This may need to be in hospital. Even if correctly triaged as P3 initially, they may deteriorate, justifying re-triage into a more seriously injured category.

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875 89/40/20-47/25, 138/16/5-19/8, INQ041856/17
876 110/38/22-39/15
877 114/64/13-65/19
14.678 P3 casualties were directed to the area across Station Approach from the War Memorial. As their numbers grew, the space occupied by the P3 casualties spread towards Hunts Bank.  

14.679 The Casualty Clearing Officer, James Birchenough, stated in evidence that he thought concerns that P3 casualties were not treated as well as they should have been were justified.  

14.680 In its closing statement, NWAS agreed: “It is … accepted that those falling into the P3 category of patients and other ‘walking wounded’ could have been managed more effectively as part of the joint-agency response.”  

14.681 The Ambulance Service Experts identified that treatment of P3 casualties could have been improved. In evidence, they suggested that “perhaps it would have been preferable for the operational commander to assign that [the P3 casualties] as a sector commander role, somebody that is purely responsible for that”. In my view, that was a sensible suggestion and is one way in which improvement might have been made.
14.682 James Birchenough stated that the management of P3 casualties fell under the Operational Commander’s remit.\(^{883}\) In my view that is correct.

14.683 At 23:41, Annemarie Rooney asked Daniel Smith over the radio: “Do you want P3 numbers … ?” Daniel Smith replied: “[N]egative for now, we won’t be moving them for a while.”\(^{884}\) I have considered whether any deficiency in the way the P3 casualties were managed was Daniel Smith’s responsibility. I have concluded that it was not. He was Operational Commander until 23:57.\(^{885}\) Up to the point at which he was relieved, his focus was rightly on those requiring more immediate attention than casualties in the P3 category. He had a significant number of such patients to manage. By 23:57, only one P1 and no P2 casualties had left the Casualty Clearing Station for hospital.\(^{886}\) Daniel Smith had imposed structure on the scene: by directing where the P3 casualties should go. Student paramedics had been asked to go to that area.\(^{887}\) In my view, that was probably sufficient at that stage, in the circumstances, although in an ideal world more would have been done.

\(^{883}\) 114/63/19-64/1
\(^{884}\) INQ034333/2
\(^{885}\) 110/182/6-184/3
\(^{886}\) INQ040366
\(^{887}\) 114/194/4-195/2
14.684 In my view, Stephen Hynes, as Operational Commander from 23:57, and NWAS, as an organisation, bear responsibility for the shortcomings in the way the P3 casualties were managed. 888

Conclusion

14.685 NWAS personnel made an important and positive contribution to the emergency response. However, there were very substantial problems with the NWAS response to the Attack from a command perspective. There is one that bears repetition as, had it not occurred, the NWAS response is likely to have been much better than it was. That is, the fundamental failure to apply the JESIP five principles of joint working to command at the scene.

14.686 Daniel Smith failed to communicate and/or co-locate with the GMP Operational/Bronze Commander, Inspector Michael Smith. As a result, there was no sharing of situational awareness between them and no joint assessment of risk by them. In turn, this meant that they did not co-ordinate the responses of their agencies in the way they should have.

14.687 Had this failure not occurred, it is likely that more paramedics would have been deployed to the
City Room. It is also likely that the evacuation plan from the City Room would have been substantially improved.

14.688 Although I have been highly critical of a number of decisions made by Daniel Smith, it is right that I acknowledge he did not receive the support he should have received from the Tactical Commander, Annemarie Rooney. In turn, she did not receive the support that she was entitled to from Neil Barnes, the Strategic Commander.
Manchester Arena Inquiry
Volume 2: Emergency Response

Volume 2-Ic
Report of the Public Inquiry into the Attack on Manchester Arena
on 22nd May 2017

Chairman: The Hon Sir John Saunders
November 2022

HC 757-I
Part 15
Fire and rescue service response to the Attack

15.1 In Part 12, I set out the relationship between North West Fire Control (NWFC) and Greater Manchester Fire and Rescue Service (GMFRS). In this Part, I will consider the response of these two organisations to the Attack. I will address the role played by each of them in turn, starting with NWFC.

15.2 There is considerable overlap between the two sections, given that I am often dealing with different sides of the same conversation. This is inevitable. For this reason, each section should be read in conjunction with the other.
North West Fire Control response

Key findings

• The decision to contact the Greater Manchester Fire and Rescue Service (GMFRS) National Interagency Liaison Officer (NILO) before mobilisation was reasonable.

• There were repeated failures to pass on relevant information by North West Fire Control (NWFC) staff. Responsibility for this lies with NWFC. This failure contributed to GMFRS’s failure to arrive at the scene before 00:36 on 23rd May 2017.

• The NWFC Team Leaders should have acted when they realised the divergence in approach between GMFRS and other emergency services, by drawing it to the attention of GMFRS senior officers.

Introduction

15.3 In Part 12, I addressed how NWFC prepared itself for an event such as the one that occurred on 22nd May 2017. In this section, I consider the key points of NWFC’s involvement in the response to the Attack. I do not provide an exhaustive rehearsal of all of NWFC’s actions. I have focused on the events that determined the
direction of the involvement of GMFRS in the response.

15.4 I have adopted as chronological an approach as possible to NWFC’s response to the Attack. However, where appropriate I have grouped calls together where they are related to each other. I have used the start time of the calls when arranging this section. I have borne in mind that relevant information was not always passed on at the start of the call. Where appropriate, I have drawn attention to the stage of the call at which the key moments occurred.

**NWFC staff on the night of the Attack**

15.5 On the night of the Attack, the duty Team Leader was Michelle Gregson. Lisa Owen was in the role of administrative Team Leader. There were a number of Control Room Operators who took important calls. They were: David Ellis, Joanne Haslam, Dean Casey and Rochelle Fallon.

15.6 Also involved in important calls was Vanessa Ennis, a trainee. As at the night of the Attack, Vanessa Ennis had not been signed off as competent to act independently as a Control Room Operator. Rochelle Fallon was acting as Vanessa Ennis’s mentor. For this reason, for the purpose of the NWFC staff rota, Vanessa Ennis
was not counted as one of the Control Room Operators.\(^1\)

15.7 When NWFC was first notified of the Attack at 22:34, Vanessa Ennis, her mentor Rochelle Fallon, and Michelle Gregson were having a meeting which may have resulted in Vanessa Ennis being signed off as able to act independently.\(^2\)

15.8 Rochelle Fallon stated that she believed Vanessa Ennis was competent to act unsupervised.\(^3\) Michelle Gregson, the Team Leader, disagreed.\(^4\) In a meeting at which Rochelle Fallon was not present, three days before the Attack, Michelle Gregson had expressed concerns about putting the control room in a vulnerable situation by including Vanessa Ennis as an independent Control Room Operator, due to the lack of opportunity to assess her.\(^5\)

15.9 Managers were also called out during the response. They travelled to NWFC from home. First to be notified was Operations Manager, Janine Carden. Janine Carden contacted Senior Operations Manager, Tessa Tracey.

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1 [136/14/12-20](#)
2 [136/14/12-14](#)
3 [136/16/21-23](#)
4 [124/34/6-16, 124/91/14-18](#)
5 [INQ100073/1, 136/15/4-16/12](#)
Tessa Tracey alerted Sarah-Jane Wilson, the Head of NWFC.

Initial notifications

Call from GMP Control (22:34)

15.10 At 22:31, David Ellis was in the course of a telephone call with GMP Control about an unrelated incident. At 22:34, GMP Control asked him if he had been told about “an explosion in the city centre”. Over the course of the next six minutes, GMP Control provided David Ellis with more information about the Attack.

15.11 He was told it was in the “foyer area of the Manchester Arena”. He was told that “a bomb has exploded” and that there were reports of 30 to 40 casualties. At 22:38, he was informed of the “RVP [Rendezvous Point] car park area outside the Cathedral”. At 22:39, David Ellis stated: “Just bear with me a second while I see if we need to get anyone on the wire, we just need to mobilise our officers.” He was provided with the BTP and NWAS log numbers.
15.12 As David Ellis was receiving this information, he was entering it into the NWFC system.\textsuperscript{14} To do so, he had to create an entry for the incident (the Arena log).\textsuperscript{15} He started typing “explosion”. He then selected the “Explosion” incident type, which was prompted by the system. This has an “Explosion” action plan associated with it. He did this because he understood this was the appropriate incident type for an exploded bomb.\textsuperscript{16}

15.13 In order to mobilise the pre-determined resources under the “Explosion” action plan, David Ellis needed to take two further steps. First, he needed to select the “proposed resource” button. This would inform him of what resources were to be sent. The “Explosion” action plan required resources to be sent directly to the scene. The system would also send a pre-alert automatically to the nearest fire station.\textsuperscript{17} The nearest fire station to the Arena was Manchester Central, which was less than a mile away. Second, he needed to initiate the mobilisation of the proposed resources.
15.14 David Ellis took the first step, but he did not take the second.\textsuperscript{18} David Ellis did not initiate the mobilisation of the proposed resources to the scene, in accordance with the “Explosion” action plan, because he was told not to by Lisa Owen.

15.15 In the early stages of the call with GMP Control, David Ellis had realised he was dealing with a very significant event. In accordance with his training, he raised his hand to attract the attention of the Team Leaders. There were two Team Leaders on duty that evening. One, Michelle Gregson, was in a meeting when the GMP call came in. The other, Lisa Owen, was sitting at the Team Leader position. For an understanding of the layout of the control room, see Figure 33 in Part 12. Lisa Owen approached David Ellis and reviewed his screen. At this point, David Ellis was advised not to mobilise resources until the on-call NILO had been spoken to.\textsuperscript{19} This was at approximately 22:39.\textsuperscript{20}

15.16 Given the nature of the information that NWFC had received at this point, the decision not to mobilise immediately and first to call the NILO was reasonable.\textsuperscript{21} Although it did not occur to David Ellis to do this, for the reasons I gave in

\begin{itemize}
\item \textsuperscript{18} 122/185/20-186/8
\item \textsuperscript{19} 122/185/3-186/2
\item \textsuperscript{20} INQ001231/5
\item \textsuperscript{21} 129/168/4-15
\end{itemize}
Part 12, it would have been reasonable for him to select the “Operation Plato Standby phase” incident type.\textsuperscript{22} If he had selected that incident type, the first prompt would have been to telephone the NILO before mobilising any resources.

15.17 The consequence of the decision not to mobilise to the scene immediately was a delay to the arrival of GMFRS at the scene. If mobilisation to the scene had been justified, NWFC was entitled to rely on the duty NILO to point this out immediately. The delay need not have been a long one provided there was rapid communication with the duty NILO and a quick decision from him.

15.18 David Ellis continued his call with GMP Control.\textsuperscript{23} At 22:40, David Ellis was told: “\textit{We have an absolute load of officers going down.}”\textsuperscript{24} A minute later, he was told: “\textit{We’ve got an off duty PCSO [Police Community Support Officer] who is on scene.}”\textsuperscript{25} At 22:43, he was informed that “\textit{ambulance state they have [up] to 5 vehicle on route as well}” and “\textit{officers are now landing on scene}”.\textsuperscript{26}
15.19 At 22:44, David Ellis raised the fact that NWFC had received reports of a “possible shooting”.\textsuperscript{27} This information came from NWAS Control in a call that I will deal with in paragraphs 15.32 to 15.39. In reply, GMP Control told David Ellis that the police were “getting reports of a shooting”.\textsuperscript{28} David Ellis said “so police, are you confirming this”.\textsuperscript{29} The response from GMP Control was, “Yeah police officer has just said injured party with gunshot wound to the leg.”\textsuperscript{30} David Ellis made an entry in the Arena log at 22:45: “**** POL HAVE CONFIRMED A GUNSHOT TO LEG OUTSIDE ENTRANCE TO VICTORIA STATION ****”\textsuperscript{31}

15.20 In an update three minutes later, GMP Control stated, “[T]hese are not gunshot … not gunshot wounds … look like shrapnel wounds.”\textsuperscript{32} David Ellis made the following corresponding entry in the log at 22:48: “*** FROM POLICE – NOT GUNSHOT WOUNDS LOOK LIKS [sic] SHRAPNEL WOUNDS ***”.\textsuperscript{33}

15.21 At 22:49, GMP Control stated: “[W]e are in the booking office over the main bridge to the main
entrance, looks like a bomb has gone off 30 casualties every available ambulance to here.”

Having repeated this back to GMP Control, David Ellis said: “[W]e’ve got a muster point of Philips Park … we’ve got 4 pumps mustering there … we are going to use that as our holding point for now.”

15.22 Five minutes later, at 22:54, GMP Control informed David Ellis: “The paramedic bronze has just arrived on scene as well.” This was a reference to Patrick Ennis, an NWAS Advanced Paramedic whom Inspector Michael Smith, the GMP Operational/Bronze Commander, had mistakenly thought was the NWAS Operational Commander. When David Ellis asked whether this meant the “paramedic bronze” was at the Rendezvous Point (RVP), he was told: “No, I think he is actually at the scene.”

GMP Control followed this up with: “He’s here now all NWAS to attend booking office asap.” GMP Control confirmed that NWAS was asking everyone to go to the booking office. This was repeated at 22:56, when GMP Control said, “all
the ambulance crew have being [sic] sent to the booking office”.

15.23 At 22:57, David Ellis had an exchange with GMP Control during which David Ellis stated: “[E]verything we’re doing is going round Philips Park fire station.” He went on to say that NWFC would be contacting its senior officers and “we will be RVP and contacting your guys”. GMP Control replied: “Ok that’s not a problem.”

15.24 A couple of minutes later, the telephone call ended. Before it did, David Ellis asked, “are you ok to stay on the line? I’ve asked my team leader if I’m ok to stay, to keep a line open. Are you ok to do the same thing?” This was a sensible suggestion from David Ellis, even though it was not as efficient as using a multi-agency control room talk group. That would have allowed all three control rooms to speak together, without occupying a telephone line. This was not an option open to NWFC. This was for two reasons. First, there was the failure by GMP, NWAS and GMFRS to make operational the proposed multi-agency control room talk group. Second,
there was the Force Duty Officer’s (FDO) failure, after he was informed of the Attack, to nominate a talk group for use by control rooms and notify them to dial into it.

15.25 The response to David Ellis by GMP Control was: “I’m going to have to clear the line because they said my silver controllers will be getting back in contact with you.” The phrase “silver controllers” was a reference to contact from the Silver Control Room at GMP Headquarters (GMP HQ). At this time, Ian Randall, the GMP Force Duty Supervisor, was getting ready to leave GMP Control to set up the GMP Silver Control Room.

15.26 The call was ended. From about 23:40, the Silver Control Room began to be operational. NWFC did not receive a call of any substance from the GMP Silver Control Room prior to GMFRS’s arrival at the Victoria Exchange Complex at 00:36 on 23rd May 2017. Shortly before 00:00, a radio operator in the GMP Silver Control Room performed a check to see if NWFC and NWAS were monitoring the proposed multi-agency control room channel. This was the extent of

45 INQ001231/17
46 99/198/16-203/5
47 99/203/9-23
48 125/39/16-41/2
the contact before 00:36 from the Silver Control Room.

15.27 The circumstances in which this telephone call between GMP Control and NWFC ended, and the subsequent lack of contact, was a failure on the part of GMP. It was inevitable that it would take a substantial amount of time to establish the GMP Silver Control Room. It would have been better if GMP Control had stayed on the line with David Ellis in order to continue the sharing of situational awareness.

15.28 David Ellis’s user handle on the NWFC system was 50061. As information was given to him, David Ellis added to the NWFC log under that user handle. He captured the substance of all the matters I have set out above.

15.29 By 23:00, David Ellis’s entries in the Arena log made clear that police officers and NWAS staff were being directed to, and had arrived at, the Victoria Exchange Complex. At 22:43, he entered into the log: “SEVERAL OFFICERS ALLOCATED AND MAKING WAY”. One minute later, he added: “AMB HAVE 5 VEHICLES ON ROUTE – POL HAVE ADVISED OFFICER LANDING ON SCENE”. At 22:46, he wrote: “POL ADVISED
**MORE OFFICERS ARRIVING ON SCENE**”.\(^{52}\)

At 22:55, he recorded: “**PARAMEDIC BRONZE COMMANDER IS AT SCENE **”.\(^{53}\) At 22:58, he input: “**ALL THE AMB HAVE BEEN DIRECTED TO THE BOOKING OFFICE**”.\(^{54}\)

15.30 So far, communication was working in accordance with the expectations of the Joint Emergency Services Interoperability Principles (JESIP). GMP Control had received reports from the scene. GMP Control had conveyed these reports to NWFC. NWFC had recorded the reports on its incident log.

15.31 The exception to this is that David Ellis did not ask GMP whether it had received a METHANE message. If he had, it is possible it would have prompted GMP to seek one. I am not critical of David Ellis for this. It was not an embedded part of NWFC operation at the time, in circumstances such as these, to ask for one.\(^{55}\) It should have been.

**Call from NWAS Control (22:37)**

15.32 While David Ellis was on the telephone to GMP Control, at 22:37, NWFC Control Room Operator Joanne Haslam received a call from NWAS

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\(^{52}\) INQ008376/5

\(^{53}\) INQ008376/8

\(^{54}\) INQ008376/9

\(^{55}\) 123/61/25-62/6, 123/62/23-63/10
Control. Joanne Haslam was informed by NWAS Control that a “bomb had gone off” at the “MEN Arena”.\textsuperscript{56} In the course of the call, Joanne Haslam made entries on the Arena log.\textsuperscript{57} Joanne Haslam’s user handle was 50032.\textsuperscript{58}

15.33 Joanne Haslam also relayed to NWAS Control the information that GMP Control had given to David Ellis. This included telling NWAS that GMP had declared an RVP.\textsuperscript{59} In doing this, Joanne Haslam was doing what was expected of her by JESIP.

15.34 At one point in the call, NWAS Control suggested that there might have been an “active shooter”.\textsuperscript{60} Joanne Haslam carefully and calmly explored this information with NWAS Control, establishing that this had not been confirmed by the police. Joanne Haslam also relayed to NWAS Control the information from GMP Control that the previously reported gunshot wounds were shrapnel injuries.\textsuperscript{61}

15.35 At 22:49, Joanne Haslam concluded the call. While that call was taking place, NWAS declared

\begin{footnotes}
\item[56] INQ001218/1
\item[57] INQ008376/5-6
\item[58] 123/55/21-56/1
\item[59] INQ001218/6-7
\item[60] INQ001218/5
\item[61] INQ001218/5-7
\end{footnotes}
a Major Incident, Patrick Ennis reported to NWAS Control that the best access was Hunts Bank, and NWAS Control was in the process of mobilising ambulance personnel to Manchester Central Fire Station and the scene. This information was not passed to NWFC by NWAS Control. It should have been.

15.36 Joanne Haslam did not ask whether NWAS had received a METHANE message. Patrick Ennis provided a METHANE message five minutes after this call ended, so there was not yet one for NWAS to share. Nevertheless, asking for a METHANE message should have formed an automatic part of Joanne Haslam’s approach, particularly as the Arena log marked that ambulances were going to the scene. As I explained in paragraph 15.31, responsibility for this omission lies with NWFC.

15.37 Joanne Haslam could have asked whether NWAS had declared a Major Incident. She explained to me, when asked about METHANE messages, that she “felt like the operator I was speaking to was panicky and I felt like the questions I was asking, I wasn’t getting clear answers back”. Having listened to the call,
I accept Joanne Haslam’s evidence. It was a difficult call which she managed well in the circumstances. While it would have been better if Joanne Haslam had asked NWAS Control whether NWAS had declared a Major Incident, I am not critical of her for not doing so.

15.38 Joanne Haslam did not inform NWAS Control that fire appliances were being mobilised to Philips Park Fire Station. At 22:40, Joanne Haslam can be heard saying to NWFC colleagues, “I’m still on hold at the moment to the ambulance just finding out further information. I know David is turning out on it.”

Less than two minutes after this, the GMFRS duty NILO had issued the instruction to mobilise fire appliances to Philips Park Fire Station.

15.39 At 22:48, approximately one minute before Joanne Haslam ended the call, Michelle Gregson created a new log for the Philips Park mobilisation (the Philips Park log).

**Call from GMP Control (22:40)**

15.40 At 22:40, NWFC received a second call from GMP Control. This call was answered by the Control Room Operator Rochelle Fallon. The call was just over two minutes long. There was an exchange of incident log numbers. At 22:40:43,
the GMP incident log number was entered on the Arena log.\textsuperscript{68} At 22:40:48, the NWFC incident log number was entered into the GMP incident log.\textsuperscript{69} Following this, Rochelle Fallon asked: “Do you have any additional information on it [the incident]?”\textsuperscript{70} She was told 30 to 40 people had been injured following an explosion at the Arena. This information had been given to GMP by Paul Johnson, the SMG Fire Safety Officer, who had called GMP immediately after the explosion.

15.41 While the call between GMP Control and NWFC was going on, Inspector Smith contacted GMP Control and said, “rather than the RV point, can you ask officers to make it to the scene directly”.\textsuperscript{71}

15.42 GMP Control informed Rochelle Fallon that the RVP “is car park area outside cathedral”.\textsuperscript{72} Rochelle Fallon confirmed that NWFC already had that fact recorded.\textsuperscript{73}

15.43 In fact, as I set out in Part 13, Inspector Smith had passed a message to GMP Control at 22:40:45, by which he intended to change the RVP to Manchester Victoria Railway Station.
Inspector Smith’s message at 22:40 to GMP Control was not relayed to NWFC at any point.

15.44 It is possible that if NWFC had been provided with the updated RVP this would have improved GMFRS’s response. The effect of the change in RVP was to move the location for where the emergency services should have come together from a place several hundred metres away from the Victoria Exchange Complex to the scene itself. From this, it could have been inferred that, following initial caution, the scene had now been determined to be an appropriate and sufficiently safe area for the non-specialist emergency services personnel to co-locate. That interpretation of the change in RVP was capable of informing the duty NILO’s decision-making in the course of the calls he had with NWFC prior to 23:00.

15.45 Towards the end of the call, GMP Control informed Rochelle Fallon: “We’ve got the RVP. We’ve got all our supervision there and all the … all our officers going as well.” This information was consistent with what David Ellis was simultaneously being told during his ongoing call with GMP Control. By the time this information was provided to NWFC, GMP officers were
responding to Inspector Smith’s message at 22:40 that they should attend the scene.\textsuperscript{75}

**Call from member of the public (22:41)**

15.46 During Rochelle Fallon’s call with GMP Control, a member of the public who had called 999 was connected to NWFC. The call was answered by the Control Room Operator Dean Casey. The connection to NWFC appears to have been a mistake by the person triaging the 999 call. The member of the public stated, to Dean Casey, that he had asked for the ambulance service.\textsuperscript{76}

15.47 The member of the public informed Dean Casey of injured people in the area of the NCP car park within the Victoria Exchange Complex. Dean Casey was informed, “\emph{It sounded like a big blast and looking at the people, I would suggest it’s a dirty bomb of some description.}”\textsuperscript{77}

**Call from BTP Control (22:44)**

15.48 At 22:44, Vanessa Ennis answered a call from BTP Control.\textsuperscript{78} Because Rochelle Fallon was on another call at the time, she was not supervising Vanessa Ennis during the call with BTP.\textsuperscript{79}
15.49 Michelle Gregson stated in evidence that on the night of the Attack, because Vanessa Ennis had not been signed off as competent to act independently as a Control Room Operator, she informed Vanessa Ennis to “step back”. Rochelle Fallon stated that she was unaware of that instruction being given at the time. Rochelle Fallon stated in evidence that she had told Vanessa Ennis, “I’m not going to be able to listen to your calls, I’m going to have to take calls myself … If anybody tells you anything, just tell everybody.”

15.50 The fact that Rochelle Fallon did not register a clear instruction from Michelle Gregson is significant. Further, it is unlikely that anyone in such a position would act as Vanessa Ennis did, by answering and making calls, if they understood that they had been firmly instructed by a Team Leader that they were forbidden from doing so.

15.51 I accept that Michelle Gregson gave some direction to Vanessa Ennis about not taking or making calls. However, I find that Michelle Gregson did not give a sufficiently clear instruction to Vanessa Ennis that she should not
have any further involvement in events on 22\textsuperscript{nd} May 2017.

15.52 Vanessa Ennis should not have been put in the position she was in. I accept that it was Rochelle Fallon’s view, given how close she was to the end of her training, that Vanessa Ennis was competent to handle calls.\textsuperscript{83} However, she had not been signed off as ready, she was not part of the NWFC roster for that night and NWFC was in the midst of managing an extremely complex and difficult situation. If Rochelle Fallon was too busy to provide supervision to Vanessa Ennis, which was a reasonable view for Rochelle Fallon to take, Vanessa Ennis should have been told to step away from the telephones and take further instructions from the Team Leaders.

15.53 In the call at 22:44, BTP Control asked Vanessa Ennis if NWFC was aware of the reports from the Arena. She confirmed that NWFC was. She asked BTP Control for the BTP incident log number. Vanessa Ennis then went on to say: “WOULD YOU LIKE ME TO CALL YOU BACK WHEN I HAVE GOT SOME MORE INFORMATION?”\textsuperscript{84} She and BTP Control agreed that she would.\textsuperscript{85}

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{83} 136/27/20-28/19
\item \textsuperscript{84} INQ001196/1
\item \textsuperscript{85} INQ001196/1
\end{enumerate}
\end{footnotesize}
15.54 At no stage in the call did Vanessa Ennis ask BTP Control what information BTP had on the incident. She should have done so. Given her inexpertise, it was not her fault that she did not. Responsibility for this lies with Michelle Gregson and Rochelle Fallon.

15.55 I am also critical of BTP Control for not offering the information it had. At 22:44, BTP was the only emergency service with personnel in the City Room. The BTP incident log, by this stage, recorded highly relevant information for GMFRS, including: BTP’s Major Incident declaration; that a METHANE message was being sought; that GMP had 15 units making their way to the scene; that GMP firearms officers were on the scene; and, before the call concluded, it also contained the fact that BTP had declared an RVP at Fishdock car park.

15.56 None of this information on the BTP incident log was provided to NWFC in this call. As a result, none of this information was available to be passed on to Station Manager Andrew Berry or any other GMFRS officer. Despite the shortcomings in NWFC’s training of its Control Room Operators, it is likely that, had a more experienced person than Vanessa Ennis
answered this call, this information would have been given to NWFC.

Call from Lancashire Fire and Rescue Service officer (22:55)

15.57 At 22:55, Rochelle Fallon received a call from a Lancashire Fire and Rescue Service (LFRS) officer. The caller informed Rochelle Fallon that he had received a call from relatives who were at the Arena. He said that one of his relatives was injured, and that there were other casualties and fatalities. He stated: “[T]hey need the paramedics there sharpish at the main entrance to the stairs.” Rochelle Fallon informed the LFRS officer that she would contact NWAS.

Calls from NWFC to other emergency services before 23:30

Call to NWAS Control (22:57)

15.58 As soon as the call with the LFRS officer ended, Rochelle Fallon telephoned NWAS Control. She passed on the information received in her previous call. Rochelle Fallon reported one of the entries in the Arena log: “ALL THE AMBULANCE HAVE BEEN DIRECTED TO THE BOOKING OFFICE.” In response, NWAS Control asked:
“ARE YOU GUYS ON SCENE?” Rochelle Fallon replied that GMFRS was not on the scene. She referred to the need for a specialist unit, possibly the terrorist unit. The call concluded with Rochelle Fallon providing NWAS Control with an update from GMP about certain injuries being shrapnel not gunshot wounds.

15.59 There were JESIP elements to this call from NWFC’s point of view. Rochelle Fallon passed on the information she had received from the LFRS officer. She also reviewed the Arena log and passed on significant information, such as the latest information on whether or not there was an active shooter. However, she did not pass on to NWAS any information about GMP deployments; she did not check that NWAS was aware of the RVP the police had declared; and, like Joanne Haslam, she did not inform NWAS that the fire appliances had been mobilised to Philips Park Fire Station. She received the first two pieces of information from GMP Control fewer than 20 minutes earlier. They were also recorded on the Arena log. Rochelle Fallon should have provided this information to NWAS Control. NWFC bears responsibility for these omissions due to the failure to embed the practicalities of JESIP in the responses of the Control Room Operators.
15.60 From the point of view of NWAS Control, there were also key pieces of JESIP information that were omitted. NWAS Control failed to inform Rochelle Fallon of either NWAS or BTP’s Major Incident declarations. NWAS Control did not inform Joanne Haslam of the content of Patrick Ennis’s 22:54 METHANE message. NWAS Control did not provide Rochelle Fallon with any information about its approach to RVPs.

15.61 Rochelle Fallon’s omissions were not capable of adversely affecting NWAS’s response. By 22:57, NWAS had already committed to an approach that would not have changed had Rochelle Fallon provided all the information she should have reported. By contrast, the information NWAS Control omitted was capable of influencing subsequent decisions by GMFRS, provided it was relayed on by NWFC. However, given that GMFRS did not act on the information it was provided with by NWFC, I consider that this missing information would have been unlikely to have made a difference.

**Call to GMP Control (23:02)**

15.62 Having relayed the information received from the LFRS officer to NWAS, Rochelle Fallon telephoned GMP Control. She provided GMP Control with the information from the LFRS officer. Rochelle Fallon stated, “I’ve let
ambulance know … but obviously just sharing all information."\(^{93}\)

15.63 Rochelle Fallon’s actions provide a good example of the need for a multi-agency talk group for control rooms. It was not efficient for Rochelle Fallon to have to contact NWAS Control and GMP Control in order to provide them both with the same information. This was not her fault.

15.64 Rochelle Fallon provided GMP Control with the information from NWAS about the number of casualties. GMP Control provided Joanne Haslam with GMP’s understanding of the casualties. They discussed the information each had in relation to the issue of an active shooter.\(^{94}\)

15.65 Rochelle Fallon did not provide GMP Control with any information about NWAS deployment or GMFRS deployment. GMP Control did not provide any information to Rochelle Fallon about GMP deployment or NWAS deployment. There was no discussion about METHANE, Major Incident declaration or RVPs. By this stage, over 30 minutes had passed since the Attack. The location of a Forward Command Post (FCP) should have been firmly in the minds of all inter-agency communication in relation to the

\(^{93}\) INQ001190
\(^{94}\) INQ001190/1-3
incident. All of these topics should have been covered, however briefly. I regard NWFC as being responsible for the fact that Rochelle Fallon did not discuss these things.

Call to BTP Control (23:17)

15.66 Vanessa Ennis’s call with BTP Control at 22:44 ended with her offering to call back with further information. At 23:17, she did so. She notified BTP Control that the RVP for GMFRS was Philips Park Fire Station. BTP Control responded by enquiring if anything further was required or if the call was just for their information. Vanessa Ennis stated that it was just for information purposes. 95

15.67 Neither BTP Control nor Vanessa Ennis sought to share any other information. This was an opportunity for them both to do so. Since the 22:44 call, the BTP incident log had been updated to include: “AMBO – WE HAVE BEEN ASKED TO RVP AT HUNTS BANK BY THE BOOKING OFFICE”, “ALL AVAILABLE PARAMEDICS ATTENDING”, “RVP – FISHDOCK CARPARK – GMP GOING TO SEARCH”, “AMBO COMMANDER ON SCENE” and “6/7 AMBO ON SCENE”. 96

15.68 Also recorded on the BTP log at 23:04 was BTP Sergeant David Cawley’s METHANE message.

95  INQ001159
96  INQ002000/34-48
This included a reference to a fire and rescue service, which BTP Inspector Benjamin Dawson, who made the entry, intended to indicate that the local fire and rescue service was required at the scene.\textsuperscript{97}

15.69 NWFC also had other information that could have been shared. By reason of having officers at the scene, BTP already knew what NWFC knew. However, that was not a reason for information not to be offered. Given her trainee status, it was not Vanessa Ennis’s fault that she did not seek to provide an update. Responsibility for that lies with NWFC.

15.70 BTP was also at fault for not seeking to provide important information to NWFC. While NWFC had already been told much of that information, it was still a significant failure by BTP not to provide it. In contrast to BTP, NWFC and GMFRS had no personnel at the scene. Consequently, NWFC and GMFRS were entirely dependent on others for situational awareness. Further information confirming what NWFC already knew was capable of giving GMFRS decision-makers greater confidence in their decision-making about deployment.

15.71 Many of these problems would have been avoided if there had been a multi-agency control
Contact with GMFRS duty NILO before 23:00

Call to Station Manager Berry (22:40)

The GMFRS duty NILO on the night of 22nd May 2017 was Station Manager Berry. At 22:40, he was telephoned by NWFC Team Leader Michelle Gregson. Lisa Owen had spoken to Michelle Gregson immediately after telling David Ellis not to mobilise. They agreed that calling the duty NILO was the appropriate next step. As I have said, I regard this as being a reasonable decision.

Before telephoning the duty NILO, Michelle Gregson made an announcement to the rest of the control room, “to remember any information they received in relation to the incident and were not sure if and who to share it with to refer to me or Lisa [Owen] and to remember our JESIP training and multi-agency working”. This was a sensible announcement for Michelle Gregson to make. However, the fact that this timely reminder was given makes the subsequent failures in communication all the more stark. Having made that announcement, Michelle Gregson telephoned Station Manager Berry.
15.74 The conversation began with Michelle Gregson informing Station Manager Berry of reports of an explosion. She told Station Manager Berry the police “are saying it is a bomb”. She said that the police had provided an RVP of “the car park area outside the cathedral”. Shortly afterwards, she said, “obviously we are not mobilising at the moment”. Michelle Gregson asked Station Manager Berry if he could speak to the police.

15.75 The use of the word “obviously” was unfortunate. It implied that the decision not to mobilise immediately to the GMP RVP was inevitable. It may have been so in Michelle Gregson’s mind, but it was not a decision that resulted from following any particular action plan. As the Fire and Rescue Expert put it, the decision not to mobilise “was presented [to Station Manager Berry] as a fait accompli”. It would have been better if Michelle Gregson had not used the word “obviously”. On the other hand, whether to mobilise was a decision for Station Manager Berry to make. He should not have been unduly
influenced by the use of the word “obviously” by Michelle Gregson.

15.76 Station Manager Berry asked about the RVP and then said, “but we would normally muster them [the fire appliances] at one of the stations wouldn’t we?”

105 He went on to comment that Manchester Central Fire Station was too close. Station Manager Berry settled upon telling Michelle Gregson that NWFC was to muster four fire appliances at Philips Park Fire Station “for now”.

106 He stated that he was going to speak to the FDO.

15.77 Michelle Gregson said that she was “thrown” by Station Manager Berry’s suggestion about what would normally occur as she was not aware that that was the procedure.

108 Her response was “Right, ok.”

109 She did not say that, so far as she was aware, what he was suggesting would not normally occur. It would have been better if she had. As Team Leader, Michelle Gregson was of sufficient seniority to be expected to speak up immediately if she believed that Station Manager Berry was not correctly expressing the expected procedure.
15.78 At the end of the call, Michelle Gregson did not anticipate that Station Manager Berry would have any difficulty contacting the FDO.\textsuperscript{111} GMP had known for a significant period of time that the FDO may become uncontactable in an event such as the Attack. Steps could and should have been taken to ensure that this single point of failure was avoided.

15.79 Shortly after the call with Station Manager Berry ended, Michelle Gregson contacted Philips Park Fire Station. She informed Watch Manager Neil Helmrich that Philips Park Fire Station had been made a muster point and “we are just onto the Force Duty Officer at the moment for the police, confirming further incident details”.\textsuperscript{112}

15.80 At 22:48, Michelle Gregson created the Philips Park log.\textsuperscript{113} Her explanation for creating a new incident log was because the incident log created by David Ellis was recorded against the Arena address and had an RVP of the car park area outside the Cathedral. She stated that mobilising resources against that incident log would result in them automatically being sent to one of those two locations.\textsuperscript{114}

\begin{itemize}
\item \textsuperscript{111} 124/22/18-21
\item \textsuperscript{112} 124/24/7-25, INQ001237
\item \textsuperscript{113} 124/21/15-22/10
\item \textsuperscript{114} 124/29/8-25
\end{itemize}
15.81 Michelle Gregson accepted, in evidence, that she could have amended the RVP to Philips Park Fire Station. This was not something that occurred to her at the time. I am not critical of Michelle Gregson for this. This situation had not been considered in any of her training.\textsuperscript{115} I am critical of NWFC for this situation. By the end of this incident, there were four incident logs. The creation of multiple incident logs for the same incident risked key information being overlooked by control room staff.\textsuperscript{116}

15.82 As a result of Michelle Gregson’s mobilising instruction, fire appliances from Manchester Central Fire Station, less than one mile from the Victoria Exchange Complex, began to drive in a direction away from the Arena. At 22:54, they arrived at Philips Park Fire Station.\textsuperscript{117}

Call to Station Manager Berry (22:44)

15.83 Rochelle Fallon called Station Manager Berry at 22:44. She did so because two minutes earlier she had received a call from a member of the Specialist Response Team.\textsuperscript{118} She tried to transfer that call to Station Manager Berry, but had been unsuccessful. As a result, Rochelle
Fallon telephoned Station Manager Berry to pass on the message.\footnote{119}

15.84 The call Rochelle Fallon made to Station Manager Berry at 22:44 connected to his answerphone. Rochelle Fallon left him a message. In that message, she informed Station Manager Berry of the call from the Specialist Response Team. Her message went on to say: \textit{“We’ve just literally had a call from ambulance now, stating that people are being shot.”}\footnote{120} This was a reference by Rochelle Fallon to the call Joanne Haslam took from NWAS at 22:38, which was ongoing as Rochelle Fallon was leaving her message for Station Manager Berry.\footnote{121} Rochelle Fallon had taken this information from the Arena log.\footnote{122}

15.85 Rochelle Fallon was correct to seek to provide Station Manager Berry with an update from the Arena log. She stated that she chose to pass on \textit{“what I’d seen and what information I thought was important”}.\footnote{123}
15.86 Station Manager Berry did not listen to this message until after all of the events of that night were over. 124

Call from Station Manager Berry (22:48)

15.87 At 22:48, as Michelle Gregson was creating a Philips Park log, Station Manager Berry telephoned NWFC. He spoke to Control Room Operator Dean Casey. Station Manager Berry began the call by saying, “I’ve been trying to get hold of the Force Duty Officer, but they’re not picking up for obvious reasons, they’re probably really busy.” 125 Station Manager Berry asked to be told “what other information we’ve got about this incident”. 126

15.88 Dean Casey told Station Manager Berry that there were “over 60 casualties” and “reports that there’s an active shooter”. 127 Seconds before Dean Casey provided this information, David Ellis had updated the Arena log to include “*** FROM POLICE – NOT GUNSHOT WOUNDS LOOK LIKS [sic] SHRAPNEL WOUNDS ****”. 128

15.89 Also included on the Arena log, before the call between Dean Casey and Station Manager Berry, was “AMB HAVE 5 VEHICLES ON ROUTE –
POL HAVE ADVISED OFFICER [sic] LANDING ON SCENE” and “POL ADVISED MORE OFFICER [sic] ARRIVING ON SCENE”. 129

15.90 Dean Casey failed to communicate the content of these three entries on the Arena log. They were highly relevant to the decisions that Station Manager Berry had to take. They went to the heart of whether or not it was safe to mobilise firefighters to the scene. If Dean Casey had told Station Manager Berry that the police and paramedics were travelling to the scene, it is possible that he would have reviewed his decision to mobilise firefighters to Philips Park Fire Station.

15.91 Dean Casey accepted, in evidence, that he should have shared this information with Station Manager Berry. He was not certain whether or not his screen had refreshed and the updated log was visible to him. 130 This may provide the explanation for Dean Casey not seeing the entry in relation to shrapnel, which was made during his conversation with Station Manager Berry. However, the information indicating that the police and paramedics were attending the scene was input prior to the entry that he read out to Station Manager Berry.

129 INQ008376/5
130 123/158/9-160/21
15.92 Information was constantly being entered into the Arena log. For an incident like the Attack this is to be expected. NWFC staff should have been trained to refresh their screens constantly, so that they could have the latest information. They should also have been better trained in reviewing the log in a careful and systematic way in order to pick up any earlier relevant information.

15.93 Dean Casey was not alone in failing to pass on important information. The number of occasions on which important information was not passed on reveals that NWFC training of its staff was not good enough in this area.  

15.94 After Dean Casey’s update, Station Manager Berry informed him that the GMFRS capability for a Marauding Terrorist Firearms Attack had been mobilised to Philips Park Fire Station.

Call from Station Manager Berry (22:52)

15.95 Shortly after Station Manager Berry’s call with Dean Casey, Station Manager Berry telephoned NWFC again, at 22:52. The call was answered by Vanessa Ennis.  

Footnotes:

131 135/4/1-8, 135/66/7-17
132 INQ001148
was not her fault that she did. In the event, her inexperience probably did not make any difference to the content of the call.

15.96 Station Manager Berry did not ask Vanessa Ennis for an update. Vanessa Ennis did not offer one. The purpose of Station Manager Berry’s call was to notify NWFC that three NILOs should be allocated to the incident.\footnote{INQ001148}

15.97 This call was an opportunity for Station Manager Berry to be provided with the information that Dean Casey had previously omitted to give to Station Manager Berry. I am not critical of either Vanessa Ennis or Station Manager Berry for the fact that this opportunity was missed. NWFC should have ensured that their staff always offer a situation report or update when speaking to a GMFRS officer.

15.98 The NWFC training was that staff should offer an update, if they were not asked for one.\footnote{123/132/2-13, 125/206/16-23} This training had not been assimilated, as was revealed by the events of 22\textsuperscript{nd} May 2017.\footnote{125/216/1-218/16} NWFC should have done more to ensure that the offering of updates formed part of every call.

15.99 Had an update been offered, Station Manager Berry may not have wanted to receive it: he had
spoken to Dean Casey only three minutes earlier. He may have asked only to be updated on anything new. Despite this, the importance of passing on information is such that an offer of an update should have been a standard part of this particular, and all, conversations.

**Call from Station Manager Berry (22:57)**

15.100 At 22:57, Station Manager Berry telephoned NWFC again. The call was answered by Joanne Haslam. Station Manager Berry was told by Joanne Haslam that the GMFRS duty Group Manager, Dean Nankivell, had been spoken to. Joanne Haslam told Station Manager Berry that Group Manager Nankivell wanted the Technical Response Unit mobilised to Philips Park Fire Station. I will address that call in paragraphs 15.114 to 15.120. Station Manager Berry confirmed that he had mobilised the capability for a Marauding Terrorist Firearms Attack and had allocated three NILOs to the incident.

15.101 Station Manager Berry did not ask for an update and he was not given one. By 22:57, the Arena log did include "**PARAMEDIC BRONZE COMMANDER IS AT SCENE **". Joanne Haslam knew this: she had informed Group Manager Nankivell of that fact seconds earlier. She stated that she was not aware that Station

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136 INQ008376/8
Manager Berry did not know this fact. She assumed that he did know. Joanne Haslam should have given Station Manager Berry this information. It is another example of the lack of effectiveness of NWFC’s training in relation to offering updates.

15.102 Had Joanne Haslam offered an update, she may have included information that Station Manager Berry had not been given, specifically David Ellis’s entry in the Arena log that the injuries thought to have been caused by gunshots were shrapnel wounds.

15.103 NWFC had failed to embed in its staff the practice of offering updates to GMFRS officers, just as GMFRS had failed to embed in its staff the practice of asking for updates.

15.104 The fact that NWAS had a Commander “at scene” was highly significant information. Station Manager Berry had made mobilisation decisions for GMFRS on the basis that the scene was not a safe place for them to go. Had he been updated, it may have caused him to reflect on his approach.

137 123/130/15-131/15
138 123/136/10-137/4
139 INQ008376/8
140 120/105/18-107/7
Mobilisation of senior NWFC staff

Call to Operations Manager (22:44)

15.105 At 22:44, Lisa Owen called Janine Carden. Janine Carden was the Operations Manager at NWFC. Ordinarily, the activity of the control room at NWFC was managed by a Team Leader. However, for a serious incident such as the Attack, under the NWFC escalation policy it was appropriate for the Operations Manager to be contacted.

15.106 Lisa Owen reported to Janine Carden that there had been an explosion at the Arena. She gave the number of known casualties. Lisa Owen explained that Station Manager Berry had directed appliances to Philips Park Fire Station. Reading from the Arena log, Lisa Owen reported that there were “GUN SHOP [sic] WOUNDS AS WELL”. Janine Carden asked the question “WHAT TALK GROUPS IT [the incident] ON?” Lisa Owen responded, “AT THE MOMENT WE HAVEN’T TURNED OUT WE ARE JUST CREATING.” The call concluded with Janine

141 124/171/23-25  
142 124/172/11-173/13  
143 INQ001234/1  
144 INQ001234/2  
145 INQ001234/2
Carden informing Lisa Owen that she was coming into NWFC.146

15.107 Janine Carden then made her way to NWFC, arriving at around 23:09.147 She received a briefing from Michelle Gregson and read the three incident logs that had been created.148 Having done so, at around 23:30, Janine Carden took charge of the management of the incident on behalf of NWFC.149 She did not announce that fact to the control room or record it on the incident log. At the time, it was not NWFC policy that she should do so.150 The policy should be improved to include this.

15.108 Janine Carden was in charge of NWFC’s response for the duration of the second hour.151

Contact with Senior Operations Manager (22:48)

15.109 At 22:48, Janine Carden sent a text message to her superior, Senior Operations Manager Tessa Tracey. The text message read: “Tessa, on way into Control. Incident in Manchester Arena and Victoria Train Station. Dirty bomb and gunshots, 30 casualties.”152 Tessa Tracey did not see the

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146 INQ001234/2
147 125/31/4-14
148 125/31/20-33/2
149 125/34/5-7
150 125/33/3-34/4
151 124/174/6-9
152 125/30/5-10, 125/188/19-25
text message from Janine Carden straight away but called her when she had seen it a few minutes later and spoke to her briefly.153

15.110 Tessa Tracey called Michelle Gregson at 23:08. Michelle Gregson provided a summary of the information NWFC had received. In respect of David Ellis’s call with GMP Control, she stated: “We asked David to stay on the phone to get the JESIP information … because I said this ‘we’ve got to share the information and make sure we get everything’.”154 At the end of the call, Michelle Gregson commented that Janine Carden had “just arrived now”.155

15.111 Michelle Gregson’s comment about “JESIP information” demonstrates that she understood, at the time, what NWFC’s role was on the night of the Attack. It was not, therefore, a lack of understanding on the part of NWFC management of what was required that led to the communication failures by NWFC. Those failures were caused by a lack of understanding on the part of the Control Room Operators. The Control Room Operators’ lack of understanding was a product of a lack of training and exercising.

153 INQ040645
154 INQ040645
155 INQ040645
15.112 After her call with Michelle Gregson, Tessa Tracey set off for NWFC. En route, she spoke to Sarah-Jane Wilson, the Head of NWFC. Tessa Tracey travelled from her home, which was about 40 miles away from NWFC. On the way, she was delayed by roadworks. She arrived at NWFC at 00:18 on 23rd May 2017. Very shortly before she arrived at NWFC, GMFRS had begun to deploy resources to the scene for the first time.

Notification of the Head of NWFC (23:15)

15.113 At 23:15, Sarah-Jane Wilson was notified of the incident via a telephone call from Tessa Tracey. Sarah-Jane Wilson decided to travel in to NWFC. She arrived at 00:01 on 23rd May 2017. She did not relieve Janine Carden, but acted in a supporting role.

Initial calls with GMFRS duty Group Manager

Call to Group Manager Nankivell (22:52)

15.114 On the night of the Attack, Group Manager Nankivell was on call. His role as duty Group Manager was to provide support to an incident. When required, he was expected to travel to the
Command Support Room at GMFRS HQ.\textsuperscript{161} At 22:52, Group Manager Nankivell was telephoned by Joanne Haslam.\textsuperscript{162}

15.115 At the start of the call, Joanne Haslam provided Group Manager Nankivell with a situation report. At one point during this report, Group Manager Nankivell interrupted to ask, “[H]as anyone declared a major incident or anything on this yet?”\textsuperscript{163} By the time Group Manager Nankivell asked this question, both NWAS and BTP had declared a Major Incident. Joanne Haslam had just finished speaking to NWAS Control. She replied, “no as far as I know”.\textsuperscript{164}

15.116 Group Manager Nankivell’s question about the Major Incident cut Joanne Haslam off as she was informing Group Manager Nankivell of the location of the RVP. She got as far as saying, “The rendezvous car park …”.\textsuperscript{165} The only other reference to an RVP was a little later in the call when Joanne Haslam said, “[W]e’ve created a job because they’ve got a rendezvous point.”\textsuperscript{166} She went on to say, “[W]e’ve created a job at Philips Park Fire Station.”\textsuperscript{167} As a result, Group
Manager Nankivell was not told that the police had declared an RVP at the car park area by the Cathedral, a short distance from the Victoria Exchange Complex.

15.117 Group Manager Nankivell informed Joanne Haslam that he intended to call the Assistant Principal Officer. He also instructed Joanne Haslam to mobilise the Technical Response Unit to Philips Park Fire Station.168

15.118 Shortly before the end of the call, Joanne Haslam stated: “Also another little message gone on, there’s a paramedic bronze commander is at the scene.”169 Group Manager Nankivell agreed, in evidence, that this was important information. He agreed that it revealed that NWAS had a command presence at the scene. He also agreed that “this was an indication that the Fire and Rescue Service should also be at the scene”.170

15.119 Group Manager Nankivell stated that he “failed to acknowledge” the information, as he was thinking about his next actions.171 The content of the call bears this out.172 I accept Group Manager Nankivell’s evidence. He did not register and process the information he was given. As a
result, he did not communicate it to anyone else or act upon it in any way.¹⁷³

15.120 It was a failing on Group Manager Nankivell’s part that he did not realise the significance of what he was being told.¹⁷⁴ However, it is inevitable that such individual lapses will occur in the course of a response to an emergency of the magnitude of the Attack. What is important is that the system operates in such a way as to provide safeguards against an individual lapse in concentration. In this situation, the simple safeguard was to ensure that all NWFC operatives informed all the GMFRS personnel they spoke to of all vital information. On the night of the Attack, Group Manager Nankivell was the only GMFRS officer informed that the NWAS Operational Commander was at the scene.

Call from Group Manager Nankivell (23:06)

15.121 At 23:06, Group Manager Nankivell called NWFC and spoke to Joanne Haslam. His call was in response to a telephone message left by Joanne Haslam. In the telephone call, Joanne Haslam informed Group Manager Nankivell that, although Station Manager Berry had requested three additional NILOs to be allocated to the incident, only two had been identified: Group Manager
Carlos Meakin and Group Manager Ben Levy. Group Manager Nankivell instructed Joanne Haslam to leave the position as just two further NILOs.\textsuperscript{175}

**Call to Group Manager Nankivell (23:11)**

15.122 At 23:11, Joanne Haslam called Group Manager Nankivell. The purpose of the call was to update him on mobilising decisions. Group Manager Nankivell informed NWFC that Chief Fire Officer Peter O’Reilly was making his way to the Command Support Room.\textsuperscript{176}

**Initial contact with GMFRS additional NILOs**

**Call to Group Manager Meakin (23:10)**

15.123 Group Manager Meakin was one of a number of on-call incident commanders.\textsuperscript{177} He was also qualified as a NILO.\textsuperscript{178} At 23:06, he received a pager message from NWFC mobilising him to Philips Park Fire Station. The pager message was sent at 23:03 by Joanne Haslam.\textsuperscript{179} It was the result of Station Manager Berry’s instruction at 22:52 to increase the number of NILOs involved in the incident by three. In an incident of this nature, a 14-minute delay between

\begin{itemize}
\item \textsuperscript{175} INQ001150
\item \textsuperscript{176} INQ034363T
\item \textsuperscript{177} 121/21/12-22/4
\item \textsuperscript{178} 121/10/18-23
\item \textsuperscript{179} INQ041473/33
\end{itemize}
instruction and the mobilising message coming through is too long.

15.124 The pager message included: “NILO THREE AND MTS CAPABILITY 2 TO RVP AT PHILLIPS PARK.” The reference to ‘MTS’ was a typographical error. It should have read ‘MTFA’. Group Manager Meakin suspected this when he read it. He tried to contact NWFC, but could not get through.  

15.125 At 23:10, Rochelle Fallon telephoned Group Manager Meakin. She provided a summary of the incident including that GMFRS was being mobilised to Philips Park Fire Station. She did not inform Group Manager Meakin of a significant amount of relevant information. This included the fact that NWFC had been told that paramedics and police officers had been deployed to the scene, that NWAS had a “Bronze Commander” on the scene by 22:55, and that GMP had provided an RVP near the scene.  

15.126 Rochelle Fallon stated that she did not include this information in her call with Group Manager Meakin because of how difficult it was to scroll back and read the Arena log.
15.127 It is notable that Rochelle Fallon did not include any multi-agency information in her report to Group Manager Meakin. This was despite the fact that there were numerous entries in the incident log about other emergency services, including one which was marked with asterisks. I accept that Rochelle Fallon was doing her best to explain why she omitted key information, but I have concluded that the information was not included because she did not realise at the time the importance of that information. Her focus was on looking for other information in the log. This was because she had not been adequately prepared by NWFC for an incident such as the Attack.

Call from Group Manager Levy (23:12)

15.128 Group Manager Levy was on call as a duty NILO. A pager message was sent to him at 23:04 by Joanne Haslam. He received it at 23:06. At 23:12, Group Manager Levy telephoned NWFC and spoke to Michelle Gregson.

15.129 Group Manager Levy’s first question was: “What’s the incident we are proceeding to please?” Michelle Gregson informed Group
Manager Levy that he had been mobilised to Philips Park Fire Station following a report from the police at 22:38 of an explosion at the Arena. She repeated what she had told Tessa Tracey: “[W]e got the operator to stay on the phone to the police to get the JESIP information … to make sure we were sharing all the information that was coming into the police at the time.”

The reference to 22:38 was to the time when David Ellis created the Arena log. In fact, the notification from the police had come four minutes prior to this. Given the stage the incident had reached, this error did not make any difference. However, it is important that accurate information is communicated.

Later in the call, Michelle Gregson stated: “I’ve just recommended that we set up a link so that we can speak to them [GMP], to again make sure we maintain this JESIP information … that we are all sharing information that we are getting in.”

Group Manager Levy asked which officers had been allocated to the incident. Michelle Gregson told him which fire appliances had been mobilised. They also had a discussion about a hazard zone. This was to prevent mobilisations to other incidents nearby.
15.132 Despite mentioning JESIP twice, Michelle Gregson did not provide Group Manager Levy with any JESIP information. She did not inform him of the movements of the police or paramedics. She did not inform him that NWAS had a “Bronze Commander”\(^{192}\) at the scene, or that GMP had provided an RVP, which Station Manager Berry had rejected.

15.133 At the time that she was speaking to Group Manager Levy, Michelle Gregson was looking at the Philips Park log.\(^{193}\) The Philips Park log had no relevant information about emergency service partners.\(^{194}\) This is a clear example of the problem caused by operating multiple logs for a single incident. Because she was not looking at an incident log which contained JESIP information, Michelle Gregson did not provide JESIP information to Group Manager Levy.

15.134 Michelle Gregson bears very little personal responsibility for not bringing up the Arena log and providing relevant information to Group Manager Levy from it. Principal responsibility for this failure lies with NWFC, both in terms of preparing Michelle Gregson for an event such as the Attack and in operating multiple incident logs for a single event.

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192 INQ008376/8
193 124/53/4-6
194 124/53/7-10
15.135 Group Manager Levy stated in evidence that, having listened to the audio of this conversation, he felt he interrupted Michelle Gregson at a point where he believed she may have been about to look at the incident log. He stated that he regretted interrupting Michelle Gregson, as he wondered whether she may have given him more information had he not. 195

15.136 This was a thoughtful concession for him to make. In my view, having listened to the call, I consider Group Manager Levy was being overly critical of himself. His conduct during the call was courteous, calm and professional.

15.137 The repeated mention of JESIP by Michelle Gregson, while at the same time failing to provide any JESIP information, demonstrates that Michelle Gregson did not understand during that call what she was supposed to be doing with the multi-agency information. This lack of understanding was shared by a number of her colleagues at NWFC. The consistency of this failure suggests that it was a systemic problem at NWFC.

15.138 As a result of this failure, Group Manager Levy, like his fellow NILO Group Manager Meakin, mobilised to Philips Park Fire Station without
knowing that the police and paramedics were at the scene and had been for some time.

Further calls with GMFRS duty Group Manager

Call from Group Manager Nankivell (23:24)

15.139 At 23:24, Group Manager Nankivell called NWFC. He spoke to David Ellis. The purpose of Group Manager Nankivell’s call was to instruct NWFC not to deploy firefighters to any incident in Manchester City Centre unless a person’s life was in danger. David Ellis referred Group Manager Nankivell to Group Manager Levy, who had already given NWFC instructions in relation to a hazard zone.¹⁹⁶

Call from Group Manager Nankivell (23:33)

15.140 At 23:33, Group Manager Nankivell spoke to David Ellis again. In the call he asked for NILOs to be paged in order to alert them to an ongoing incident and ask them to monitor their radios.¹⁹⁷

Call to Group Manager Nankivell (23:42)

15.141 At 23:42, Dean Casey called Group Manager Nankivell. This was to notify Group Manager Nankivell that his instruction to David Ellis was being actioned. It was also to ask if there were

¹⁹⁶ INQ001206/1
¹⁹⁷ INQ001230
any talk groups he wished the NILOs to monitor. Group Manager Nankivell said that he only wanted pagers monitored at that time.\textsuperscript{198}

**Call from Group Manager Nankivell (23:46)**

15.142 At 23:46, Group Manager Nankivell telephoned NWFC. He spoke to Janine Carden. Group Manager Nankivell informed Janine Carden that he and Area Manager Paul Etches had arrived at the Command Support Room. I will address Area Manager Etches’ involvement in paragraphs 15.159 to 15.163. In the course of the call, he asked: “\textit{[H]ave you had any more updates that we’re … not privy of?”}\textsuperscript{199} Janine Carden answered: “\textit{No we haven’t.”}\textsuperscript{200} She provided information about the activities of GMFRS officers. Group Manager Nankivell asked: “\textit{[W]e’ve got no pumps down at the actual scene of it, have we?”}\textsuperscript{201} Janine Carden told him that the appliances were at Philips Park Fire Station.\textsuperscript{202}

**NWFC’s management of further calls with duty Group Manager**

15.143 At the point that David Ellis spoke to Group Manager Nankivell for the first time, over 30
minutes had passed since Group Manager Nankivell’s last update from NWFC. David Ellis could have offered an update in that call or his subsequent one.\(^{203}\)

15.144 David Ellis was an experienced\(^{204}\) and competent Control Room Operator. I do not criticise David Ellis for not offering updates. This is further evidence of NWFC’s failure to prepare its staff for an event such as the Attack and of its inadequate systems.

15.145 Dean Casey, who was less experienced than David Ellis and not fully qualified as a Control Room Operator,\(^{205}\) could also have offered an update. NWFC should have prepared him better for his role.\(^{206}\)

15.146 Group Manager Nankivell should have asked both David Ellis and Dean Casey for an update.

15.147 In reaching the conclusions I have about the need to offer and ask for updates, I am conscious that since David Ellis terminated his call with GMP at 23:01, no new information had come into NWFC from GMP, BTP or NWAS. Had the call with BTP at 23:17 been adequately managed, it should have resulted in important information

\(^{203}\) 122/199/11-22  
\(^{204}\) 122/168/24-169/8  
\(^{205}\) 123/144/11-145/6  
\(^{206}\) 123/145/17-146/11
being passed to NWFC. Information was also being received during this period from Philips Park Fire Station. I turn to those calls now.

**First two calls from Philips Park Fire Station**

**Call from Watch Manager Simister (23:06)**

15.148 Watch Manager Andrew Simister was stationed at Manchester Central Fire Station on the night of 22nd May 2017.\(^{207}\) At 22:38, he received a mobilisation pre-alert. This pre-alert was automatically generated as a result of David Ellis creating an incident log for the Arena. Manchester Central Fire Station was the closest fire station to the Arena.\(^{208}\)

15.149 Manchester Central Fire Station crews received a mobilisation to Philips Park Fire Station.\(^{209}\) Watch Manager Simister and his two fire appliances drove to Philips Park Fire Station. Once there, at 23:06, Watch Manager Simister called NWFC and spoke to Lisa Owen. Watch Manager Simister stated: “ALL THE AMBULANCES PULLED ON AT CENTRAL AS WE LEFT.”\(^{210}\) Lisa Owen responded by confirming that it had been the NILO’s decision to mobilise to Philips Park Fire Station and that further information was awaited.
15.150 Lisa Owen stated that when Watch Manager Simister informed her that “ALL THE AMBULANCES” were arriving at Manchester Central Fire Station, she assumed those ambulances were doing that in order to follow the fire appliances to Philips Park Fire Station. Lisa Owen made no entry in the incident log in relation to the information she had been given. She should have done so.

15.151 In addition to making a record, Lisa Owen should also have asked Watch Manager Simister whether the ambulances did, in fact, follow the fire appliances. There was no basis in the incident log or in anything that NWFC had been told until that point to conclude that ambulances were being sent to Philips Park Fire Station. The information in the incident log was to the opposite effect: ambulances were being deployed to the scene. Lisa Owen should not have made the assumption she did. As a result, a further opportunity to note the contrast in the approach being taken by NWAS and that being taken by GMFRS was missed.

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211  125/150/7-24
212  125/150/25-151/4
Call from Watch Manager Simister (23:25)

15.152 At 23:25, Watch Manager Simister again contacted NWFC. On this occasion, he spoke to Rochelle Fallon. He asked her for an update. He gave the following reason for the request: “I’VE GOT A FIREMAN HERE WHOSE WIFE IS A PARAMEDIC AND SHE’S ON SCENE AND WE ARE STOOD BY DOING NOTHING AND HE’S GETTING A BIT FRUSTRATED.” Rochelle Fallon explained that Group Manager Meakin and Group Manager Levy were on their way to Philips Park Fire Station. She apologised for the lack of update. Watch Manager Simister asked if there were “ANY FIRE SERVICE THERE YET ACTUALLY ON SCENE”. Rochelle Fallon replied: “NO.” She stated: “BECAUSE … THERE WAS WELL THERE WAS BELIEVED TO BE … A SECOND BOMB I THINK, I THINK THAT IS WHAT THE POLICE WERE SEARCHING FOR … I DON’T KNOW.”

15.153 The reference by Watch Manager Simister to “A FIREMAN” was to Crew Manager Nicholas Mottram. His wife, the “PARAMEDIC … ON SCENE” was Helen Mottram. She attended the Victoria Exchange Complex that night as part of NWAS’s response to the Attack. Watch Manager
Simister’s call contained important information. The contrast between NWAS’s approach and GMFRS’s approach was starkly revealed by his subsequent question about whether there were any firefighters at the scene. Watch Manager Simister had reliable information directly from the scene. He passed it on. It should have been acted upon.

15.154 The Control Room Operator, Rochelle Fallon, should have immediately escalated this information to a Team Leader. It was an opportunity, more than 45 minutes after the Attack, for NWFC to re-evaluate their approach. If she had escalated this information, it would have led to a realisation, even at this late stage, that GMFRS had taken a completely different approach to that of NWAS. It was obvious to Watch Manager Simister that this was so. It was a failure in NWFC training that resulted in Rochelle Fallon not doing this.

15.155 On a separate point, it is regrettable that Rochelle Fallon gave Watch Manager Simister inaccurate information about why NWFC had not mobilised GMFRS to the scene. No harm resulted from it, but Rochelle Fallon should not have speculated as she did. It was capable of being repeated and confusing the picture.
15.156 There is no record of Rochelle Fallon’s call with Watch Manager Simister on any of the logs. Rochelle Fallon stated that she may have made an entry on an incident log to reflect that Watch Manager Simister was seeking an update about the NILOs. She stated that sometimes the NWFC system does not record entries. She stated that this was something she and others had raised with NWFC. By the time she gave her evidence in July 2021, Rochelle Fallon said that it had still not been resolved. 216

15.157 In light of her evidence, I am unable to reach a firm conclusion about whether or not Rochelle Fallon attempted to record her conversation. It is imperative that NWFC ensures that all entries are saved to an incident log. Rochelle Fallon’s evidence about this issue was of concern to me.

15.158 In evidence, Rochelle Fallon stated that if she had made an entry in the incident log it would have read: “Call from Golf 16, asking for an update off a NILO.” 217 This would have been inadequate, as it would not have recorded the important and reliable information about paramedics being at the scene.

216 136/45/3-47/2
217 136/45/3-23
Initial call from GMFRS duty Assistant Principal Officer

Call from Area Manager Etches (23:11)

15.159 After the call with Group Manager Meakin, Rochelle Fallon took an incoming call from Area Manager Etches at 23:11. He was the duty Assistant Principal Officer for GMFRS that night. The Assistant Principal Officer’s role during any substantial incident is a strategic one, considering the impact of the incident on GMFRS’s capabilities across its entire area. Area Manager Etches had been contacted about the Attack by Group Manager Nankivell at 22:57.

15.160 The purpose of Area Manager Etches’ call was to inform NWFC that he was making his way to the Command Support Room at GMFRS HQ. Area Manager Etches wanted to be marked on the incident log as such. In the course of the call, Area Manager Etches said: “I we … had anything back from anywhere? I’ve just spoken to Dean Nankivell and obviously I think at the moment we’ve just got standby’s at Philip’s Park.”

15.161 Area Manager Etches stated that, in asking his question, he was “seeking further information”. He stated that he was not seeking information...
specific to the movements of the police or paramedics.\textsuperscript{221} In response, Rochelle Fallon confirmed that GMFRS was mustering at Philips Park Fire Station and that NWFC was receiving “\textit{more information from ambulance and police every time they get anything about a fatality}”.\textsuperscript{222} Rochelle Fallon did not provide any information about the deployment of the police and paramedics to the scene.

15.162 It was not clear from Area Manager Etches’ question what he wanted to know. Consequently, I am not critical of Rochelle Fallon for not interpreting it as a request for JESIP information. It does not appear that Area Manager Etches was seeking that information in any event.\textsuperscript{223} However, it was the first time Area Manager Etches had made contact with NWFC about the incident. Rochelle Fallon should have offered a situation report based on the latest information. This should have included information about what the other emergency services were doing.

15.163 An entry was made in an incident log at 23:13 by Rochelle Fallon to record the fact that Area Manager Etches was mobilising to the Command Support Room (the Command Support Room log). This incident log had been created at 22:44
by Dean Casey. The 23:13 entry by Rochelle Fallon is the first substantial action recorded in it. It was subsequently used to mobilise other GMFRS officers to the Command Support Room. It was also used to record Group Manager Nankivell’s decision to deploy himself to the Command Support Room.224

Calls from GMFRS Contingency Planning Unit manager

Call from Group Manager Fletcher (23:22)

15.164 Group Manager John Fletcher called NWFC at 23:22. Group Manager Fletcher was qualified as a NILO. He was the manager of the Contingency Planning Unit at GMFRS. In this management role he had responsibility for GMFRS’s NILOs.225 Group Manager Fletcher had received a WhatsApp message about the Attack.226 As a result, he telephoned and spoke to Station Manager Berry.227 He also spoke to other GMFRS officers. I will address these calls in the section about the GMFRS response.

15.165 In his call to NWFC at 23:22, Group Manager Fletcher spoke to Joanne Haslam. He informed her that he was booking himself on duty and

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224 INQ004290/1-3
225 63/49/19-24, 127/193/25-194/9
226 INQ019040/1
227 127/194/10-18
making his way to the Command Support Room. In the course of the conversation, a proposed multi-agency control room talk group was mentioned. Group Manager Fletcher stated: “THIS IS WHAT WE WERE PUTTING IN AFTER DOING THE EXERCISES.” He went on to say: “CAUSE IT MIGHT BE A WAY THAT THE POLICE CONTROL GET IN TOUCH WITH YOURSELVES.”

15.166 This call was another occasion on which an NWFC operative did not offer a situation report or update to GMFRS. Joanne Haslam was a very experienced Control Room Operator. This is another example of the failure by NWFC to embed the offering of updates.

15.167 Following the call with Group Manager Fletcher, Joanne Haslam spoke to Janine Carden about the proposed multi-agency control room channel. Group Manager Fletcher’s self-deployment to the Command Support Room and reference to the proposed multi-agency control room channel were recorded in the Command Support Room log.
Call to Group Manager Fletcher (23:25)

15.168 At 23:25, Janine Carden called Group Manager Fletcher on his mobile. The call lasted just over a minute.\(^{232}\) They discussed the proposed multi-agency control room talk group. Group Manager Fletcher asked for that channel to be monitored.\(^{233}\)

15.169 Group Manager Fletcher stated in evidence that during this call he asked Janine Carden if there were “any further updates, particularly on the status of the active shooter and the ambulances, where are the ambulances are going?” He stated that he heard Janine Carden ask a colleague this question. He said the reply was that NWFC did not have any updates at that moment in time.\(^{234}\)

15.170 Group Manager Fletcher stated that his question to Janine Carden was poorly phrased. He said that he believed Janine Carden misunderstood what he was asking.\(^{235}\) At the time of his call, NWFC had not had any updated information from NWAS or GMP for nearly 20 minutes. In Major Incident terms, that meant that NWFC had not recently received an update. Understanding Group Manager Fletcher’s question in this way,

\(^{232}\) INQ041473/47  
\(^{233}\) INQ004290/4, 128/31/20-32/11, 125/39/24-40/5  
\(^{234}\) 128/31/20-32/8  
\(^{235}\) 128/32/20-33/3
it is easy to see why there was no “update” to give him.

15.171 At 23:36, Janine Carden made the following entry on the Command Support Room log: “From GM [Group Manager] Fletcher can we monitor police [proposed multi-agency control room talk group].”236 Approximately 15 minutes later, the GMP Silver Control Room broadcast on this channel. NWFC acknowledged that broadcast. I will deal with it in paragraph 15.198.

15.172 The miscommunication between Janine Carden and Group Manager Fletcher is a good example of the need for a clear understanding between GMFRS and NWFC of the process for passing on information during Major Incidents. For any update, it is important to establish when the person receiving the update was last provided with information.

Call from Group Manager Fletcher (23:41)

15.173 At 23:41, Group Manager Fletcher called NWFC a second time. He spoke to Janine Carden. The purpose of his call was to have Merseyside Marauding Terrorist Firearms Attack capability put on standby. In the course of the call, he stated: “OBVIOUSLY I’VE BEEN A BIT INFO BLIND WHILE I’VE BEEN EN ROUTE TO

236 INQ004290/4
HEADQUARTERS, I’M NEARLY THERE NOW.” Janine Carden did not offer to provide Group Manager Fletcher with a situation report or an update either at that point or when he arrived. She should have done so.

Third call from Philips Park Fire Station

Call from Group Manager Meakin (23:28)

15.174 Group Manager Meakin arrived at about the time of Watch Manager Simister’s second call to NWFC. Upon arrival, he spoke to the GMFRS officers present. At 23:28, he called NWFC and spoke to Lisa Owen. He began by stating he was at Philips Park Fire Station and that he had not had a briefing or instructions. He asked: “HAVE WE GOT A BRIEF OR ANY INSTRUCTIONS?” In reply, Lisa Owen informed him of the movements of GMFRS personnel, but that “WE’VE GOT NO INSTRUCTIONS WITH REGARDS TO MOBILISING YET.”

15.175 Group Manager Meakin continued the conversation by saying: “I’VE JUST HAD REPORTS FROM CREWS AT PHILIPS PARK THAT I THINK THERE FROM CENTRAL …
The reference to “the forecourt” was to the forecourt of Manchester Central Fire Station. Given the terms of her response, this was the way in which Lisa Owen understood it. Lisa Owen’s response was to say that the deployment to Philips Park Fire Station was Station Manager Berry’s decision. She went on to say to Group Manager Meakin: “AMBULANCE OBVIOUSLY I CAN’T SPEAK OF WHY THEY’VE SENT THEM THERE BUT THEY ARE AWARE THAT OUR RENDEZVOUS POINT IS PHILIPS PARK.”

She stated that it was possible that Station Manager Berry was speaking to the FDO at GMP.

There was a substantial body of information that Lisa Owen did not provide to Group Manager Meakin. She did not provide any information relating to the deployments of the paramedics or police. Group Manager Meakin had asked directly for a briefing. She should have provided him with that “critical” information.
15.177 This was the second call Lisa Owen had taken from Philips Park Fire Station. In both calls, the GMFRS officer calling deliberately drew attention to the contrast between GMFRS’s approach and that of NWAS. Her assumption at the end of the first call was that ambulances were following fire appliances to Philips Park Fire Station. Just 22 minutes later, it should have been apparent from Group Manager Meakin’s call that no ambulances had arrived at Philips Park Fire Station.

15.178 Lisa Owen was a Team Leader. She should have appreciated the significance of what she was being told and sought to contact NWAS to find out what was going on.245 She should also have sought to contact Station Manager Berry.

GMP, NWAS and the Forward Command Post

Call from GMP Control (23:44)

15.179 At 23:44, GMP Control contacted NWFC. Rochelle Fallon answered the call. GMP notified NWFC that the Silver Control Room at GMP HQ was being set up. A request for the attendance of a “liaison officer” was made by GMP. Rochelle Fallon stated that she would “ring one and ask them to attend”.246
Call to Station Manager Berry (23:46)

15.180 Rochelle Fallon telephoned Station Manager Berry at 23:46. By this time, Station Manager Berry and Group Manager Levy had reached Philips Park Fire Station. Station Manager Berry was with Group Manager Levy when Rochelle Fallon called. Rochelle Fallon relayed GMP’s request. Group Manager Levy replied that Station Manager Michael Lawlor was en route to GMP HQ. Station Manager Berry then asked: “Ok is there anything else … have we got any further information at all? Anything confirmed so far?” Rochelle Fallon gave the latest number of casualties. Group Manager Levy asked if there was a Forward Command Post (FCP) “to co-locate with police and ambulance”. Rochelle Fallon said she would ring back.

15.181 Rochelle Fallon did not know what an FCP was. This was a shortcoming in her training. If the importance of an FCP had been adequately communicated to Rochelle Fallon, I have no doubt she would have understood what it was and why GMFRS was asking for it.
Call to GMP Control (23:47)

15.182 At 23:47, Rochelle Fallon called GMP Control. This was the second time NWFC proactively contacted GMP Control. As with the previous call Rochelle Fallon made at 23:02, it was for a specific purpose rather than to obtain a general situation update. Rochelle Fallon informed GMP Control that Station Manager Lawlor was on his way to GMP HQ. She asked if there was an FCP. GMP Control informed her that “someone will call you back as soon as we can with the info”. 251

15.183 This sequence of calls contains a familiar pattern of omissions on the part of NWFC. In the call with GMP at 23:47, Rochelle Fallon did not take the opportunity to obtain an update from GMP Control. Over 40 minutes had passed since Rochelle Fallon had last spoken to GMP Control. No one from NWFC had spoken to GMP Control in the meantime. This was an obvious opportunity for Rochelle Fallon to take.

15.184 In the call a minute earlier with Station Manager Berry and Group Manager Levy, Rochelle Fallon did not provide a comprehensive update. She should have enquired when each had last received an update. She should have informed Station Manager Berry and Group Manager Levy that GMP and NWAS had been at the scene for

251 INQ001175
at least 45 minutes and that NWAS had a “Bronze Commander”\textsuperscript{252} present. She should also have been placed in a position in which the BTP METHANE message was available.

15.185 The call with GMP Control at 23:47 presented another opportunity to obtain a situation update from GMP. Instead, Rochelle Fallon confined herself to the narrow question she had been instructed by Group Manager Levy to ask. When it became apparent that the answer to this was not immediately available, Rochelle Fallon should have taken the opportunity to obtain other important information from GMP Control.

15.186 Had Rochelle Fallon requested any information held by GMP Control between 23:00 and 23:45 she could have been told that the GMP incident log included:

\begin{itemize}
\item “\textit{WE NEED AS MANY STAFF TO THE FOYER INSPECTOR HAS ASKED ALL CASUALTIES OUT OF THE AREA ASAP.”}\textsuperscript{253}
\item “\textit{CONFIRMED WITH AMB – THEY HAVE 11 AMB AND A NUMBER OF RESPONSE VEHS EN ROUTE.”}\textsuperscript{254}
\item “\textit{PATROLS TO MAKE HUNTSBANK.”}\textsuperscript{255}
\end{itemize}
15.187 All of the above information was capable of being of assistance to the GMFRS decision-makers who were at Philips Park Fire Station.

Call to NWAS Control (23:50)

15.188 As a result of not receiving an immediate answer from GMP Control to Group Manager Levy’s request for an FCP, at 23:50 Rochelle Fallon called NWAS Control. This was the first contact with NWAS Control by an NWFC operative since Rochelle Fallon had called to pass on the information about the LFRS officer’s relative. That call had concluded 50 minutes earlier.

15.189 This was an unacceptably long period of time for NWFC not to be in contact with NWAS Control. The contact only occurred because Rochelle Fallon had been asked a question that GMP Control was not able to answer.

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256 INQ007214/23
257 INQ007214/23
258 INQ007214/25
259 INQ001158
15.190 Rochelle Fallon asked NWAS Control if there was an FCP. NWAS Control replied: “A LOT OF OUR VEHICLES ARE GOING TO THOMPSON STREET FIRE STATION.” Rochelle Fallon asked, “SO HAVE YOU GOT AMBULANCES ON SCENE?” It was surprising that Rochelle Fallon asked this question as, in her call with NWAS Control at 22:57, Rochelle Fallon had informed NWAS Control from the Arena log that “ALL THE AMBULANCE HAVE BEEN DIRECTED TO THE BOOKING OFFICE.”

15.191 In the call at 23:50, NWAS Control responded: “WE’VE GOT EVERYBODY THERE.” Given the time that had passed since the previous contact with NWAS Control, Rochelle Fallon should have asked for a general update from NWAS. It was a further opportunity for NWFC to be provided with the NWAS Advanced Paramedic Patrick Ennis’s METHANE message.

15.192 Although Rochelle Fallon did not ask for it directly, the information provided by NWAS Control was important. Rochelle Fallon stated in evidence that she intended “ON SCENE” to be a reference to Manchester Central Fire Station, rather than the Arena or the Victoria Exchange.
Complex. She stated that she did not understand NWAS Control to be confirming that there were ambulances at the scene of the Attack. 264 This was an unfortunate interpretation by Rochelle Fallon, as it affected what information she relayed to GMFRS.

15.193 Rochelle Fallon’s understanding of the phrase ‘on scene’ is of wider concern. She interpreted ‘on scene’ as meaning ‘at your RVP/FCP’, rather than ‘at the scene of the explosion’. By contrast, it is likely that NWAS Control understood Rochelle Fallon’s use of ‘on scene’ to mean ‘at the scene of the explosion’ or ‘at the Victoria Exchange Complex’. That is because, at 23:50, NWAS had only two vehicles at Manchester Central Fire Station; but had 21 vehicles on Hunts Bank or Station Approach at that time. Gerard Blezard, NWAS Director of Operations, who produced and released statements on behalf of NWAS as an organisation, described these 21 vehicles as “Total ambulances at scene.” 265

15.194 The JESIP publication Joint Doctrine: The Interoperability Framework (the Joint Doctrine), under the title of “Communication”, had a section headed “Common terminology”. Within that section it stated: “Using terminology that either means different things to different people, or is

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264 136/49/19-50/25
265 INQ041992/1
simply not understood is a potential barrier to interoperability … Agreeing and using common terminology is a building block for interoperability.”\textsuperscript{266} It went on to refer to the ‘Lexicon of UK civil protection terminology’. In that document, ‘scene’ is defined as: “Point or area of the immediate impact of an incident or emergency”.\textsuperscript{267}

15.195 It is important that GMP, BTP, NWAS and NWFC consider their use of terminology to ensure that they are all using the same definitions for key terms. Given the stage at which this conversation was taking place, this misunderstanding was incapable of affecting the treatment of casualties in the City Room. However, it may have delayed the GMFRS arrival time.

Call to Group Manager Levy (23:52)

15.196 At 23:52, Rochelle Fallon called Group Manager Levy. She informed him that she was waiting to hear back from GMP in relation to the FCP. She went on to say that NWAS had “ADVISED THAT A LOT OF THEIR APPLIANCES ARE RENDEZVOUSING AT THOMPSON STREET”.\textsuperscript{268} Group Manager Levy replied: “THOMPSON STREET WHAT, BY OUR FIRE

\begin{itemize}
\item \textsuperscript{266} INQ004542/7
\item \textsuperscript{267} Cabinet Office, ‘Lexicon of UK civil protection terminology’, 2010
\item \textsuperscript{268} INQ001233
\end{itemize}
STATION THOMPSON STREET”.269 Rochelle Fallon confirmed this. Group Manager Levy asked her to stand by.270

15.197 The information provided to Group Manager Levy by Rochelle Fallon about Manchester Central Fire Station confirmed what he had been told by firefighters when he arrived at Philips Park Fire Station.271

Proposed multi-agency control room talk group

Broadcast from GMP Silver Control Room (23:58)

15.198 At 23:58, GMP Police Constable (PC) Ian Carter used the proposed multi-agency control room talk group. He broadcast: “Silver Control to any … to any Ambulance or Fire monitoring this channel please.”272 The response by Janine Carden was not recorded. However, her response was that NWFC was listening.273 PC Carter replied: “Yep, that’s received, thank you very much. Any Ambulance on this Channel please?”274 For the reason I gave in Part 14, NWAS did not respond.275

269 INQ001233
270 INQ001233
271 122/15/17-16/3
272 INQ030816T
273 125/40/18-20
274 INQ030816T
275 125/40/21-41/2
15.199 Following her reply, Janine Carden entered into the Command Support Room log: “Call on [proposed multi-agency control room talk group], GMP Silver asking if fire or amb monitoring confirmed fire monitoring. Group Manager Fletcher informed and asked for Group Manager Levy to be informed.”

Final calls with GMFRS prior to GMFRS arrival at the scene

Call from Group Manager Levy (00:15)

15.200 At 00:15 on 23rd May 2017, Group Manager Levy called NWFC. He spoke to Rochelle Fallon. By the time of this call, Group Manager Levy and others from Philips Park Fire Station had moved to Manchester Central Fire Station.

15.201 Rochelle Fallon stated: “The police still haven’t advised us on this … going forward point.” This was a reference to the FCP. GMP had had over 25 minutes to provide NWFC with the FCP. This was an unacceptable period of delay. At 23:54, GMP Control had provided Station Manager Berry with “the old Boddingtons car park” as an FCP. This did not negate the need for GMP to answer the request from NWFC.
15.202 Group Manager Levy asked: “I don’t believe that anyone has declared Operation Plato yet have they?” Rochelle Fallon replied: “No.” Group Manager Levy asked Rochelle Fallon to record him as the Incident Commander. Group Manager Levy stated in evidence that the reason he had asked whether Operation Plato had been declared was because, until that point, he had considered that he was responding to “a Plato-style incident”. At Manchester Central he had found non-specialist ambulances and this had prompted his question.

15.203 At the same time as Group Manager Levy made the enquiry about Operation Plato, GMP Temporary Superintendent Christopher Hill informed Station Manager Lawlor that GMP had declared Operation Plato. Station Manager Lawlor subsequently communicated this to the NILOs over the NILO talk group.

Call from Group Manager Nankivell (00:18)

15.204 At 00:18 on 23rd May 2017, Group Manager Nankivell called NWFC. He spoke to Joanne Haslam. He informed Joanne Haslam that two standard fire appliances were being deployed to
Corporation Street with Station Manager Berry. Joanne Haslam informed Group Manager Nankivell about the RVP at the “car park outside the Cathedral.” Group Manager Nankivell asked when this RVP was provided. Joanne Haslam stated: “That was from the initial call.”

15.205 Joanne Haslam had begun to tell Group Manager Nankivell about this RVP in her call with him at 22:52, but had been cut off by Group Manager Nankivell who asked a question about whether a Major Incident had been declared.

Conclusion

15.206 There were a number of areas in which NWFC’s response to the Attack was inadequate. There was a failure on a number of occasions to offer or provide adequate information or updates to GMFRS officers when speaking to them. There was a failure on a number of occasions to seek JESIP information when speaking to BTP, NWAS and GMP. There was a failure to contact BTP, NWAS and GMP for the purpose of gaining situational awareness.

15.207 Most fundamentally, there was a failure by NWFC staff to recognise and act upon the fact that the approach being taken by GMFRS was obviously
divergent from the approach NWAS and the police were known to be taking. Control Room Operators should have been escalating the inconsistency in approach to the Team Leaders. The Team Leaders should have been proactively contacting and challenging GMFRS officers in light of what was known about other emergency services.

15.208 By 23:00, the Team Leaders should have identified that over 15 minutes had passed since Station Manager Berry had said he would contact the FDO. The Team Leaders should have contacted Station Manager Berry and enquired whether a different approach was required. They should have offered to help him get the information he needed. They should have considered contacting GMP, BTP and NWAS to obtain a full situation report to give to Station Manager Berry to assist him in his decision-making. This was not something they had been trained to do.

15.209 I have identified throughout the section above where individuals should have acted differently. NWFC as an organisation is responsible for these failures. There was a failure to prepare staff adequately for an incident such as the Attack.

15.210 The important calls for this incident were managed by eight people. This seems to be one
of the things that caused problems on the night. It meant that the information was not concentrated in one or two people’s minds, but spread across several people. David Ellis, Joanne Haslam, Rochelle Fallon, Dean Casey, Vanessa Ennis, Lisa Owen, Michelle Gregson and Janine Carden all took part in important calls within the first 75 minutes.

15.211 I recommend NWFC consider whether a better system can be devised where fewer people manage calls relating to Major Incidents.
Greater Manchester Fire and Rescue Service response

Key findings

• The Greater Manchester Fire and Rescue Service (GMFRS) duty National Interagency Liaison Officer (NILO) should have instructed North West Fire Control to mobilise GMFRS resources to the Rendezvous Point provided by Greater Manchester Police (GMP).

• The duty NILO should have re-evaluated his plan when he could not get through to the GMP Force Duty Officer (FDO) after several attempts.

• The duty NILO should have remained at home and supported the GMFRS response from there.

• Other senior GMFRS officers who became involved in the response should have acted more decisively than they did prior to 23:45.

• Other means of obtaining situational awareness should have occurred to GMFRS officers beyond contacting the GMP FDO.
• Because GMFRS personnel had not arrived on scene, GMFRS was without any one in command of the incident until 23:45. The GMFRS response stalled, principally because of GMFRS’s approach to appointing someone to the role of Incident Commander.

• The GMFRS duty Principal Officer should have deployed himself to GMP Headquarters rather than the GMFRS Command Support Room.

• The GMFRS duty Principal Officer should have deployed the Specialist Response Team to the scene when he was informed of the Operation Plato declaration.

Introduction

15.212 In Part 12, I concluded that GMFRS was well prepared for a Marauding Terrorist Firearms Attack or other terrorist attack. Despite this, GMFRS officers did not attend the Victoria Exchange Complex until two hours and six minutes after the explosion. There are a number of causes of this unacceptable delay.

15.213 As I set out in the section addressing NWFC’s response, at paragraphs 15.206 to 15.211, NWFC’s communication with GMFRS and other emergency services was inadequate. There were also inadequacies in the way that the other
emergency services communicated with NWFC. This adversely impacted on NWFC’s ability to play its part. The difficulty contacting the FDO was also very significant at an early stage in the incident.

15.214 In addition, there were occasions of inadequate communication between GMFRS officers, assumptions made by some of them on insufficient information, and instances of critical challenge failing to take place and poor decision-making by some.

15.215 There was also a structural issue, which GMFRS had failed to foresee. It operated a system in which the Incident Commander only took up the command role on arrival at the scene. In a situation where no one goes to the scene, there is then no GMFRS Incident Commander. The lack of a single person in charge of the incident made a major contribution to the delay.

15.216 In its closing statement, GMFRS stated:

“No one can doubt that GMFRS firefighters, including officers and commanders, take real risks on a day to day basis, putting themselves and those they command into dangerous situations to rescue others. They do so willingly without complaint. It cannot fairly be said that there is a general aversion to risk within GMFRS. It is clear, however, that
15.217 The topic of risk aversion is one to which I will return at the conclusion of this section.

15.218 Finally, before turning to the detail of GMFRS’s response, in the course of this section I have had to resolve a number of disagreements in the evidence between senior GMFRS officers as to what they told each other over the telephone in the early stages of their involvement. I accept that all witnesses were doing their best to give accurate and truthful evidence. Resolving those disputes is not always straightforward.

15.219 On the one hand, the fact that there are differences in the ways in which senior colleagues remember events might be viewed by some as a positive thing. It demonstrates that each witness is giving their own account, without having been influenced by the recollection of another.

15.220 On the other hand, it is capable of leading to confusion and of obscuring what actually happened. On occasions, this has led to me criticising individuals on a factual basis that does
not fit with their own memory of events. This is regrettable but necessary.

15.221 This clearly illustrates the need for there to be a recording of what is said. This record could be through the use of a recorded communication system, the operation of a Dictaphone or a body-worn video camera.

15.222 It is not just for the benefit of a public inquiry. Any subsequent review for the purpose of learning or investigating liability will have an accurate record of who said what to whom. This can form the foundation of any investigation or debrief. It will bring the focus on why things were said and done, rather than focusing on resolving what was said and done. It will also improve the prospect of real change, as people are more likely to accept criticism and feedback if they agree with the facts on which it is based.

15.223 In Part 19 in Volume 2-II, I shall return to the issue of the recording of what occurs during a Major Incident more generally.

**Mobilisation by duty NILO**

**Call from NWFC to Station Manager Berry (22:40)**

15.224 Station Manager Berry was the duty NILO. In paragraphs 15.72 to 15.82, I rehearsed significant parts of the conversation he had with
Michelle Gregson at 22:40. Station Manager Berry should have challenged Michelle Gregson when she stated, “obviously we are not mobilising.” Station Manager Berry did not have the GMFRS action plans or Major Incident Plan in front of him at the time of call.

15.225 As I said in paragraph 15.75, the use of the word “obviously” by Michelle Gregson was unfortunate. It implied that it was inevitable that mobilisation to the GMP RVP would not immediately occur. Station Manager Berry should have challenged Michelle Gregson’s use of the word “obviously” so as to better understand her thought process.

15.226 Station Manager Berry’s reaction was to say, “[W]e would normally muster them [the fire appliances] at one of the stations wouldn’t we?” This response endorsed Michelle Gregson’s use of the word “obviously”. It was not GMFRS normal procedure to muster at a fire station. For an Operation Plato situation, GMFRS action plans envisaged mobilisation to an RVP nominated by the FDO. For an explosion, the GMFRS action plan directed mobilisation to the

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287 INQ001198
288 INQ001198/1
289 INQ042436/15-17 at paragraphs 57 and 61
290 INQ001198/2
291 INQ019116/3
incident. Station Manager Berry was wrong in expressing himself in this way.

15.227 Following Michelle Gregson’s unfortunate use of “obviously” and Station Manager Berry’s endorsement of it, by mis-stating the normal position, Station Manager Berry decided to mobilise four fire appliances to Philips Park Fire Station.

Station Manager Berry’s decision-making

15.228 Station Manager Berry explained his selection of Philips Park Fire Station on the basis that he was “drawing cordons in [his] mind”. He stated that, although Manchester Central Fire Station was outside the cordon he drew, he ruled it out on the basis that if the incident “shifts” it would be inside the cordon and compromised as a location. He stated that he ruled out the RVP given to him from GMP as it was “quite close” and that if the incident were to “become an MTFA [Marauding Terrorist Firearms Attack] … it would be within that cordon”. He stated that he did not think to evacuate Manchester Central Fire Station.

292 INQ004404
293 INQ001198/2
294 119/183/13-14
295 119/183/5-20, 119/186/4-25
296 119/184/4-23
297 119/187/8-12
15.229 Station Manager Berry stated that he “assumed that this has just happened” and it may be a prelude to something else. 298 He stated that he wanted “some reassurances because I thought it had just happened … and the RVP being nominated so fast”. 299 He stated that “it was never in [his] mind that two of the [fire appliances] would be selected” from Manchester Central Fire Station and mobilised to Philips Park Fire Station. 300

15.230 Station Manager Berry stated that he accepted now that Manchester Central Fire Station was “probably a better location” for a muster point than Philips Park Fire Station. 301

15.231 I accept Station Manager Berry’s evidence about his decision-making process. I also accept that he was doing his best in difficult circumstances. However, he made unjustified assumptions, he acted outside the training he had been given and not in accordance with GMFRS’s plan for this type of incident. I recognise that officers in his position must be granted operational discretion. A deviation as great as this required clear justification, which was lacking.

298 119/184/18-185/4
299 119/188/17-20
300 119/182/19-183/4
301 119/187/17-25, INQ042436/18 at paragraph 64
15.232 There was no adequate basis for Station Manager Berry’s rejection of the GMP-nominated RVP.\textsuperscript{302} If the issue of the timing of the explosion was a determining factor, Station Manager Berry should have asked Michelle Gregson when exactly it had occurred. Instead, he made an assumption, and then based his decision-making on this assumption. He should not have done this.

15.233 Had fire appliances been mobilised to the GMP-nominated RVP, they would have picked up situational awareness.\textsuperscript{303} They would also have been sufficiently close to cautiously investigate the scene from that location.

15.234 Having decided to reject the RVP, it was still open to Station Manager Berry to make a limited deployment to the location in order to gain situational awareness and co-locate with other emergency services.\textsuperscript{304}

15.235 Manchester Central Fire Station was an obvious and correct choice for a GMFRS muster point, if the RVP was to be rejected. It brought fire appliances to a close but safe distance from Victoria Exchange Complex. Station Manager Berry’s concern that there may be a marauding
terrorist and that that terrorist might maraud in the direction of Manchester Central Fire Station, which is in the opposite direction to the city centre, was unjustifiably cautious.

15.236 The effect of Station Manager Berry’s selection of Philips Park Fire Station was to send two fire appliances further away from the Victoria Exchange Complex and added further minutes to any response. Philips Park Fire Station was sufficiently far away to completely isolate GMFRS from the incident.

15.237 Before turning to Station Manager Berry’s next actions, it is important to recognise that, although Station Manager Berry’s initial decision was flawed, it could have been reversed quickly had he been able to speak to the FDO immediately and gain important information.

Next actions of duty NILO

Calls to Force Duty Officer

15.238 As soon as he had finished his call with Michelle Gregson, Station Manager Berry got his laptop out in case he needed to make notes. He then called the FDO. He had the FDO number pre-programmed into his mobile phone. Station Manager Berry did not get through to the FDO. He heard the engaged tone. He tried calling the
FDO number several times. In his witness statement, Station Manager Berry estimated that he tried the FDO seven times before he left home. None of the calls connected to the FDO.\footnote{119/199/3-200/23}

15.239 Station Manager Berry did not attempt to use the multi-agency hailing talk group to contact the FDO. He was not aware of this facility.\footnote{119/204/5-19} He should have been. It was GMFRS’s failing that he was not.

15.240 Station Manager Berry stated that he expected the FDO, or one of the FDO’s team, to contact him.\footnote{119/213/17-214/9} At no point during the critical period of the response, by which I mean the period from the explosion at 22:31 to the removal of the final living casualty from the City Room at 23:39, did anyone from GMP Control call and speak to the GMFRS duty NILO, Station Manager Berry. As I set out in Part 13 in the section addressing GMP’s response, the FDO was overburdened. As a result, important inter-agency communication did not take place. This was a failing on the part of GMP, which had not provided adequate support for the FDO. I have dealt with this criticism in detail in Part 13.
15.241 Shortly before 22:48, Station Manager Berry received a call from Group Manager Peter Buckley. Group Manager Buckley was part of the Specialist Response Team. Group Manager Buckley had heard of an incident at the Arena. He wanted to know if the Specialist Response Team could be released from a road traffic incident. Station Manager Berry instructed the Specialist Response Team to leave that incident if they could, return to their fire station and put on their ballistic protection. Station Manager Berry instructed the Specialist Response Team to meet him at Philips Park Fire Station.  

15.242 At 22:48, Station Manager Berry called NWFC and spoke to the Control Room Operator Dean Casey. By the time of the call, Station Manager Berry was probably in his car setting off for Philips Park Fire Station. At the outset of the call, Station Manager Berry stated: “I’ve been trying to get hold of the Force Duty Officer, but they’re not picking up for obvious reasons, they’re probably really busy.” In saying this, Station Manager Berry correctly identified the reason for the difficulty in communication. His recognition of this should have caused him to reassess his plan. As I explained in paragraphs...
15.87 to 15.94, Station Manager Berry was not assisted in this by the fact that Dean Casey did not provide an adequate update. Station Manager Berry informed Dean Casey that he had spoken to Group Manager Buckley and instructed the Specialist Response Team to muster at Philips Park Fire Station. 312

15.243 Station Manager Berry stated that he expected NWFC to try and get through to the FDO on his behalf. 313 He did not give Dean Casey an instruction to that effect. Station Manager Berry should not have assumed that NWFC would try to contact the FDO. It is important that, in a fast-moving incident in which the capacity of all the emergency services will be stretched, clear instructions are given in relation to important tasks.

Opportunity to re-evaluate

15.244 By the end of his call with Dean Casey, Station Manager Berry had been aware of the Attack for over 10 minutes. In fact, 20 minutes had passed since the explosion, but Station Manager Berry was not aware of this because he had not asked. He had mobilised resources three miles away from the location of the Attack. He had made numerous attempts to contact the FDO, all of

312 INQ001215/1
313 119/214/1-24
which were unsuccessful. He had recognised that the FDO was very busy. He set off in his car to the muster point at Philips Park Fire Station.

15.245 Before getting into his car, Station Manager Berry should have re-evaluated his strategy. He should have asked what NWAS and BTP were doing. Had he thought to ask these specific questions of NWFC, he would have learned that ambulances were being dispatched to the scene, as the NWAS approach was set out in clear terms in the NWFC Arena log. An instruction to NWFC to call BTP and request information would have quickly revealed that BTP officers had reached the seat of the explosion fewer than two minutes after the detonation.

15.246 Like GMFRS, NWAS operated a system of NILOs. At no point during the critical period of the response did Station Manager Berry contact his equivalent NILO at NWAS, whether through NWFC or any other means. This was an error on his part. It was an obvious way to mitigate the problem he was faced with. While I am critical of Station Manager Berry for not doing this, principal responsibility for him not doing so lies with GMFRS.

15.247 As I set in out in Part 12, the FDO becoming overburdened during a Major Incident, such as the Attack, was well known within GMP prior to
22nd May 2017. In all of its planning, training and exercising, GMFRS failed to identify this fact and make provision for it. GMFRS had not, for example, ensured that its own NILOs had the contact details of NWAS NILOs. It should have done so. Station Manager Berry had received no training on what he should do if he could not speak to the FDO. Although I am critical of Station Manager Berry for not trying to find out what other emergency services were doing, he had not been adequately prepared by GMFRS for the situation in which he found himself on 22nd May 2017.

Decision to travel to Philips Park Fire Station

Station Manager Berry was at home when he received the call from Michelle Gregson. At over 20 miles from Philips Park Fire Station, he expected his journey there to take at least 30 minutes. He travelled under blue lights. On the night, roadworks caused Station Manager Berry to become lost. This added to the stress he was under and diminished his ability to make the best decisions.

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314 INQ042436/16-17 at paragraph 59
315 121/31/14-32/9
316 INQ042436/33-34 at paragraph 119
317 121/29/11-25, 121/30/19-31/13
318 119/190/10-18
319 120/44/16-17
320 120/45/25-47/18
15.249 At the time he departed, Station Manager Berry was not to know that these problems would occur. But a journey of that length, at speed and at night was always going to give rise to a risk of delay. It would never have provided an ideal environment in which to focus on important telephone calls and make decisions critical to the GMFRS response.

15.250 Station Manager Berry would have been better placed participating in the incident from his home, rather than travelling to Philips Park Fire Station. The issue of whether or not the NILO should mobilise or perform his or her function remotely had not been tested by GMFRS prior to the Attack.\(^{321}\) This was a failing on the part of GMFRS, which placed Station Manager Berry in a position where he was left doing what he thought was right based on the information he had.\(^{322}\)

**Journey to Philips Park Fire Station**

15.251 The tracking system on Station Manager Berry’s vehicle recorded him as setting off at 22:56. In fact, he set off earlier than this, probably prior to 22:48. He arrived at Philips Park Fire Station at

\(^{321}\) 119/192/1-8

\(^{322}\) 119/192/1-13, INQ042436/18-19 at paragraph 68
23:40. During the journey, he continued to try calling the FDO.

15.252 While he was driving, Station Manager Berry participated in a number of telephone calls with senior GMFRS personnel. He also called NWFC at 22:48, 22:52 and 22:57. During those calls, NWFC did not inform Station Manager Berry that there were police and paramedics at the scene. Nor was he told that the NWAS “Bronze Commander” was at the scene.

15.253 Station Manager Berry stated that, if he had been given this information, “we’d quite clearly deployed probably straight to the arena, proceeding with caution.” In my view, it is possible that Station Manager Berry would have mobilised GMFRS resources to the scene if he had been given this information. I am not convinced that he would have done so. During this period, Station Manager Berry was focused on contacting the FDO as the route by which his decision would be reviewed. That is what Station Manager Berry believed he needed to do.

Challenged as he was by the incident and his particular circumstances, Station Manager Berry
was not thinking flexibly at that time. The circumstances were far from ideal for making what could be life-saving decisions.

15.254 At 23:02, Station Manager Berry called Group Manager Nankivell back, having missed a call from him earlier. They spoke for over two minutes.\(^{328}\) At 23:13, Station Manager Berry spoke to Group Manager Fletcher for over two minutes.\(^{329}\)

15.255 Station Manager Berry spoke to Group Manager Levy at 23:18 for over a minute. By this stage Group Manager Levy had been mobilised as a NILO and had just spoken to NWFC.\(^{330}\)

15.256 At 23:26, Station Manager Berry was called by Crew Manager Anthony Henshall. Crew Manager Henshall had missed a call from Station Manager Berry at just after 23:00.\(^{331}\) Crew Manager Henshall was Station Manager Berry’s support officer and delivered training to the Specialist Response Team officers in Marauding Terrorist Firearms Attack response. Station Manager Berry asked Crew Manager Henshall to mobilise and assist with the response to the Attack. He

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328 INQ041473/32
329 INQ041473/42
330 INQ041473/44
331 INQ041473/48
directed Crew Manager Henshall to Philips Park Fire Station.\textsuperscript{332}

15.257 Station Manager Berry told Crew Manager Henshall that he \textit{“had tried to get hold of the FDO but couldn’t get hold of them via phone”}.\textsuperscript{333} It had been over 40 minutes since Station Manager Berry had first tried the FDO. A different approach was required and should have been explored in the preceding 40 minutes.

15.258 Shortly after his arrival at Philips Park Fire Station at 23:33, Group Manager Meakin rang Station Manager Berry. They spoke for nearly two minutes.\textsuperscript{334} At 23:37, Station Manager Berry spoke to Group Manager Fletcher for a second time.\textsuperscript{335}

15.259 At 23:40, Station Manager Berry arrived at Philips Park Fire Station.\textsuperscript{336}

15.260 I shall consider some of the calls I mentioned above in due course. Before I do, I shall set out what happened as a consequence of Station Manager Berry’s mobilise instruction to NWFC.

\begin{footnotesize}
\begin{enumerate}
\item 332  INQ024677/7
\item 333  INQ024677/7
\item 334  INQ041473/51
\item 335  INQ041473/53
\item 336  INQ004300/1
\end{enumerate}
\end{footnotesize}
Mobilisation of non-specialist fire appliances

At Philips Park Fire Station

15.261 Following her call with Station Manager Berry, at 22:45 Michelle Gregson called Watch Manager Helmrich at Philips Park Fire Station. She informed him that Philips Park Fire Station had been made the muster point by Station Manager Berry “because you are some distance from … the incident”. She told Watch Manager Helmrich that the FDO was being spoken to. In the course of the call, Michelle Gregson said, “[T]here’s confirmed … gunshot wounds.”

15.262 The information in relation to gunshot wounds reflected an entry made in the Arena log by David Ellis in the course of his call with GMP Control. The entry was made at the same time as Michelle Gregson’s call to Watch Manager Helmrich. By the time GMP Control had provided updated information confirming that the injury in question was from shrapnel, Michelle Gregson’s call with Watch Manager Helmrich had ended.

15.263 It is unfortunate but unavoidable in situations such as the Attack that some people involved in a response may receive only a snapshot of
information, and that information may then turn out to be incorrect. I am not critical of Michelle Gregson for providing this information: it was information that was recorded on the Arena log as she was speaking to Watch Manager Helmrich. I heard no evidence that led me to conclude that the provision of this information to Watch Manager Helmrich adversely affected the emergency response. Watch Manager Helmrich’s reaction was to believe it was “just a local issue” as “gunshot wounds [are] not uncommon in Greater Manchester”.  

15.264 There was one fire appliance at Philips Park Fire Station on the night of the Attack. At 22:49, this fire appliance was allocated to the GMFRS response to the Attack. As it was already at Philips Park Fire Station, it was already at the muster point identified by Station Manager Berry.

From Manchester Central Fire Station

15.265 On the night of 22nd May 2017, Watch Manager Simister was in command of a crew manager and six firefighters at Manchester Central Fire Station. There were two fire appliances available to him.

341 70/77/23-78/8
342 70/71/5-8
343 INQ041473/19
Watch Manager Simister and his team had come on duty at 19:00.\textsuperscript{344}

15.266 Watch Manager Simister heard the explosion when the bomb was detonated. He was used to hearing bangs and did not realise the noise he had heard was from a bomb.\textsuperscript{345}

15.267 At 22:38, a pre-alert was sent to Manchester Central Fire Station because David Ellis had selected it, on the Arena log, as the closest fire station to the Arena. Manchester Central Fire Station is 1.2 kilometres from the Arena.\textsuperscript{346} Watch Manager Simister and his team got into their “fire gear” and waited for confirmation of the mobilising instruction.\textsuperscript{347} Eight minutes later, a second pre-alert was automatically transmitted to Manchester Central Fire Station.\textsuperscript{348}

15.268 At about the time of the second pre-alert, one of Watch Manager Simister’s team answered a call from Watch Manager Julie Walker at Gorton Fire Station, asking why the Manchester Central team had not mobilised to the Arena. Watch Manager Walker informed the Manchester Central team that a bomb had gone off.\textsuperscript{349} I will deal with how
Watch Manager Walker came to learn of the Attack in paragraphs 15.273 to 15.277.

15.269 Watch Manager Simister thought that he and his team would be mobilised to the Arena at “any minute”.\(^{350}\) He instructed his crews to open the fire station doors and board their fire appliances. He could see “a sea of blue lights heading towards the arena”.\(^{351}\) He stated that he and his crew wanted to go to the Arena “because that’s our job … We’ve got first aid capabilities … people are in distress and that’s our job to go.”\(^{352}\)

The standard fire appliances based at Manchester Central Fire Station each had a type of stretcher called a spinal board, a tourniquet and dressings on board.\(^{353}\)

15.270 Once they were in their firefighting gear following the first pre-alert, it would have taken Watch Manager Simister and his team, travelling in the two fire appliances, three minutes to reach the Arena.\(^{354}\) Eight firefighters could have been at the Arena by 22:45, had they been mobilised to go there at 22:42.

15.271 The mobilisation instruction came through to Manchester Central Fire Station at 22:49:

\(^{350}\) 69/136/9
\(^{351}\) 69/136/12
\(^{352}\) 69/137/4-13
\(^{353}\) 70/4/19-24/24
\(^{354}\) 69/137/14-21, 71/116/16-21
Watch Manager Simister and his team were directed, not to the Arena but to Philips Park Fire Station.\(^{355}\) As he was leaving, Watch Manager Simister saw two ambulances pulling on to the forecourt of Manchester Central Fire Station. The driver of Watch Manager Simister’s fire appliance was told by one of the occupants of the ambulances: “\(W\)e’ve been told to come here.”\(^{356}\) These two ambulances were the first of six ambulances which assembled at Manchester Central Fire Station between 22:49 and 23:02. Those ambulances drove to Hunts Bank in convoy at 23:06.\(^{357}\)

15.272 At 22:54 and 22:55, the two fire appliances from Manchester Central Fire Station arrived at Philips Park Fire Station.\(^{358}\)

**From Gorton Fire Station**

15.273 Crew Manager Mottram was on duty at Gorton Fire Station on the night of the Attack. Gorton Fire Station is approximately three miles from Manchester Central Fire Station.\(^{359}\) Also present was his line manager, Watch Manager Walker.

15.274 Shortly after 22:30, Crew Manager Mottram received a telephone call from his wife, Helen
Mottram, who worked as a paramedic for NWAS. She was on duty that night. At 22:37, the ambulance she was in was allocated by NWAS Control to attend the Arena. Mottram asked her husband whether he had heard anything about a bomb going off at the Arena. She told him that she had been mobilised to attend and was on her way to the Arena.

15.275 In due course, Helen Mottram was diverted by NWAS Control to Manchester Central Fire Station. She arrived there at 22:53. She subsequently drove to Hunts Bank, with five other ambulances, leaving the fire station at 23:06.

15.276 Crew Manager Mottram told Watch Manager Walker about the telephone call from Helen Mottram. Together, they investigated what GMFRS mobilisations to the Arena had occurred. They discovered that there had been none. Watch Manager Walker telephoned Manchester Central Fire Station and had the conversation I described in paragraph 15.268.

15.277 At 22:49, the fire appliance to which Crew Manager Mottram was assigned was mobilised to
Philips Park Fire Station. He arrived five minutes later.

Mobilisation of specialist crews

Mobilisation from Fire Station A

15.278 On the night of 22nd May 2017, Watch Manager Jonathan Nolan was based at a fire station in the Greater Manchester area (Fire Station A). Watch Manager Nolan was the leader of the Specialist Response Team and was in command of four of its operatives located at Fire Station A. There was one Specialist Response Team appliance at Fire Station A on the night of the Attack.

15.279 Specialist Response Team appliances did not have a firefighting capability. The design of the vehicle was suitable for operation in an area where there might be firearms. The vehicle was equipped with ballistic protection for the Specialist Response Team operatives. It contained first aid equipment over and above that of a standard fire appliance. The first aid equipment included a blast dressing, ballistic dressings and blood clotting dressings. It contained chest seals for puncture wounds and tourniquets. This equipment was carried in a
rucksack by Specialist Response Team operatives attending an incident. Specialist Response Team appliances also carried five skeds: a type of stretcher designed for the rapid evacuation of casualties. Specialist Response Team operatives were trained in the use of this equipment. They trained with NWAS’s Hazardous Area Response Team (HART) operatives. This training anticipated that they would operate alongside paramedics and top up their first aid equipment from paramedics.\(^{368}\)

15.280 At the time of the Attack, Watch Manager Nolan and his Specialist Response Team colleagues were attending a road traffic collision about one mile from Fire Station A. They had attended in a standard fire appliance. All of the Specialist Response Team equipment was at Fire Station A.\(^{369}\) Shortly before 22:45, Watch Manager Nolan was informed by police officers, who had attended the road traffic incident, that something had happened in Manchester City Centre and the police officers needed to leave.\(^{370}\)

15.281 Watch Manager Nolan instructed Crew Manager Andrew Waterhouse to contact the duty NILO through NWFC. At 22:42, Crew Manager Waterhouse spoke to Rochelle Fallon.

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368 71/12/25-18/24, 71/24/19-26/12, INQ024677/3
369 71/30/23-31/18
370 71/32/5-12
He explained that he needed to speak to the NILO. Rochelle Fallon called Station Manager Berry at 22:44. The call went to Station Manager Berry’s voicemail and Rochelle Fallon left a message.

15.282 Watch Manager Nolan then spoke to Group Manager Buckley, who was also present at the road traffic incident. Group Manager Buckley called Station Manager Berry. Station Manager Berry instructed Watch Manager Nolan’s Specialist Response Team crew to leave the road traffic incident, if they could, and put on their kit for a Marauding Terrorist Firearms Attack.

15.283 In his call to NWFC at 22:48, Station Manager Berry informed Dean Casey that he had spoken to Group Manager Buckley. He told Dean Casey: “They [the Specialist Response Team crew] are going to pick the vehicle up and the capability for the MTFA [Marauding Terrorist Firearms Attack] … And they are going to rendezvous at Philips Park, until we are instructed otherwise and get some more information about this incident.”

15.284 At 22:53, Watch Manager Nolan called NWFC. He informed the Control Room Operator he spoke to that, “On the instruction of Station
Manager Berry we’re taking [the Specialist Response Team appliance] to Philips Park … that’s the rendezvous point isn’t it?"³⁷⁴

15.285 Watch Manager Nolan’s Specialist Response Team appliance was mobilised on NWFC’s system by Joanne Haslam at 23:02. At this point, Watch Manager Nolan and his Specialist Response Team crew were at Fire Station A and were close to leaving.³⁷⁵ Eight minutes later, NWFC was notified by radio that the Specialist Response Team appliance was en route to the RVP.³⁷⁶

15.286 At 23:21, Watch Manager Nolan’s Specialist Response Team appliance arrived at Philips Park Fire Station.³⁷⁷

Mobilisation from Fire Station B

15.287 Watch Manager Nolan’s team were not the only specialist firefighters mobilised to Philips Park Fire Station. At 22:52, Station Manager Berry had directed NWFC to “make … MTFA capability two”.³⁷⁸ At 23:02, Joanne Haslam mobilised a second Specialist Response Team appliance.³⁷⁹
This Specialist Response Team appliance was based at Fire Station B.

15.288 At 23:03, Lisa Owen telephoned Fire Station B and spoke to a watch manager. Lisa Owen explained that she was mobilising two Specialist Response Team appliances. She mentioned the Technical Response Unit “with MTFA capability”. This was because shortly before this call Group Manager Nankivell had directed Joanne Haslam to mobilise the Technical Response Unit “with their MTFA kit”.

15.289 The watch manager that Lisa Owen spoke to said: “[W]e’ve just been talking about that. We’re gonna take the TRU [Technical Response Unit] and MRU [Major Response Unit], so we’ll take three vehicles but we will have got the MTFA capability and … we’ll have the ballistics sets as well.” The Major Response Unit appliance is an enhanced response vehicle with rescue capabilities.

15.290 As a result of this conversation, three specialist vehicles mobilised from Fire Station B: a Specialist Response Team appliance, a Technical Response Unit appliance and a Major Response
By 23:46, these specialist vehicles had arrived at Philips Park Fire Station.\footnote{385}

Before considering what took place at Philips Park Fire Station, it is necessary to deal with the mobilisation of a number of senior GMFRS officers, two of whom were to attend Philips Park Fire Station.

Mobilisation of duty Group Manager

Call from NWFC (22:52)

Group Manager Nankivell was the duty Group Manager. The initial call from NWFC to him was at 22:52. I set out in paragraphs 15.114 to 15.120 the information he was given. He was told that there had been an explosion at the Arena, that a bomb had gone off, and that fire appliances had been mobilised to Philips Park Fire Station. He was also told that there was an unconfirmed report of an active shooter. Joanne Haslam started to tell him about the GMP RVP, but Group Manager Nankivell spoke across her to ask if a Major Incident had been declared. He was told that NWAS had a "bronze commander … at the scene".\footnote{386}
15.293 Group Manager Nankivell stated that the significance of the information about the NWAS “bronze commander” did not register with him, as he was thinking about his next actions.\textsuperscript{387} I accept his evidence. While it was a failing on his part, he should not have been the only GMFRS officer given this information by NWFC.

15.294 So far as the use of Philips Park Fire Station was concerned, Group Manager Nankivell stated: “I took the view that the duty NILO had made that decision for a tactical or strategic reason and that’s why we were sending the pumps [fire appliances] to Philips Park.”\textsuperscript{388} Group Manager Nankivell should have challenged this decision when he spoke to Station Manager Berry.\textsuperscript{389}

15.295 In the course of the call, Group Manager Nankivell directed Joanne Haslam to mobilise the Technical Response Unit “with their MTFA kit” to Philips Park Fire Station.\textsuperscript{390}

**Call to Station Manager Berry (23:02)**

15.296 At 23:02, Group Manager Nankivell called Station Manager Berry. Group Manager Nankivell informed Station Manager Berry that he was

\textsuperscript{387} 128/202/17-204/6

\textsuperscript{388} 129/9/14-20

\textsuperscript{389} 142/153/2-22, INQ042436/25 at paragraph 90

\textsuperscript{390} INQ001224/3
mobilising to the Command Support Room. Station Manager Berry informed Group Manager Nankivell that he had mobilised additional NILOs. 391

15.297 Group Manager Nankivell stated that he was not told by Station Manager Berry about difficulties in contacting the FDO. 392 Station Manager Berry stated that he did tell Group Manager Nankivell this. 393 I prefer Station Manager Berry’s evidence on this point, as I think it is more likely to be correct in view of what was happening at the time. This is for a number of reasons. First, Station Manager Berry mentioned that he was having difficulty getting hold of the FDO in a conversation with the Control Room Operator Dean Casey approximately 15 minutes earlier, to Crew Manager Henshall about 20 minutes later and to Group Manager Meakin half an hour later. Second, Group Manager Nankivell accepted that his recollection of the conversation was “a bit grainy”. 394 Third, getting hold of the FDO had been Station Manager Berry’s preoccupation for some time. I consider it unlikely that he would not have mentioned that fact in his first call with the duty Group Manager.
15.298 Although I accept that Station Manager Berry informed Group Manager Nankivell that he was having difficulties getting hold of the FDO, I do not consider that Station Manager Berry made it sufficiently clear to Group Manager Nankivell that GMFRS’s whole mobilisation strategy was dependent on speaking to the FDO. If Station Manager Berry had informed Group Manager Nankivell of this, I consider it likely that Group Manager Nankivell would have remembered being told and would have reacted. Station Manager Berry should have been clearer with Group Manager Nankivell about the strategy.

15.299 Station Manager Berry stated that he asked Group Manager Nankivell to contact the FDO, to which Group Manager Nankivell responded “Right.” Although I accept Station Manager Berry’s evidence that he did mention the difficulties he was having contacting the FDO, I consider Station Manager Berry to be mistaken in his recollection that he asked Group Manager Nankivell to call the FDO.

15.300 As I set out at paragraph 15.297, Group Manager Nankivell had no recollection of the FDO being mentioned at all. While he was very experienced, Group Manager Nankivell was not and never had been a NILO. Group Manager Nankivell struck
me as a conscientious officer, doing what he could to support the GMFRS response. Group Manager Nankivell saw Station Manager Berry “as the incident commander”. In my view, if Group Manager Nankivell had received a clear request from Station Manager Berry to contact the FDO, he would have done so.

15.301 Station Manager Berry stated that he had told Group Manager Nankivell that he hadn’t deployed to the scene or the RVP. Again, I consider Station Manager Berry to be mistaken in his recollection of the GMP RVP being mentioned by him. Station Manager Berry believed he had mentioned this to other GMFRS officers, but they did not recall him doing so. I will deal with these calls in paragraphs 15.366 to 15.372, 15.376 to 15.387 and 15.425 to 15.427. Station Manager Berry had rejected the GMP RVP early in his involvement. On balance, I consider it more likely that Station Manager Berry did not mention the rejected GMP RVP to Group Manager Nankivell. As I have already said, deciding between two different recollections of phone calls is not easy.

15.302 Station Manager Berry should have told Group Manager Nankivell that GMP had provided an
RVP early in the incident, which he had rejected on safety grounds.

Other calls before arrival at Command Support Room

15.303 In the section dealing with NWFC’s response, from paragraph 15.139 onwards, I set out a number of calls Group Manager Nankivell had with NWFC after his call with Station Manager Berry. In his call with NWFC at 23:11, Group Manager Nankivell confirmed that he was content that the Major Response Unit appliance and Technical Response Unit appliance from Fire Station B had been mobilised to Philips Park Fire Station.399

15.304 Group Manager Nankivell made a number of other calls before arriving at the Command Support Room. Those calls were with the duty Assistant Principal Officer, duty Principal Officer, Group Manager Fletcher and Group Manager Levy. I will address those calls as I come to consider the start of each of those GMFRS officers’ involvement in the response.

15.305 Group Manager Nankivell arrived at the Command Support Room at approximately 23:41.400
Mobilisation of duty Assistant Principal Officer

Call from Group Manager Nankivell (22:57)

15.306 Following his call with NWFC at 22:52, Group Manager Nankivell called the duty Assistant Principal Officer, Area Manager Paul Etches. They spoke at 22:57 for just over two minutes. Area Manager Etches was concerned to establish whether this was a real incident rather than a live exercise. They both sought to find out more from the news. They agreed to meet at the Command Support Room.\(^{401}\)

15.307 As a result of Group Manager Nankivell failing to register the significance of the information from Joanne Haslam, regarding the NWAS “bronze commander” being at the scene, as mentioned in paragraph 15.293, he did not pass this information on to Area Manager Etches.\(^{402}\) Group Manager Nankivell did not pass this information on to any other GMFRS officer at any point during the critical period.

15.308 After the call had concluded, Area Manager Etches watched the television news reports on the Attack, to try to get some situational awareness.\(^{403}\)

\(^{401}\) 129/1/25-2/13, 129/173/7-21
\(^{402}\) 129/173/22-174/8
\(^{403}\) 129/179/5-25
15.309 NWFC’s incident logs can be viewed via the iNet platform. In common with other GMFRS officers who responded to the Attack, Area Manager Etches had access to iNet via a laptop. Area Manager Etches did not seek to obtain situational awareness though iNet, and neither did other GMFRS officers. Area Manager Etches and those other GMFRS officers should have done so.\textsuperscript{404}

15.310 I am not critical of Area Manager Etches and his colleagues for not doing this. It was a training and exercising failure by GMFRS. It was not part of the culture of a GMFRS response to a Major Incident for officers to review iNet as a way of learning more about a Major Incident while it was ongoing.\textsuperscript{405}

15.311 There was evidence of one GMFRS officer, who did not become involved in the response to the Attack during the critical period, using iNet. I shall address that in paragraphs 15.391 to 15.392.

15.312 A number of GMFRS officers had an opportunity, in the early stages of their involvement in the response, to take a few minutes and access the NWFC incident log on iNet. Had they done so, this would have improved the GMFRS response. It is highly likely that the presence of police and paramedics at the scene would have been

\textsuperscript{404} 129/180/1-16  
\textsuperscript{405} 129/180/17-181/11
identified and acted upon sooner by senior GMFRS officers.

15.313 It is notable that Station Manager Michael Lawlor stated that his reason for not asking NWFC for an update was concern at how busy NWFC was. This should not have been a deterrent to proper communication with NWFC for any GMFRS officer. One way in which GMFRS officers could occupy less of NWFC operatives’ time could be if they also referred to the incident log in appropriate circumstances.

15.314 Such checks should not take priority over individuals mobilising to an incident ground. Nor should such checks replace direct communication with NWFC. NWFC staff are more expert in the interpretation and management of information in their incident logs. It is also very important that NWFC and GMFRS work together and maintain an ongoing dialogue. Agreement will need to be reached between GMFRS and NWFC on the circumstances in which the checking of incident logs by GMFRS officers will occur so that each organisation knows what the other is doing.

15.315 I recommend GMFRS and NWFC conduct a joint review of the circumstances in which it is appropriate for GMFRS personnel to check the NWFC incident log. Policies should be written by both organisations to reflect the outcome of this
review and training delivered to embed it into practice.

Call from Group Manager Nankivell (23:09)

15.316 Group Manager Nankivell telephoned Area Manager Etches for a second time at 23:09, immediately after Group Manager Nankivell had spoken to the duty Principal Officer.⁴⁰⁶ I will address Group Manager Nankivell’s call with the duty Principal Officer in paragraphs 15.325 to 15.331. Area Manager Etches stated that he thought, but was not sure, that it was in this second call, rather than the first, that Group Manager Nankivell informed him about the mobilisation to Philips Park Fire Station.⁴⁰⁷

15.317 It is not necessary for me to resolve whether it was in this first call or the second. By reason of a call made by Area Manager Etches at 23:11, which I deal with in paragraphs 15.159 to 15.163, I am satisfied that it was in one of those two conversations that Area Manager Etches was told about the Philips Park mobilisation.

15.318 They did not discuss whether or not Philips Park Fire Station was an appropriate RVP. Group Manager Nankivell’s view was that this was a decision for the duty NILO to make.⁴⁰⁸

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⁴⁰⁶ INQ041473/37
⁴⁰⁷ 129/174/9-17
⁴⁰⁸ 129/9/4-20
15.319 Based on what he knew, Area Manager Etches considered the choice of Philips Park Fire Station to be an appropriate one. He did not know, however, that approximately 30 minutes or more had passed since the explosion. He assumed that he would have been contacted earlier on in the incident response. He accepted, in evidence, that he should have asked how long it had been since the explosion.

Call to NWFC (23:12)

15.320 Shortly after his second call with Group Manager Nankivell, Area Manager Etches contacted NWFC at 23:12. He spoke to Rochelle Fallon. The purpose of his call was recorded on the incident log as mobilising to the Command Support Room. It is clear from what he says in this call that Area Manager Etches had learned from Group Manager Nankivell about the deployment to Philips Park Fire Station.

15.321 In the course of the call, Area Manager Etches asked Rochelle Fallon whether NWFC had “had anything back from anywhere?” Area Manager Etches then informed Rochelle Fallon that he had spoken to Group Manager Nankivell and knew of the Philips Park Fire Station.
mobilisation. Rochelle Fallon told Area Manager Etches that they were getting more information from the police and ambulance services “every time they get anything about a fatality”.  

15.322 Area Manager Etches stated in evidence:

“I think potentially I was seeking more information … they were just getting more information from ambulance and police and we got that update around the fatalities at that point in time. It started to paint the picture. I’m not sure I was seeking more at that time in my role.”

15.323 I set out my criticism of NWFC’s role in this call with Area Manager Etches in paragraphs 15.159 to 15.163. In Area Manager Etches’ case, given that this was his first contact with NWFC and he had not reviewed the incident logs himself, he should have made a clear request for a comprehensive briefing on the incident.

15.324 At 23:22, Area Manager Etches left his home. He arrived at the Command Support Room at 23:40.
Mobilisation of duty Principal Officer

15.325 At 23:08, Group Manager Nankivell called the duty Principal Officer, Chief Fire Officer Peter O’Reilly. The call lasted one minute and 20 seconds. Group Manager Nankivell called Chief Fire Officer O’Reilly a second time at 23:23 for approximately 40 seconds. At 23:37, Chief Fire Officer O’Reilly spoke to Group Manager Nankivell on the telephone for a third time in a call lasting nearly three and a half minutes.

Call from Group Manager Nankivell (23:08)

15.326 In the first of these calls, Group Manager Nankivell informed Chief Fire Officer O’Reilly that there had been an incident at the Arena. Group Manager Nankivell said that he and Area Manager Etches were going to open up the Command Support Room. Chief Fire Officer O’Reilly said that he would meet Group Manager Nankivell at the Command Support Room. This surprised Group Manager Nankivell as his expectation was that, as Gold Commander, the duty Principal Officer would go to GMP HQ.

15.327 Group Manager Nankivell stated in evidence that he had informed Chief Fire Officer O’Reilly of the
mobilisation to Philips Park Fire Station.\textsuperscript{422} Chief Fire Officer O’Reilly stated, when he gave evidence, that he did not believe he was told about the mobilisation to Philips Park Fire Station until a call at 23:37 with Group Manager Nankivell. Chief Fire Officer O’Reilly stated that he was told in that later call that the Marauding Terrorist Firearms Attack capability was at Philips Park Fire Station. He also stated that he assumed the Marauding Terrorist Firearms Attack resources were being held back and that other resources were at the scene.\textsuperscript{423}

15.328 I prefer the evidence of Group Manager Nankivell on this point. In my view, it is likely that Group Manager Nankivell did tell Chief Fire Officer O’Reilly about the mobilisation to Philips Park Fire Station in the earlier conversation.

15.329 Group Manager Nankivell told Area Manager Etches about the mobilisation to Philips Park Fire Station prior to 23:12. At 23:12, Area Manager Etches called NWFC and informed Rochelle Fallon that Group Manager Nankivell had told him about the mobilisation to Philips Park Fire Station.\textsuperscript{424} This could only have come from Area Manager Etches’ calls with Group Manager Nankivell at 22:57 and/or 23:09. I consider it

\textsuperscript{422} 129/8/17-9/3  
\textsuperscript{423} 132/7/2-11, 132/9/22-11/12  
\textsuperscript{424} INQ034353T
unlikely that Group Manager Nankivell would have provided this information to the duty Assistant Principal Officer but not to the duty Principal Officer, especially when the conversations occurred at around the same time. It is probable that Chief Fire Officer O’Reilly is mistaken as to when Group Manager Nankivell provided this information.

15.330 I accept Chief Fire Officer O’Reilly’s evidence that when he was told about Philips Park Fire Station he incorrectly assumed it was being used for resources that were being held back.

15.331 Following the first call with Chief Fire Officer O’Reilly, Group Manager Nankivell informed NWFC at 23:11 that Chief Fire Officer O’Reilly would be mobilising to the Command Support Room. At 23:15, a mobilisation to the Command Support Room notification was sent by NWFC to Chief Fire Officer O’Reilly.

Call from Group Manager Nankivell (23:23)

15.332 Group Manager Nankivell made a second call to Chief Fire Officer O’Reilly at 23:23. It related to Group Manager Nankivell’s intention to inform NWFC not to authorise GMFRS resources to Manchester City Centre unless there were a
threat to life. Chief Fire Officer O’Reilly ratified this decision by saying “good call, Dean”.\textsuperscript{427}

15.333 At the conclusion of this short call, Group Manager Nankivell immediately telephoned NWFC. He spoke to the Control Room Operator David Ellis and gave the instruction.\textsuperscript{428}

Call to Group Manager Nankivell (23:37)

15.334 After missed calls both ways in the minute before, at 23:37 Chief Fire Officer O’Reilly called Group Manager Nankivell. He informed Chief Fire Officer O’Reilly that news of the Attack was starting to be reported in the media. He told Chief Fire Officer O’Reilly that Group Manager Levy was on his way to Philips Park Fire Station.\textsuperscript{429} By the end of the call, Group Manager Nankivell was at the Command Support Room with Area Manager Etches.

15.335 Chief Fire Officer O’Reilly replied to say that he was only a short distance from the Command Support Room.\textsuperscript{430}
Decision to mobilise to Command Support Room

15.336 In the call at 23:08, Chief Fire Officer O’Reilly decided to mobilise to the Command Support Room. In evidence he stated:

“Based on the information that I had at that time, I was quite confident that going to my own headquarters, to speak to the CSR [Command Support Room], to see what the incident actually was, was the best course of action.”\(^{431}\)

15.337 Chief Fire Officer O’Reilly could have chosen to go to GMP HQ. This would have provided him with a greater understanding of at least two things: where GMP had deployed its resources and what GMP knew about the incident. He might also have spoken to representatives of NWAS who were present. By 23:15, Annemarie Rooney, the NWAS Tactical Commander, was at GMP HQ.\(^{432}\)

15.338 At the time Chief Fire Officer O’Reilly decided to go to the Command Support Room, no one from GMFRS had been allocated to attend GMP HQ. Chief Fire Officer O’Reilly did not learn that GMP planned for emergency response commanders to go to GMP HQ until half an hour after he made the decision to go to the Command Support Room.

\(^{431}\) 132/5/5-11

\(^{432}\) INQ014791/5
In my view, it would have been better if Chief Fire Officer O’Reilly had gone to GMP HQ rather than the Command Support Room. My conclusion is not based on hindsight, but on the information Chief Fire Officer O’Reilly had at the time.

On the information Chief Fire Officer O’Reilly was given by Group Manager Nankivell, the response to the Attack was inevitably a multi-agency one. The scale of the incident also meant that it was inevitable other agencies would appoint Strategic/Gold Commanders. Group Manager Fletcher stated that it was well known from the policies and procedures in place that multi-agency discussions would take place at GMP HQ. Group Manager Meakin’s expectation was that “if a Gold structure is established, then the Principal Officer for the evening would ordinarily go to Gold Command … generally at Force [GMP] Headquarters.” Chief Fire Officer O’Reilly did not think it was likely that the GMP Strategic/Gold Commander would be at GMP HQ. He was incorrect. Assistant Chief Constable (ACC) Deborah Ford arrived at GMP HQ at 23:15.
15.340 Much later that night, shortly after 02:00, Chief Fire Officer O’Reilly went to GMP HQ. He did so having been notified of a Strategic Co-ordinating Group meeting at 02:30. Chief Fire Officer O’Reilly arrived in the Silver Command Room at GMP HQ at 02:10. In the end, the meeting took place at 04:15.

15.341 Returning to consider Chief Fire Officer O’Reilly’s decision-making process: at 23:08, Chief Fire Officer O’Reilly had not been told that GMFRS had any resources at the scene. The only location mentioned was Philips Park Fire Station. It was of paramount importance for GMFRS to gain situational awareness. The best way to do that was to co-locate with partner agencies. GMP HQ was the obvious place to do that. It was the expectation of Group Manager Nankivell and Group Manager Meakin that the duty Principal Officer would ordinarily go to GMP HQ in response to a Major Incident.

15.342 I recognise that there was no written GMFRS policy directing the duty Principal Officer or Gold Commander to GMP HQ during a Major Incident. There should have been. The GMFRS guidance on the Command Support Room stated: “The duty APO [Assistant Principal Officer] will
ordinarily take command of the CSR [Command Support Room] supported by a suitably trained CSRO [Command Support Room Officer].” References to the duty Principal Officer in this guidance did not indicate where the duty Principal Officer should locate themselves. The most assistance it gave was, “The CSR will ordinarily be led by the duty APO, or in some circumstances by the duty PO [Principal Officer].”

15.343 The role of Gold Commander in the GMFRS is not to command the incident, but to act in support. Group Manager Nankivell and Area Manager Etches were capable of managing the Command Support Room.

15.344 Chief Fire Officer O’Reilly needed to make a short journey from his home in any event, whether going to the Command Support Room or to GMP HQ. The balance of the decision about where to go may have been different if Chief Fire Officer O’Reilly had already been in the Command Support Room when he learned of the incident.

15.345 Chief Fire Officer O’Reilly arrived at the Command Support Room at 23:49.
Assistant Chief Fire Officer Keelan

15.346 Assistant Chief Fire Officer David Keelan was off duty on the night of the Attack. After he returned from a meal out, he saw a news report on Sky News. At 23:02, he forwarded a tweet from Sky News to a GMFRS NILO WhatsApp group. The headline read: “Greater Manchester Police warning people to stay away from Manchester Arena as officers respond to ‘incident’ amid reports of an explosion.” At 23:08, he sent a message to the same WhatsApp group enquiring, “Any update?”

15.347 He sent the messages because “that’s something we would do for incidents that occurred that we were aware of”.

15.348 Assistant Chief Fire Officer Keelan played a very limited role during the critical period of the response. He received three calls: at 23:28, 23:35 and 23:37. These were from Group Manager Fletcher, Group Manager Nankivell and Station Manager Lawlor respectively. He also sent some messages to the GMFRS command leadership team.

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445 INQ019040/1
446 133/4/18-5/13
447 INQ041473/52-53
448 133/6/24-7/14
15.349 Assistant Chief Fire Officer Keelan made the decision not to involve himself further that night. He was conscious that the response by emergency services would not be confined only to the night of 22nd May 2017. He recognised that at some point it would fall to him to take over strategic leadership from Chief Fire Officer O’Reilly. In my view, Assistant Chief Fire Officer Keelan made an appropriate decision. Any criticism levelled at him for not self-deploying is misplaced.

**Mobilisation of second NILO**

**Call from NWFC (23:10)**

15.350 Group Manager Meakin was on call at 23:06, when he received the pager message mobilising him to the incident. He was at home, approximately 12 or 13 miles from the centre of Manchester. He was one of a number of on-call incident commanders. He was not mobilised in this capacity, but in his NILO capacity.

15.351 In paragraphs 15.123 to 15.127, I addressed the content of the pager message at 23:06 mobilising Group Manager Meakin to Philips Park Fire Station and his subsequent call at 23:10. I also addressed the shortcomings in this call by both participants.

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449 133/7/3-8/13
450 121/21/12-22/20
15.352 Group Manager Meakin realised from the pager message that he was being mobilised to what might be a very serious incident. Following the call with NWFC, Group Manager Meakin got in his car and drove to Philips Park Fire Station.

**Journey to Philips Park Fire Station**

15.353 In the course of the journey, Group Manager Meakin did not make any calls to GMFRS colleagues. His expectation was that Station Manager Berry was contacting the FDO. Group Manager Meakin did not try to contact the NWAS NILO. It did not occur to him to do so. He did not have the contact number for the NWAS NILO, although he believed he could have got it from NWFC.

15.354 It was not part of Group Manager Meakin’s training to contact the NWAS NILO. He was in a different position from Station Manager Berry. Group Manager Meakin was the second NILO to become involved. As the first contacted NILO, Station Manager Berry was responsible for the strategy to mobilise to Philips Park Fire Station and contact the FDO. Station Manager Berry knew that he could not get hold of the FDO.

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451 121/25/8-12
452 121/28/4-10
453 121/28/21-29/6
15.355 While I have criticised Station Manager Berry for not contacting the NWAS NILO, I do not criticise Group Manager Meakin for not doing so. I am critical of GMFRS for not training Group Manager Meakin to do this in these circumstances. The NWAS NILOs presented an opportunity for Group Manager Meakin to add to GMFRS’s situational awareness.

15.356 Group Manager Meakin arrived at Philips Park Fire Station at approximately 23:25.\(^{454}\)

**Mobilisation of third NILO**

15.357 Group Manager Levy was at home when he received the pager message mobilising him to the incident. He was one of a number of duty NILOs.\(^{455}\) At 23:06, he received the same pager message as Group Manager Meakin, which included: “NILO THREE AND MTS CAPABILITY 2 TO RVP AT PHILLIPS PARK.”\(^{456}\) Like Group Manager Meakin, he recognised that “MTS” was a typographical mistake, which he interpreted as “MTFA” or “MTA”.\(^{457}\) Four minutes later, he was sat in his car ready to leave. He thought the likelihood was that he was responding to a Marauding Terrorist Firearms Attack.\(^{458}\)

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454 121/32/11-14  
455 121/153/20-154/2  
456 INQ019078  
457 121/156/1-16  
458 121/157/24-158/4
15.358 As he was about to depart, Group Manager Levy saw that he had a message from the NILO WhatsApp group. This was the message sent by Assistant Chief Fire Officer Keelan. Group Manager Levy did not read it until he reached Philips Park Fire Station.\(^{459}\)

15.359 Group Manager Levy lived approximately 18 miles from Philips Park Fire Station. He travelled there under blue lights.\(^{460}\)

**Call to NWFC (23:12)**

15.360 After he had set off, at 23:12, Group Manager Levy made a call to NWFC, which was answered by Michelle Gregson.\(^{461}\)

15.361 I addressed the content of that call and the NWFC shortcomings during it in paragraphs 15.128 to 15.138.

15.362 When he received the pager message, Group Manager Levy assumed that the incident had just occurred. During the call, Group Manager Levy realised that this assumption was incorrect. He stated that, if he had been given the information on the Arena log about other emergency services, “without a doubt” he would

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\(^{459}\) 121/158/5-21
\(^{460}\) 121/177/5-21
\(^{461}\) INQ001185
have advised a mobilisation of GMFRS to the scene earlier than occurred. 462

15.363 Group Manager Levy stated that, if he had been provided with the JESIP information on the Arena log and arrived at Philips Park Fire Station to find that there had been no mobilisation, “[W]e’d have just driven straight towards the city centre, not gone via Manchester Central.” 463 Group Manager Levy said that he would have held some resources at Philips Park Fire Station and sent the Specialist Response Team to the Victoria Exchange Complex. 464 I accept this evidence from Group Manager Levy.

15.364 If Group Manager Levy had been provided with information from the Arena log about the police and paramedics being at the scene in his call with NWFC at 23:12, it is likely that GMFRS’s Specialist Response Team would have been at the Victoria Exchange Complex before 00:00 on 23rd May 2017. While this is outside the critical period of the response, it was a considerable improvement on what was achieved by GMFRS on the night of the Attack. Even at 00:00, there remained a substantial opportunity for the trauma skills of the Specialist Response Team to make a positive contribution in helping the casualties in

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462 121/170/9-171/23
463 121/173/15-17
464 121/173/9-21
the Casualty Clearing Station and the walking wounded still at the scene.

15.365 During the call with Michelle Gregson, a hazard zone was discussed. Group Manager Levy stated, in evidence, that he “suspected” the Attack had been declared as a Marauding Firearms Terrorist Attack, and “expected” NWFC to have elements of the Operation Plato action cards in front of them. Group Manager Levy did not task Michelle Gregson with finding out from GMP whether Operation Plato had been declared. Bearing in mind his thoughts at the time, he should have done so.

Call to Station Manager Berry (23:18)

15.366 At 23:18, Group Manager Levy called Station Manager Berry. Station Manager Berry explained his reasoning for selecting Philips Park Fire Station, saying it was “because he didn’t have a rendezvous point or words to the effect of”. Group Manager Levy stated that he agreed with Station Manager Berry’s decision on the basis of what Station Manager Berry told him. Group Manager Levy was not aware of GMP having nominated an RVP earlier and Station Manager Berry’s rejection of it. These were significant facts that Group Manager Levy did not have when he

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465 121/164/17-165/1
466 121/179/18-180/20
467 121/175/7-15, 121/179/18-180/20
concluded during this call that Station Manager Berry had made the correct mobilisation decision. 468

15.367 Station Manager Berry should not have told Group Manager Levy that there was no RVP. He should have told Group Manager Levy about the GMP RVP.

15.368 Station Manager Berry also informed Group Manager Levy that he had been unable to get hold of the FDO, but would keep trying. 469 Station Manager Berry stated that, in his call with Group Manager Levy, he had asked Group Manager Levy to make his own efforts to contact the FDO. 470 Group Manager Levy stated that he had not understood that Station Manager Berry was experiencing a real problem getting through. 471

15.369 In my view, Station Manager Berry did not make the extent of the difficulty he was having getting through to the FDO sufficiently clear to Group Manager Levy. This was a failing on Station Manager Berry’s part. Group Manager Levy assumed that Station Manager Berry had been informed of the incident at the same time that he

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468 121/180/21-181/19
469 121/180/7-20
470 120/52/18-22
471 121/182/21-24
had. The way Station Manager Berry spoke in this call did not dispel that assumption.

15.370 There was no reason for Group Manager Levy not to have made his own attempt to contact the FDO, if he had been asked to or had realised that Station Manager Berry was experiencing substantial problems doing so himself. Group Manager Levy was a conscientious and highly experienced NILO.

15.371 I accept Group Manager Levy’s evidence when he stated:

“I’d been a NILO for many years at that point and made many telephone calls to the force duty officer. I had two telephone numbers for the force duty officer on my phone and I think with the experience I’ve had, had another NILO said to me, ‘I cannot get through to the force duty officer, please will you try’, I’d have considered that quite significant and that would have been quite an early warning sign.”

15.372 Following his call with Station Manager Berry at 23:21, Group Manager Levy spoke to Station Manager Lawlor. I shall deal with this call when

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472 121/181/20-182/8
473 120/51/21-22
474 121/182/25-183/11
I come to Station Manager Lawlor’s involvement in paragraphs 15.394 and 15.395.

Call to Group Manager Nankivell (23:26)

At 23:26, Group Manager Levy telephoned Group Manager Nankivell. He told Group Manager Nankivell that he was on his way to Philips Park Fire Station. Group Manager Nankivell said that he wanted all messages to go through NWFC. 475

Group Manager Levy arrived at Philips Park Fire Station fewer than ten minutes after this call, at almost exactly 23:35. 476

Mobilisation of Contingency Planning Unit manager

Group Manager Fletcher was the manager of the Contingency Planning Unit at GMFRS. In that role, he was in charge of GMFRS’s NILO capability. Group Manager Fletcher was also a NILO. 477 Group Manager Fletcher received notification of the Attack through a message sent to a GMFRS NILO WhatsApp group at 23:02. 478

Call to Station Manager Berry (23:13)

At 23:13, Group Manager Fletcher called Station Manager Berry. The call lasted two and a half
minutes. As the person in charge of the Contingency Planning Unit, Group Manager Fletcher was Station Manager Berry’s line manager.479 Station Manager Berry stated that he had a high regard for Group Manager Fletcher and trusted him.480

15.377 Station Manager Berry began by informing Group Manager Fletcher “that it was a bomb and an active shooter”.481 Group Manager Fletcher replied that he had not seen anything about either. Station Manager Berry stated that it was both. The reference to “active shooter” had come from the Control Room Operator Dean Casey in the call with Station Manager Berry at 22:48.

15.378 Just prior to this call, the Control Room Operator David Ellis had, in fact, just entered new information onto the Arena log: “*** FROM THE POLICE – NOT GUNSHOT WOUNDS LOOKS LIKS [sic] SHRAPNEL ****”.482 As I set out in paragraphs 15.87 to 15.104, Dean Casey did not pass this information on. Nor was it passed on to Station Manager Berry in his call with Vanessa Ennis at 22:52 or in his call with Joanne Haslam at 22:57.

479 120/48/10-11
480 120/49/5-8
481 128/113/9-21
482 INQ008376/6
15.379 The picture which had developed in Station Manager Berry’s mind was that he was organising the GMFRS response to a Marauding Terrorist Firearms Attack. He thought that the explosion at the Arena may be a prelude to such an attack.\textsuperscript{483} At the time, he thought the attack would be “multi-seated”.\textsuperscript{484} The NILO training at the time had a focus on multi-seated attacks, such as those in Paris and Mumbai, so it was reasonable for Station Manager Berry to include in his consideration the possibility that a Marauding Terrorist Firearms Attack might be under way.\textsuperscript{485} Being informed that there were reports of “an active shooter” would inevitably increase the likelihood that it was a Marauding Terrorist Firearms Attack in Station Manager Berry’s mind.

15.380 It is well recognised that false or exaggerated information can be provided on a well-intentioned basis in the early stages of a Major Incident. It was important for Station Manager Berry to remain open-minded. It was also important for him to seek regular updates from NWFC as the intelligence picture was capable of developing by the minute.

\textsuperscript{483} 119/185/2-8
\textsuperscript{484} 119/186/8-15
\textsuperscript{485} 142/203/6-204/4
15.381 Finding out what mobilisation decisions other emergency services were making was capable of improving Station Manager Berry’s decision-making. He should also have tried to find out the situational awareness of other emergency services beyond GMP. There was no good reason why he did not try and contact his equivalent at NWAS. He should also have attempted to hear BTP’s view. It was important that Station Manager Berry should challenge his own assumptions.

15.382 In his call with Group Manager Fletcher at 23:13, Station Manager Berry set out his mobilisation decision. Group Manager Fletcher asked Station Manager Berry why he had selected Philips Park Fire Station rather than Manchester Central Fire Station. Station Manager Berry’s reply was that Manchester Central Fire Station was “too close, the MTFA [Marauding Terrorist Firearms Attack], I know the area … I used to work there”. Group Manager Fletcher stated that he may have told Station Manager Berry that he would have used Manchester Central Fire Station.
15.383 Group Manager Fletcher also stated in evidence that he did not challenge Station Manager Berry’s selection of Philips Park Fire Station. He stated that he had been told that “it was a bomb and an MTFA, this was going down the Plato response, it was a specialist response that we would need to go in”.

He stated that GMFRS needed to wait for the identification of the FCP, “which we were expecting to come fairly quickly”.

15.384 Group Manager Fletcher stated that he was not told about the GMP RVP. Station Manager Berry stated that he did inform Group Manager Fletcher of the GMP RVP. For a number of reasons, I prefer Group Manager Fletcher’s evidence. First, from the outset Station Manager Berry had rejected the GMP RVP as an appropriate location. This provides an explanation for why Station Manager Berry would not mention what was otherwise important information. Second, Group Manager Fletcher gave persuasive evidence about his own thought process and what his reaction would have been if he had known about the RVP. Third, Group Manager Fletcher’s evidence is consistent with Group Manager Meakin and Group Manager Levy’s evidence that they were not told about the

489 127/198/6-8
490 127/198/2-12
491 127/198/13-18
492 120/49/9-13
GMP RVP by Station Manager Berry in conversations at around the same time.\footnote{121/57/6-9, 121/175/7-15}

15.385 Station Manager Berry should have told Group Manager Fletcher about the GMP RVP. Group Manager Fletcher stated that if he had known of the GMP RVP he may have told Station Manager Berry to mobilise to that location or he would have told him to use Manchester Central Fire Station.\footnote{127/199/11-20} I accept Group Manager Fletcher’s evidence. If Station Manager Berry had told him about the GMP RVP, it is likely that GMFRS appliances would have been moved to within one mile of the Arena by 23:30. From that position, it is probable that GMFRS would have deployed to the Victoria Exchange Complex sooner than they did.

15.386 In the course of the call, Station Manager Berry asked Group Manager Fletcher to contact the FDO. Station Manager Berry said that he was having real difficulties contacting the FDO and was having problems on his journey.\footnote{120/49/18-20, 128/2/12-23} Group Manager Fletcher said that he would try the FDO for him “to take some of that load off him”.\footnote{128/3/21-4/16} Group Manager Fletcher called the number he had for the FDO “a couple of times” before his
call with Group Manager Nankivell and “several times” after that, but the line was engaged and there was no voicemail facility.  

15.387 Group Manager Fletcher stated that Station Manager Berry seemed significantly distressed and frustrated on the telephone call, due to the problems he was having on his journey.

Call to Station Manager Lawlor (23:16)

15.388 After his call with Station Manager Berry, Group Manager Fletcher called Station Manager Lawlor at 23:16. Group Manager Fletcher gave Station Manager Lawlor a short briefing. Group Manager Fletcher said that he planned to go to the Command Support Room. They discussed Station Manager Lawlor travelling to GMP HQ instead.

15.389 It was a good idea for Station Manager Lawlor to go to GMP HQ. If Chief Fire Officer O’Reilly had decided to go to GMP HQ, as was the expectation of some, Station Manager Lawlor’s attendance there would have been less significant. Station Manager Lawlor was not on duty or on call, but he was able to respond to the incident. GMFRS accepted in the Inquiry that it should have had a plan, specifying in advance,
who would go to GMP HQ in the event of a Major Incident.\textsuperscript{500} I agree. Either the duty Principal Officer should go or he should nominate another senior officer who could get there sooner or at about the same time.

Call to Group Manager Nankivell (23:18)

15.390 Group Manager Fletcher called Group Manager Nankivell at 23:18. He informed Group Manager Nankivell of his intention to travel to the Command Support Room. Group Manager Fletcher was being cautious about self-mobilising, as self-mobilisation can lead to confusion about command structures and deployments. Group Manager Nankivell approved of Group Manager Fletcher’s plan to go to the Command Support Room, which he described as “a right move, a good move so far as I was concerned”.\textsuperscript{501} Group Manager Nankivell regarded Group Manager Fletcher as having a good knowledge of NILOs, the FDO, Operation Plato and the Airwave radio network used by emergency services. Group Manager Nankivell instructed Group Manager Fletcher not to make any decisions without informing him first.\textsuperscript{502}

15.391 During Group Manager Fletcher’s call with Group Manager Nankivell, at 23:18, a GMFRS NILO

\textsuperscript{500} INQ042436/31 at paragraph 110

\textsuperscript{501} 129/15/7-8

\textsuperscript{502} 129/13/8-16/5
posted on the NILO WhatsApp group: “Just on inet Dave it looks really bad. Police are reporting minimum number of 18 fatalities! Dean is DGM [duty Group Manager] and I think opening CSR [Command Support Room]. Andy Berry in NILO and stepping up MTFA [Marauding Terrorist Firearms Attack] capability.”

15.392 The reference to “inet” was to iNet, NWFC’s incident log system. I explained in paragraph 15.312 why GMFRS officers should have considered checking iNet, in the early stages of their involvement in the incident. It was an opportunity to gain situational awareness.

15.393 Shortly after his call with Group Manager Nankivell, Group Manager Fletcher set off for the Command Support Room under blue lights. Near the start of his journey, at 23:25, Janine Carden at NWFC telephoned him. I dealt with this call in paragraphs 15.168 to 15.172 in respect of NWFC’s response to the Attack.

Call from Station Manager Lawlor (23:26)

15.394 Station Manager Lawlor called Group Manager Fletcher at 23:26. Group Manager Fletcher
confirmed the plan they had agreed in their previous call. 506

15.395 By this stage, Station Manager Lawlor had spoken to Group Manager Levy, as I will set out in paragraphs 15.402 to 15.403. Group Manager Levy said that he was making his way to Philips Park Fire Station. Station Manager Lawlor believed that this was “a second rendezvous point for other resources”. 507 He assumed at this time that GMFRS “would have had resources there [at the scene]”. 508 As a result, he did not query the use of Philips Park Fire Station. 509

Call to Station Manager Berry (23:37)

15.396 At 23:37, Group Manager Fletcher called Station Manager Berry. They discussed the FDO and the fact that neither of them had managed to get through to him. They discussed whether this incident was a “Paris-type scenario”. 510 This was a reference to the multi-seated terrorist attack in Paris in November 2015. As a result, Group Manager Fletcher decided that a further crew with Marauding Terrorist Firearms Attack capability needed to be put on standby. 511
15.397 By the end of this call, Station Manager Berry had nearly reached Philips Park Fire Station.\textsuperscript{512}

Call to Area Manager Etches (23:40)

15.398 As a result of his discussion with Station Manager Berry, Group Manager Fletcher telephoned Area Manager Etches and advised that a further crew with Marauding Terrorist Firearms Attack capability should be put on standby.\textsuperscript{513}

15.399 Group Manager Fletcher arrived at the Command Support Room about ten minutes after this call, at 23:49.\textsuperscript{514}

Mobilisation of NILO lead

15.400 Station Manager Lawlor was the NILO lead for GMFRS and the North West region. He was the GMFRS single point of contact around contingency planning, working with multi-agency liaison officers in GMP HQ. He had been embedded for a number of years in Counter Terrorism Policing North West at GMP HQ. For the majority of the time, Station Manager Lawlor worked at GMP HQ.\textsuperscript{515}
15.401 Station Manager Lawlor was not on duty on the night of 22\textsuperscript{nd} May 2017. He was at home asleep following an 80-hour on-call weekend.\textsuperscript{516} He was woken up by the NILO WhatsApp group messages sent at 23:02 and 23:08. Five minutes after the second WhatsApp message was sent, Station Manager Lawlor attempted to speak to Station Manager Berry. The two calls he made did not connect. This was because Station Manager Berry was on the telephone to Group Manager Fletcher at that time.\textsuperscript{517}

Call from Group Manager Levy (23:21)

15.402 As I set out in paragraphs 15.388 to 15.389 and 15.394 to 15.395, Station Manager Lawlor spoke to Group Manager Fletcher at 23:16 and 23:26. Between those calls, at 23:18, Station Manager Lawlor received a call from Group Manager Levy. It lasted just under three minutes.

15.403 Group Manager Levy said that he was travelling to Philips Park Fire Station. They agreed to speak on the NILO talk group. Station Manager Lawlor did not query the choice of Philips Park Fire Station as a muster point.\textsuperscript{518}
Call to Group Manager Fletcher (23:33)

15.404 At 23:33, Station Manager Lawlor called Group Manager Fletcher. Station Manager Lawlor had already spoken to Group Manager Fletcher at 23:16 and 23:26. The purpose of this call was to let Group Manager Fletcher know that Station Manager Lawlor was leaving his house. 519

Call to NWFC (23:35)

15.405 Two minutes after calling Group Manager Fletcher, Station Manager Lawlor called NWFC to notify the control room that he was on his way to GMP HQ. In the course of this call, Station Manager Lawlor did not ask NWFC for any information about the incident. When asked why he had not, he stated: “I do know from historic events or incidents how busy North West Fire Control can be, and officers phoning them up for various bits of information. I do know how impactive that can be on North West Fire Control.” 520

15.406 Station Manager Lawlor was implying that a reason for GMFRS officers not to ask for information was because of a concern that it interrupted NWFC at busy times. If this is a widely held view and/or the explanation for why any of the GMFRS officers did not ask for information when speaking to NWFC,
both GMFRS and NWFC must move swiftly to address it.

15.407 The time it takes for information or an update to be given during a Major Incident can be reduced through at least two routes. First, through the appropriate GMFRS use of the iNet system. Second, by improvements to the way in which key information is captured and stored on the NWFC incident logs.

15.408 Station Manager Lawlor should have asked NWFC for an update. He should also have been offered an update by the Control Room Operator to whom he spoke.

15.409 Station Manager Lawlor was going to GMP HQ to represent GMFRS as a liaison officer. He had obtained relatively little information from Group Manager Fletcher and Group Manager Levy. So low was the level of his understanding of the incident that he mistakenly believed that GMFRS had resources at the scene. He did not appreciate that the explosion had been caused by a terrorist.521 Station Manager Lawlor stated that, had he realised that GMFRS had not mobilised to the scene, he “would have definitely been making more phone calls to the people who were attending or mobilised the on-call officers”.522

521 126/85/9-25
522 126/92/21-93/4
Philips Park Fire Station (23:00 to 23:53)

15.410 Having set out in some detail how the GMFRS senior officers came to be mobilised, I return to consider the situation at Philips Park Fire Station.

Four original fire appliances

15.411 By 23:00, the four fire appliances Station Manager Berry had requested to muster at Philips Park Fire Station were present at the station.\(^{523}\) Watch Manager Simister was on board one of those fire appliances. He had come from Manchester Central Fire Station. Another contained Crew Manager Mottram, who had come from Gorton Fire Station.

15.412 Shortly after he arrived at Philips Park Fire Station, Crew Manager Mottram received a second telephone call from Helen Mottram. She informed him: “\([I]t’s some form of nail bomb, there was several fatalities and at least 60 casualties, and that they were proceeding to the scene.\)”\(^{524}\) Crew Manager Mottram understandably described himself as feeling “\([v]ery frustrated that we weren’t there as well\)”\(^{525}\).

15.413 Watch Manager Simister made two calls to NWFC after he arrived at Philips Park Fire

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523  INQ031123/1-3
524  70/12/11-16
525  70/12/23-13/1
Station: one at 23:06 and one at 23:25. In the first, Watch Manager Simister told NWFC that he had seen ambulances arriving at Manchester Central Fire Station. In the second, having spoken to Crew Manager Mottram, Watch Manager Simister informed NWFC that there was “a fireman here whose wife is a paramedic and she’s on scene”.

Arrival of first Specialist Response Team appliance (23:21)

Between the two calls from Watch Manager Simister to NWFC, Watch Manager Nolan arrived at Philips Park Fire Station at 23:21, on the Specialist Response Team appliance. By 23:25, Watch Manager Nolan regarded his Specialist Response Team crew as ready to deploy to an incident.

Arrival of Group Manager Meakin (23:25)

Group Manager Meakin arrived at Philips Park Fire Station at approximately 23:25. On arrival, he spoke to Watch Manager Simister. Group Manager Meakin was told by Watch Manager Simister that there were ambulances at Manchester Central Fire Station. Group Manager
Meakin accepted that he did not know whether Station Manager Berry knew this information. Station Manager Berry did not know this information at that time.

15.416 Group Manager Meakin then called NWFC at 23:28. I rehearsed the detail of that call in paragraphs 15.174 to 15.178. Group Manager Meakin informed NWFC what he had been told by Watch Manager Simister.

15.417 When asked during his evidence why he did not act upon the information given to him by Watch Manager Simister, Group Manager Meakin described the information from NWFC as being “conveyed in an assured tone”. He stated that he thought that Station Manager Berry had chosen Philips Park Fire Station “based on intel that he’d potentially got from the FDO”.

15.418 Group Manager Meakin was asked whether the information Lisa Owen did not pass on to him in that call, about the police and paramedics, would have changed his decision-making. Group Manager Meakin’s evidence was that he would have contacted Station Manager Berry to provide him with that information if he had received it

531 121/37/22-38/5
532 121/35/3-36/2
533 121/42/5-6
534 121/41/17-42/8
from Lisa Owen.\textsuperscript{535} I accept his evidence on this point. Had he contacted Station Manager Berry, it is possible that he and Station Manager Berry would have agreed immediately to mobilise to the scene or, at the very least, send a firefighter back to Manchester Central Fire Station to investigate further.

15.419 When asked why, in that call, he asked NWFC for instructions, Group Manager Meakin stated:

“My belief at that time was that Andy Berry, as the duty NILO, would be or was in touch with [the] force duty officer. I was surprised on arrival at Philips Park that I was the first one and that there was no further information that came during that journey from any of the officers who had been mobilised. I asked that question because I was keen, having got there, for us to be able to deploy.”\textsuperscript{536}

15.420 Group Manager Meakin was asked during his evidence who the Incident Commander was at this stage. He stated that at that time there were three advisers, the NILOs, but no Incident Commander.\textsuperscript{537} Under GMFRS’s approach at the time, Group Manager Meakin was correct.\textsuperscript{538} No GMFRS officer had reached the incident ground.
Consequently, no GMFRS officer had become Incident Commander.

15.421 Group Manager Meakin was asked in evidence whether, at this stage, it would have been a reckless decision to have deployed staff in ballistic personal protective equipment (PPE) to Manchester Central Fire Station. He stated that it would not have been a reckless decision. He accepted that it would have been a reasonable decision. I agree and go further. In my view, Group Manager Meakin should have given that direction. There was no good reason not to. It would have resulted in co-location between GMFRS and NWAS for the first time. From this, situational awareness could have been shared.

15.422 In evidence, Group Manager Meakin agreed that if he had deployed specialist resources forward to Manchester Central Fire Station at 23:30, they would have discovered that there were ambulances at the scene. He was correct about this.

15.423 At 23:40, NWAS Ambulance A720 pulled up on the forecourt of Manchester Central Fire Station. It remained there for just under an hour. It had been allocated to the NWAS response to the Attack and was using Manchester Central Fire Station as an RVP, while it waited to be called forward. At 00:37 on 23rd May 2017, it left
Manchester Central Fire Station and travelled to the Victoria Exchange Complex.\textsuperscript{539} Ambulance A720 was not the only NWAS vehicle to use Manchester Central Fire Station during this period.

15.424 I have no doubt that any firefighter who had gone to Manchester Central Fire Station would have spoken to the NWAS staff in Ambulance A720. They would have immediately discovered that NWAS was sending ambulances to Hunts Bank in significant numbers and had been for over an hour.

15.425 At 23:33, Group Manager Meakin called Station Manager Berry. Station Manager Berry reported to Group Manager Meakin that he was having “some difficulties” getting hold of the FDO.\textsuperscript{540}

15.426 Station Manager Berry stated that he gave Group Manager Meakin “the information that I had” in that call.\textsuperscript{541} Group Manager Meakin stated he was not told about the rejected GMP RVP. Group Manager Meakin stated that he would have regarded this information as important. He stated that, in the absence of contact with the FDO, he would have expected GMFRS to deploy to the GMP RVP.\textsuperscript{542}

\begin{verbatim}
539  INQ040368/8
540  121/51/15-17
541  120/53/25-54/5
542  121/57/6-16
\end{verbatim}
15.427 I accept Group Manager Meakin’s evidence on this point. I am satisfied that he would have regarded information about the GMP RVP as sufficiently important to have remembered being told. In my view, Station Manager Berry had dismissed that GMP RVP from his mind at an early stage and, in common with conversations he had with other GMFRS officers, he did not mention it to Group Manager Meakin. He should have done so. It was capable of informing Group Manager Meakin’s approach to the incident. Telling him may have resulted in an earlier mobilisation from Philips Park Fire Station.

15.428 At some point between 23:25 and 23:34, Crew Manager Mottram tried to tell Group Manager Meakin what he had learned from Helen Mottram. Group Manager Meakin said that he could not speak to Crew Manager Mottram because he was busy. 543 I am not critical of Group Manager Meakin for not speaking to Crew Manager Mottram during the time when Group Manager Meakin was the only NILO at Philips Park Fire Station. This was a period of fewer than ten minutes, during which Group Manager Meakin spoke to Watch Manager Simister, NWFC and Station Manager Berry. Group Manager Meakin also spoke to Watch Manager Nolan, who said that there were ten Specialist Response Team

543 70/15/25-16/4
responders ready to deploy. I can, however, understand that Crew Manager Mottram would have felt considerable frustration about not being able to tell Group Manager Meakin the important information he had.

**GMFRS incident command (23:30)**

15.429 Before dealing with the arrival of the other NILOs at Philips Park Fire Station, it is worth pausing to take stock of where GMFRS had reached in terms of incident command at 23:30.

15.430 A number of watch managers and crew managers had mustered at Philips Park Fire Station. Each was capable of being the Incident Commander under the GMFRS command policy. The most senior would have become Incident Commander upon arrival on the incident ground. This rule did not apply automatically to arrival at RVPs.

15.431 Station Manager Berry had made some initial mobilisation decisions as the NILO but was still travelling to Philips Park Fire Station at this time. His role was advisory. Group Manager Meakin had arrived but was also in an advisory role. Group Manager Levy was still en route. He was also an adviser.
15.432 Group Manager Nankivell, as duty Group Manager, had a support role. Area Manager Etches, who at this time had just arrived at the Command Support Room, also had a support role as duty Assistant Principal Officer. Chief Fire Officer O'Reilly, as duty Principal Officer, had a strategic responsibility for the whole of GMFRS. He had not, by this time, arrived at the Command Support Room.

15.433 Two other senior GMFRS officers, the Contingency Planning Unit manager and the NILO lead, had put themselves on duty and been mobilised. Neither was intending to attend the scene. Neither was the Incident Commander.

15.434 The standard response time for GMFRS is six minutes. This is measured from the time resources are mobilised by NWFC to the arrival of the first appliance on the incident ground.

15.435 It is astonishing and completely unacceptable that, one hour after the explosion, GMFRS did not have an Incident Commander. Between two Station Managers, four Group Managers, an Area Manager and the Chief Fire Officer, all of whom were participating in the response, not one was in charge of the response to the incident nor did they attempt to take charge.
15.436 The incident needed to be gripped by one person who regarded themselves as responsible for the GMFRS response. In the case of the Group Managers and above, any of them was of sufficient seniority to decide to grip the incident, given that the GMFRS response had clearly stalled. Each could have authorised the mobilisation of GMFRS resources towards the Arena shortly after they became involved. I shall return to the question of why they did not at the conclusion of this section.

Arrival of Group Manager Levy (23:35)

15.437 Group Manager Levy arrived at Philips Park Fire Station at 23:35. On arrival, Group Manager Levy saw the NILO WhatsApp group messages.

Arrival of Station Manager Berry (23:40)

15.438 Station Manager Berry arrived at Philips Park Fire Station five minutes later, at 23:40. At the time of Station Manager Berry’s arrival, there were four standard fire appliances, two Specialist Response Team appliances, the Technical Response Unit appliance, the Major Response Unit appliance and three NILOs assembled at Philips Park Fire Station.

549 121/47/6-15
550 121/158/22-161/5
551 119/195/22-196/11, INQ004300/1
552 INQ041473/46, INQ041473/47, INQ041473/50-52
15.439 Crew Manager Mottram stated that he “told the NILOs” that ambulances were being deployed to the scene.\textsuperscript{553} Group Manager Levy stated that he did not recall being told that. He stated that it was “quite possible” that he was told that information but in the midst of everything that was happening and everything he was being told he just missed it.\textsuperscript{554}

15.440 I accept Crew Manager Mottram’s evidence that he told the NILOs that ambulances were going to the scene. I also accept Group Manager Levy’s evidence that, in what was becoming a heated and difficult environment,\textsuperscript{555} Group Manager Levy and the other NILOs did not register that information. I accept Group Manager Levy’s evidence that he would have been “quite strong in … [his] reaction” if he had registered what Crew Manager Mottram was saying.\textsuperscript{556}

15.441 At 23:42, Group Manager Meakin spoke to Area Manager Etches on the telephone for just over two minutes.\textsuperscript{557} The purpose of Group Manager Meakin’s call was to try to obtain some information from the Command Support Room. Group Manager Meakin told Area Manager

\begin{itemize}
\item \textsuperscript{553} 70/15/20-24
\item \textsuperscript{554} 122/6/17-7/23
\item \textsuperscript{555} 71/41/7-14
\item \textsuperscript{556} 122/9/7-17
\item \textsuperscript{557} INQ041473/55
\end{itemize}
Etches that ambulances were at Manchester Central Fire Station. In light of what he was told, Area Manager Etches should have encouraged Group Manager Meakin to send at least some resources to Manchester Central Fire Station. He did not. He stated, “All the energy was around communication with GMP.”

**Group Manager Levy: Incident Commander (23:45)**

15.442 Group Manager Levy had always expected that he would be Incident Commander. He was the most experienced of the three NILOs who had been deployed. He was one of the two group managers who had been mobilised. He was an experienced commander. By 23:45, Group Manager Levy “realised the stresses that Mr Berry had been under over the last hour”. Group Manager Levy recognised that he was probably fresher and in a better position to take control. At approximately 23:45, Group Manager Levy informed Station Manager Berry that he was taking up the role of Incident Commander.
15.443 NWFC was notified that Group Manager Levy had assumed the role of Incident Commander in a call he made at 00:15 on 23rd May 2017. 562

Forward Command Post

15.444 At 23:46, NWFC called Station Manager Berry. In the course of the call, Group Manager Levy, who was next to Station Manager Berry when the call came in, spoke to NWFC and asked for the location of the Forward Command Post (FCP) to be obtained from GMP. This started a series of calls involving NWFC, GMP Control and NWAS Control. I dealt with these calls in paragraphs 15.179 to 15.199.

15.445 While those calls were taking place, at 23:47 Group Manager Meakin switched on the Dictaphone he had on him. It was only on for a few minutes. 563 At the start of the recording, Group Manager Meakin spoke to an unidentified individual and asked the person if he had got hold of the FDO yet. Group Manager Levy said that he had spoken to NWFC and asked whether there was an FCP “that we can go and co-locate with police and ambulance”. 564 During the recording, a firefighter asked Group Manager Meakin: “What’s the chance of us actually
going?” Group Manager Meakin replied: “Well as soon as they declare forward control point we’ll go to wherever that is and then we’ll start getting people into the warm zone.”

15.446 During the period when Group Manager Meakin’s Dictaphone was recording, at 23:50, Station Manager Berry got through on the FDO’s telephone line. He spoke to David Myerscough, a member of police support staff. I dealt with how David Myerscough came to be answering the FDO line in Part 13, in the section in which I addressed GMP’s response to the Attack. I repeat that there is no criticism of David Myerscough in this regard.

15.447 Station Manager Berry’s conversation with David Myerscough was unsatisfactory. This was due to the fact that David Myerscough should not have been answering the FDO’s telephone line. Station Manager Berry asked for an FCP. David Myerscough replied, “I think they’ve been liaising at the Cathedral.” This was in reference to the GMP RVP, which Inspector Smith had declared but then replaced minutes later.

15.448 Station Manager Berry rejected this, saying, “[W]e’ll need somewhere to go … and co-locate
with the ambulance service.’”

David Myerscough said that he would ask a colleague. When he returned, David Myerscough said: “Nothing at the moment but it’s being updated.” Station Manager Berry replied: “We’re not going to deploy anywhere until we have a nailed-on co-location point … a forward control point.”

15.449 David Myerscough suggested GMP HQ, to which Station Manager Berry responded, “[T]hat might be an RV but we need a forward control point.” The call concluded with David Myerscough saying that he had spoken to “the Inspector”. He asked GMFRS to go to “the Old Boddington’s car park, near the Arena”. Station Manager Berry said: “The ambulance service apparently are at Thompson Street [Manchester Central] Fire Station … We’re going to muster there.”

15.450 Station Manager Berry’s evidence about this call was that: “The person at the other end of the phone didn’t seem to know what I was talking about, so it made it difficult … So I wasn’t really convinced the information was right.”

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569 INQ018835T/13
570 INQ018835T/13
571 INQ018835T/12-15
572 INQ018835T/14
573 INQ018835T/15
574 INQ018835T/12-15
575 120/155/2-9
Manager Berry stated that he “didn’t think at the time” to ask to speak to the FDO or the Force Duty Supervisor.\textsuperscript{576}

15.451 The call was highly unsatisfactory from Station Manager Berry’s point of view. However, it was inappropriate for him to reject a location given to him by GMP on the FDO phone line and end the call simply by telling the person he was speaking to what GMFRS was doing. At the point at which Station Manager Berry realised he was not speaking to someone whom he could rely upon, he should have asked to speak to someone more senior.

15.452 JESIP requires co-location. It requires co-ordination. Station Manager Berry knew this was a terrorist attack. When he arrived at Philips Park Fire Station, Station Manager Berry still believed that there was a gun battle going on in the City of Manchester. This was his state of mind because “No one has told me there was not a gun battle going on.”\textsuperscript{577} GMP was the lead agency. Station Manager Berry had been trying for over an hour to speak to GMP. It was his responsibility to ensure that he obtained information that he regarded as reliable and could act upon. The resolution of this telephone call by Station Manager Berry was the antithesis of JESIP.
15.453 I am critical of Station Manager Berry for the way he approached the call with David Myerscough. I am also critical of GMP for putting David Myerscough, and therefore Station Manager Berry as well, in that difficult position. Station Manager Berry was correct to perceive that David Myerscough was out of his depth. It was this fact that generated the response from Station Manager Berry. I have no doubt that, if Station Manager Berry had managed to speak to the FDO or Force Duty Supervisor, he would have accepted what he was told by them. At that stage in the evening, it is likely that the FDO or Force Duty Supervisor would have made clear that it was safe enough for at least specialist resources to be at the Victoria Exchange Complex.

15.454 While Station Manager Berry was speaking to David Myerscough, NWFC called Group Manager Levy at 23:52 and informed him that NWAS had advised that their ambulances were rendezvousing at Manchester Central Fire Station.578

15.455 Immediately following this call at 23:53, Group Manager Levy called Chief Fire Officer O’Reilly. By this time Chief Fire Officer O’Reilly had reached the Command Support Room.579
Command Support Room (23:40 to 00:05)

Arrival

15.456 At 23:40, Area Manager Etches reached GMFRS HQ. Area Manager Etches attracted the attention of a security guard and was let into the building. There was no one else in the Command Support Room and it was in darkness. Area Manager Etches switched on the equipment in the Command Support Room.\(^{580}\)

15.457 It would have been better, as GMFRS recognised in its closing statement, if the job of getting the Command Support Room up and running had fallen to someone other than the duty Assistant Principal Officer while he was involved in responding to a Major Incident.\(^{581}\) Area Manager Etches had contacted a Command Support Room officer, but Area Manager Etches arrived first. Resolution of this issue is something that GMFRS informed me is under consideration. It should have been resolved before the hearing.

15.458 Group Manager Nankivell arrived at the Command Support Room very shortly after Area Manager Etches.\(^{582}\) At 23:46, Group Manager Nankivell spoke to Janine Carden at NWFC.

\(^{580}\) 129/187/11-13, 129/189/16-190/1
\(^{581}\) INQ042436/26-27 at paragraph 94
\(^{582}\) INQ041473/55
I dealt with some of the content of that call in paragraph 15.142. The call lasted 3 minutes.

15.459 Group Manager Nankivell began the call by saying, “Just to let you know me and Paul [Etches] are in the command support room now, and the chief is … is two minutes away.”\(^{583}\) As he was concluding the call, he said: “[J]ust to let you know John Fletcher and the Chief are now in the command support room.”\(^ {584}\) By 23:50, all four senior GMFRS officers who had mobilised to the Command Support Room had arrived.\(^ {585}\)

15.460 Two minutes later, Chief Fire Officer O’Reilly sent a text message to Assistant Chief Fire Officer Geoffrey Harris, instructing him to come to the Command Support Room. This text was in reply to an earlier query from Assistant Chief Fire Officer Harris as to whether Chief Fire Officer O’Reilly needed anything.\(^ {586}\) Chief Fire Officer O’Reilly instructed Assistant Chief Fire Officer Harris to come to the Command Support Room for two reasons. First, because Chief Fire Officer O’Reilly considered at that stage that it was possible that he would deploy to the incident. If that happened, he wanted to make sure that another Principal Officer could go to the Strategic

\(^{583}\) INQ001140/1

\(^{584}\) INQ041473/59

\(^{585}\) 128/130/6-20 (Fletcher), 132/11/19-24 (O’Reilly), 128/187/6-8 (Nankivell), 129/189/16-20 (Etches)

\(^{586}\) 132/19/10-13, 130/81/18-24
Co-ordinating Group meeting. Second, Chief Fire Officer O’Reilly regarded Assistant Chief Fire Officer Harris as having substantial experience in dealing with a multiple fatality incident.\(^{587}\)

15.461 Assistant Chief Fire Officer Harris arrived at the Command Support Room at 00:07 on 23\(^{rd}\) May 2017.\(^{588}\)

Call from Group Manager Levy (23:53)

15.462 At 23:53, Group Manager Levy telephoned Chief Fire Officer O’Reilly. Group Manager Levy informed Chief Fire Officer O’Reilly that there were ambulances at Manchester Central Fire Station. Group Manager Levy’s evidence was that he had told Chief Fire Officer O’Reilly that he had decided to mobilise to Manchester Central Fire Station to co-locate with NWAS and to deploy from there to the scene. Group Manager Levy stated in evidence that he called Chief Fire Officer O’Reilly as the most senior officer involved in the incident because he was about to break protocol. The protocol breach, as Group Manager Levy saw it, was that he was attending an incident without having been mobilised to it by NWFC.\(^{589}\)
15.463 Group Manager Levy also stated that he did not present his decision as a request. He stated: “I don’t know how I would have phrased it, but any recipient of that call would have known this is my decision and this is what we are doing.” Group Manager Levy’s evidence was that Chief Fire Officer O’Reilly instructed him to wait at Manchester Central Fire Station. He stated that Chief Fire Officer O’Reilly’s instruction “didn’t surprise me” as “I’m moving towards potentially a hot zone, I’m breaking a policy and procedure, I’m taking additional risk”.

15.464 Chief Fire Officer O’Reilly’s evidence was that he did not realise that Group Manager Levy had assumed command. Chief Fire Officer O’Reilly also disputed that he had told Group Manager Levy to wait at Manchester Central Fire Station. He stated that Group Manager Levy had told him that GMFRS resources were mobilising to Manchester Central Fire Station, to which Chief Fire Officer O’Reilly stated that he had replied: “Absolutely, go for it.”

15.465 Area Manager Etches, who spoke to Group Manager Meakin at 00:01 on 23rd May 2017, gave the following evidence about the mobilisation from Philips Park Fire Station:

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590 122/19/14-21
591 122/22/21-23/2, 122/23/9-24
592 132/28/5-29/9
“The decision was to relocate everything to Central. Whether ... they were going to find out more information when they got to Central that gave them a richer picture of where people were actually working from, ambulance crews, and for them to take that decision, then I was anticipating when they got to Central, they’d find that golden piece of information that said, right, this is where we are now we need to go.”

15.466 Area Manager Etches stated that, once GMFRS resources reached Manchester Central Fire Station, “[t]hey would find out more”.

15.467 Group Manager Fletcher was present with Chief Fire Officer O’Reilly when the conversation between Chief Fire Officer O’Reilly and Group Manager Levy took place. His evidence was:

“Mr Levy informed the chief of the information that was received at Philips Park about ambulances initially turning up at Manchester Central fire station and rendezvousing there, so the decision was made then to co-locate our resources with theirs.”

15.468 Group Manager Fletcher’s evidence was that he was “party to one side of a conversation”, in
which he thought, “Mr Levy had said that he was incident commander, but what time that was, [he] couldn’t definitely say.”

Group Manager Fletcher was asked whether it was well known by everyone in the Command Support Room that Group Manager Levy was Incident Commander. He stated: “I couldn’t actually say. I think I picked it up on hearsay … but I couldn’t actively state now that I definitely knew Mr Levy at that time was the incident commander.”

15.469 In light of all the evidence I heard, I make the following findings about this conversation. First, although Group Manager Levy had assumed incident command at this stage, he did not make this clear to Chief Fire Officer O’Reilly. Given the policy at the time, he should have been more explicit about his decision. Second, Group Manager Levy did not clearly communicate to Chief Fire Officer O’Reilly that it was his intention to go on from Manchester Central Fire Station. This led to a misunderstanding between the two of them, which left Group Manager Levy with the impression that he should not go further than Manchester Central Fire Station.

15.470 If Group Manager Levy had said to Chief Fire Officer O’Reilly, ‘I have assumed incident command. I am mobilising to Manchester Central
Fire Station. Once there I will deploy some resources forward to the Arena’, the misunderstanding would not have occurred.
I accept that this was what Group Manager Levy thought he was conveying, but he failed to do so. As he believed he was Incident Commander, it was Group Manager Levy’s responsibility to challenge Chief Fire Officer O’Reilly if he believed he was being countermanded.

15.471 I am satisfied that the other GMFRS officers would have been aware that Chief Fire Officer O’Reilly had given a clear countermand of the intention to go to the scene, if that had occurred. Instead, both Area Manager Etches and Group Manager Fletcher understood that the mobilisation was to Manchester Central only. I am also satisfied that Group Manager Levy misinterpreted Chief Fire Officer O’Reilly’s endorsement of mobilising to Manchester Central Fire Station as an instruction not to go any further.

15.472 I acknowledge that Group Manager Levy showed considerable initiative by assuming the position of Incident Commander within minutes of arrival at Philips Park Fire Station. He instigated the chain of events that finally got GMFRS to the scene. He was an impressive officer, who struck me as being highly competent. He was also in a difficult
situation which was not of his making. He was doing his best to fix it.

15.473 The conversation Group Manager Levy was having was further complicated by the fact that he was speaking not just to the duty Principal Officer but to the Chief Fire Officer. Group Manager Levy perceived Chief Fire Officer O’Reilly to be “authoritative”. Chief Fire Officer O’Reilly accepted of himself that he could be “autocratic” when a decision needed to be made.

15.474 Nevertheless, Group Manager Levy was a senior officer best placed to decide what needed to be done. In order to achieve grip in a chaotic situation, which policy did not provide for, Group Manager Levy needed to speak plainly and firmly. Had he done so, the misunderstanding would not have occurred.

15.475 In my view, having considered all of the evidence, if Chief Fire Officer O’Reilly had understood that Group Manager Levy, as Incident Commander, intended to deploy forward from Manchester Central Fire Station, Chief Fire Officer O’Reilly would not have countermanded that deployment at that stage.

598 122/16/9-25
599 132/21/9-22/6
Call from Janine Carden (23:58)

15.476 Following the broadcast on the proposed multi-agency control room channel, at 23:58 Janine Carden called Group Manager Fletcher. She also spoke to Group Manager Levy one minute later.  

15.477 Following these calls, Janine Carden made the following entries on the NWFC incident logs. At 00:01 on 23rd May 2017, she wrote in the Command Support Room log: “Called on [proposed multi-agency control room talk group] GMP Silver [Control Room] asking if fire or amb monitoring confirmed fire monitoring. GM Fletcher informed and asked for GM Levy to be informed.”

15.478 At 00:02, she input into the Philips Park log: “Following liaison with Chief Fire Officer O’Reilly and in absence of forward control point being declared by GMP, crews have moved forward to … Thompson Street [Manchester Central Fire Station] to co-locate with ambulance standby.”

Call to Force Duty Officer (00:03)

15.479 At 00:03 on 23rd May 2017, Group Manager Fletcher got through on the FDO telephone line. His call was answered by David Myerscough.
Group Manager Fletcher informed David Myerscough of the following: that the proposed multi-agency control room talk group was being monitored; that the Command Support Room was open; that Station Manager Lawlor was going to GMP HQ; and that GMFRS was mobilising to Manchester Central Fire Station. Group Manager Fletcher asked for a GMP presence at Manchester Central Fire Station. 603

15.480 David Myerscough replied that he would speak to the FDO and “see what I can do”. 604

15.481 In the notes made after the incident, Group Manager Fletcher recorded that in this call he asked for an FCP. He wrote: “[D]uring the conversation I asked him if the ‘active shooter’ threat had been neutralised which he was unable to do and I confirmed with him that this time, it was still a viable threat.” 605 The document is headed: “The log below was commenced on 23 May 2017, whilst events of the incident were still fresh in my mind.” 606

15.482 Group Manager Fletcher did not ask David Myerscough for an FCP. He did not ask David Myerscough about an active shooter. He was not told by David Myerscough that GMP thought an
active shooter was still a viable threat. These facts are known because GMP recorded the call. Had the call not been recorded, I would have been adjudicating between Group Manager Fletcher’s account and that of David Myerscough. I have no doubt these notes would have been relied upon in good faith.

15.483 I accept Group Manager Fletcher’s explanation that he became confused about this conversation having spoken to others in the immediate aftermath. I accept that it was an honest mistake on his part. But it was a mistake that could have significantly changed the analysis of this period of the event. If GMP had told GMFRS that there might still be an active shooter, then that would be a good reason for great caution by GMFRS at that stage. As it was, this is not what GMP was telling GMFRS.

15.484 This example serves to reinforce the importance of contemporaneous recording of what is said by commanders during a response to a Major Incident. What learning and improvement can be derived from an event is determined by what is understood to have occurred. If changes are made based on a false understanding of events, the necessary alterations to policies and procedures will not be made.

607 128/74/15-76/22
Mobilisation to Manchester Central Fire Station

Philips Park Fire Station to Manchester Central Fire Station (23:55 to 00:05)

15.485 Group Manager Levy’s call with Chief Fire Officer O’Reilly ended at around 23:55. This was at the same time as Station Manager Berry’s call with GMP. Group Manager Levy was not told by Station Manager Berry that GMP had given the Boddingtons car park as an RVP/FCP in that call or that Station Manager Berry had rejected it. Station Manager Berry should have given Group Manager Levy this information.

15.486 At this stage, Station Manager Berry knew that Group Manager Levy was the Incident Commander. I can understand why Station Manager Berry was frustrated by his call with David Myerscough, but, having taken the approach to the call that he did, he should have informed Group Manager Levy what he had been told.

15.487 Group Manager Levy’s evidence was that, if he had known what GMP had said about Boddingtons car park, he would have mobilised resources there, but would probably have held

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608  INQ018835T/12-15
609  122/24/18-25/1
some back at Manchester Central Fire Station.\textsuperscript{610} I accept Group Manager Levy’s evidence on this point. It would have formed a basis for explaining to Chief Fire Officer O’Reilly why he was going beyond Manchester Central Fire Station, which is what Group Manager Levy wanted to do. The Boddingtons car park was on Trinity Way, diagonally opposite the Trinity Way tunnel exit of the Victoria Exchange Complex.

15.488 Following his conversation with Chief Fire Officer O’Reilly at 23:55, Group Manager Levy directed the GMFRS resources at Philips Park Fire Station to mobilise to Manchester Central Fire Station. The first GMFRS appliance to reach Manchester Central Fire Station did so at 00:02 on 23\textsuperscript{rd} May 2017.\textsuperscript{611}

15.489 Station Manager Berry arrived at Manchester Central Fire Station at 00:05. By 00:08, Group Manager Levy was also at Manchester Central Fire Station. At that time, Group Manager Levy called Chief Fire Officer O’Reilly.\textsuperscript{612}

Command Support Room (00:05 to 00:18)

Call from Group Manager Levy (00:08)

15.490 Shortly before Group Manager Levy called Chief Fire Officer O’Reilly at 00:08 on 23\textsuperscript{rd} May 2017,
Chief Fire Officer O’Reilly had spoken, on the telephone, to the NWAS Chief Executive, Derek Cartwright. In this call, Chief Fire Officer O’Reilly learned that the NWAS Deputy Director of Operations, Stephen Hynes, was at the scene. Stephen Hynes was someone Chief Fire Officer O’Reilly knew. Derek Cartwright told Chief Fire Officer O’Reilly to “Ring Steve, he is at the scene.” Derek Cartwright informed Chief Fire Officer O’Reilly that NWAS had “one of their … Golds on the way to police headquarters”. This was a reference to the Strategic Commander Neil Barnes.

15.491 In Group Manager Levy’s call to Chief Fire Officer O’Reilly at 00:08, Group Manager Levy said that he was ready to go from Manchester Central Fire Station to the Victoria Exchange Complex.

Call to Stephen Hynes (00:12)

15.492 Having learned that Stephen Hynes was at the scene, Chief Fire Officer O’Reilly telephoned him at 00:12. By this stage, Stephen Hynes was the NWAS Operational Commander, having relieved Daniel Smith at 23:57. Chief Fire Officer O’Reilly
was outside the Command Support Room when he spoke to Stephen Hynes.  

15.493 Stephen Hynes informed Chief Fire Officer O’Reilly that GMFRS “needed to get down there”. Chief Fire Officer O’Reilly asked Stephen Hynes, “[W]hat did he need?” Stephen Hynes replied that he “just needed 12 firefighters”. Chief Fire Officer O’Reilly asked Stephen Hynes if the Marauding Terrorist Firearms Attack crew with ballistic protection was needed. Stephen Hynes responded, “Absolutely not, I just need 12 firefighters … and an officer.” Chief Fire Officer O’Reilly also recalled that Stephen Hynes added “that the NWAS MTFA [Marauding Terrorist Firearms Attack] resource was still at Manchester Central fire station at the direction of GMP”. Stephen Hynes stated that the firefighters were “to help with casualty recovery from the scene”. Chief Fire Officer O’Reilly said, “Leave it with me, I’ll get them there as soon as I can.”
15.494 Stephen Hynes’ recollection of this short conversation was that he said words to the effect “it’s not MTFA Peter. We just require your firefighters down here.” He stated that what he wanted was support in basic trauma and moving equipment such as stretchers or trolleys. In his witness statement he described asking for “12 trauma-trained firefighters and a commander”. In fact, as a later message demonstrates, Stephen Hynes wanted “trauma technicians”. I will return to the evidence for that and what a trauma technician is in paragraphs 15.518 to 15.525.

15.495 Chief Fire Officer O’Reilly did not recall a request for “trauma-trained” firefighters from Stephen Hynes.

15.496 I am unable to resolve exactly what was said in this call. What is clear is that Stephen Hynes stated that support from specialist firefighters was not required by NWAS.

15.497 After the call, Chief Fire Officer O’Reilly returned to the Command Support Room.
Deployment decision

15.498 There were five senior GMFRS officers in the Command Support Room at this point. Group Manager Nankivell, Group Manager Fletcher and Area Manager Etches were all of the view that the specialist responders should be sent to the Arena.\textsuperscript{630} Having spoken to Stephen Hynes, it was Chief Fire Officer O’Reilly’s view that non-specialists should be sent in.\textsuperscript{631} Assistant Chief Fire Officer Harris, who had arrived at the Command Support Room just before Chief Fire Officer O’Reilly returned to the room, agreed with Chief Fire Officer O’Reilly.\textsuperscript{632}

15.499 The reasoning behind the two positions was explored in the evidence. There were a number of relevant considerations. First, the capabilities of the Specialist Response Team in terms of their enhanced first aid abilities, as against the non-specialist firefighters. Second, there was the question of hazards. At this stage, those in the Command Support Room were unaware that Operation Plato had been declared. Even so, the possibility that the Specialist Response Team might be able to go into areas that unprotected firefighters could not was also a consideration.

\begin{itemize}
\item \textsuperscript{630} 128/80/25-81/5, 129/78/6-8, 129/207/7-208/20, 130/94/21-23, 132/36/15-18
\item \textsuperscript{631} 132/34/13-37/15
\item \textsuperscript{632} 130/95/17-21
\end{itemize}
15.500 Both those factors were debated. In the end, despite strong professional disagreement, Chief Fire Officer O’Reilly decided to follow Stephen Hynes’ request. This was a difficult decision. The only direct situational awareness was coming from Stephen Hynes who was at the scene. In my view, Chief Fire Officer O’Reilly cannot be criticised for acting upon what he had been told. It is essential that the emergency services work together. Deferring to the NWAS Operational Commander, who had a better situational awareness and a better understanding of what was required, was a reasonable position.

15.501 I am not critical of either side of this debate for having a short, professional and robust discussion. It was right that they did so. But a decision needed to be made. In the circumstances, Chief Fire Officer O’Reilly’s decision was a reasonable one at the time he made it.

15.502 The problem with the decision to mobilise 12 non-specialist firefighters and a commander lay with the Operation Plato declaration. At this time, no one in GMFRS knew that Operation Plato had been declared. GMFRS officers were rightly wondering if Operation Plato would be declared, but Chief Fire Officer O’Reilly had raised this with Stephen Hynes, who had dismissed it as a concern. Stephen Hynes had dismissed the need
for crews that were ballistically protected because Stephen Hynes did not become aware of the Operation Plato declaration until over half an hour after this discussion.

15.503 I do not criticise Chief Fire Officer O’Reilly’s decision on the basis of this problem. Nor do I criticise Stephen Hynes for saying that he did not want Marauding Terrorist Firearms Attack specialists on this basis. Responsibility for this incorrect decision lies with GMP and Inspector Dale Sexton for failing to communicate the Operation Plato declaration. I discuss this in Part 13.

Call to Group Manager Levy (00:15)

15.504 At 00:15, Group Manager Levy notified NWFC that he was the Incident Commander. Immediately following this, he made a call to Chief Fire Officer O’Reilly. In that call, Chief Fire Officer O’Reilly informed Group Manager Levy of his conversation with Stephen Hynes. Group Manager Levy queried whether NWAS required operatives with Marauding Terrorist Firearms Attack capability. Chief Fire Officer O’Reilly informed him that Stephen Hynes had said NWAS did not.633

633 122/14/22-15/5, 122/29/8-30/22
15.505 Chief Fire Officer O’Reilly stated he wanted Group Manager Levy to know as “a courtesy”.\(^{634}\) Chief Fire Officer O’Reilly stated that this was the instruction the Command Support Room was going to give to NWFC for mobilisation. He wanted Group Manager Levy to know what the Command Support Room was asking NWFC to send to the scene.\(^{635}\) Group Manager Levy was not happy with this decision. He challenged it.\(^{636}\)

15.506 GMFRS policies did not envisage a situation in which the Command Support Room would give mobilisation instructions to the Incident Commander. The policies expected the opposite: the Incident Commander in full command of the incident, with the Command Support Room in a support role. However, GMFRS policies also did not envisage an Incident Commander with only second- or third-hand situational awareness, none of which came from a commander of another emergency service.

15.507 Decisive action was required. Chief Fire Officer O’Reilly had better situational awareness than Group Manager Levy following his conversation with Stephen Hynes. It was reasonable for Chief Fire Officer O’Reilly to direct NWFC to provide Group Manager Levy with a mobilisation

\(^{634}\) 132/34/25-35/14  
\(^{635}\) 132/35/1-24  
\(^{636}\) 122/36/7-9, 122/36/24-37/5
instruction. It is regrettable that this mobilisation decision was, for the reason I gave in paragraphs 15.501 to 15.503, flawed.

15.508 As Incident Commander, Group Manager Levy did not regard himself as obliged to follow the instruction from Chief Fire Officer O’Reilly. In his mind was the thought “if I’d … disobeyed the chief … and something terrible had happened”. Although Group Manager Levy’s plan to mobilise the Specialist Response Team was correct, I am not critical of him for acting upon the instruction he received. It was important that a command hierarchy be maintained. Group Manager Levy was also correct to take the view that Chief Fire Officer O’Reilly might have access to better information than he did.

GMP Headquarters (00:05 to 00:18)

Arrival at GMP Headquarters (00:05)

15.509 Station Manager Lawlor made his way from his home to GMP HQ. He arrived at 00:05. This was approximately the same time that firefighters arrived at Manchester Central Fire Station. Station Manager Lawlor made his way to the Silver Control Room. He described the atmosphere in the Silver Control Room as “busy, as you would expect, but no different, really, to
any other event that we support in Silver”. 638
He took up his place at the desk allocated to GMFRS. 639

15.510 At approximately 00:15, Station Manager Lawlor was approached by GMP Temporary Superintendent Hill. Temporary Superintendent Hill asked Station Manager Lawlor, “Mick, are you aware of Operation Plato being declared?” 640 Station Manager Lawlor replied, “[N]o. … When was it declared?” 641 Temporary Superintendent Hill said that he was not sure and would get back to Station Manager Lawlor. 642 Station Manager Lawlor’s evidence was that Temporary Superintendent Hill informed him in this conversation that: the Arena itself was the Operation Plato hot zone; the Operation Plato warm zone was the outer perimeter of the Arena, still within the Victoria Exchange Complex; and the Operation Plato cold zone was outside the Victoria Exchange Complex. 643

15.511 Station Manager Lawlor communicated the Operation Plato declaration over the NILO talk group. Station Manager Lawlor’s evidence was that he passed on the information about

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638 126/103/17-19
639 126/100/12-103/19
640 126/107/14-15
641 126/107/16-17
642 126/106/9-108/7, 104/211/21-212/3
643 126/117/14-118/7
zoning. Zoning of the Victoria Exchange Complex is not something that appears in Station Manager Lawlor’s notes in his 00:15 entry. There is no record timed earlier than 04:01 on 23rd May 2017 in Station Manager Lawlor’s notes about zoning. Temporary Superintendent Hill stated that he did not have a conversation with anyone about zones until 00:51, at which point he spoke to Chief Inspector (CI) Mark Dexter about zoning.

I am satisfied that Station Manager Lawlor was notified of the zoning after 00:51. I am also satisfied that Station Manager Lawlor did not ask Temporary Superintendent Hill about zoning when Temporary Superintendent Hill first notified him of the Operation Plato declaration at 00:15. Station Manager Lawlor should have asked about zoning when learning of the Operation Plato declaration. This information should have formed part of the information he was giving to the NILOs and the Command Support Room. It was capable of affecting the mobilisation decision. It is likely that if he had asked Temporary Superintendent Hill about zoning at 00:15, Station Manager Lawlor would have prompted GMP to think more

644 126/118/8-12
645 INQ026726
646 104/199/1-10, INQ040657/65-66
rigorously about the zoning of the Victoria Exchange Complex at that stage.

Command Support Room (00:18 to 00:22)

Call from Station Manager Lawlor (00:18)

15.513 At 00:18, Station Manager Lawlor telephoned Group Manager Fletcher. Station Manager Lawlor informed Group Manager Fletcher of the Operation Plato declaration. Group Manager Fletcher spoke to Chief Fire Officer O’Reilly about deploying the Specialist Response Team in light of the information about Operation Plato. Chief Fire Officer O’Reilly replied that just the non-specialist firefighters would be deployed.

15.514 Chief Fire Officer O’Reilly’s reasoning for this was as follows. First, he stated that he was responding to the request from NWAS. Second, he stated: “What we wanted – the priority for us – was to have an incident commander there, and that incident commander would then have immediate situational awareness because they would be speaking to ambulance Bronze and … the police Bronze.”

\[647 \text{ INQ004348/66} \]
\[648 \text{ 128/81/14-19} \]
\[649 \text{ 128/82/3-7} \]
\[650 \text{ 128/81/14-85/8} \]
\[651 \text{ 132/43/24-44/19} \]
Chief Fire Officer O’Reilly’s decision at this stage was flawed. He should have immediately recognised that, once his non-specialist firefighters arrived, they might not have been able to assist the paramedics in some areas. He was entitled to place substantial weight on Stephen Hynes’ knowledge from the scene. However, the new information demonstrated that Stephen Hynes’ information was incorrect: in the call at 00:12 Stephen Hynes had dismissed the suggestion that this might be a Marauding Terrorist Firearms Attack.

On learning of the Operation Plato declaration, Chief Fire Officer O’Reilly should have mobilised the Specialist Response Team. This would have provided GMFRS with an immediate Operation Plato warm zone capability at the scene, if it were required. Adding to what Stephen Hynes had requested was justified in light of the new information. Waiting for Station Manager Berry to arrive, before potentially discovering that there were areas in which his firefighters could not operate, and only then mobilising resources, had the potential to waste precious time. Which is what, in fact, occurred to a modest degree.
Call to NWFC (00:18)

15.517 At 00:18, Group Manager Nankivell telephoned NWFC. In the call, Group Manager Nankivell informed NWFC:

“We’re sending two [fire appliances] … they’re going down now to … Corporation Street to meet with HART … with Andy Berry, is gonna be taking them down there.”

Call to NWFC (00:21)

15.518 At 00:21, Group Manager Nankivell spoke to Janine Carden at NWFC. In the course of the call, Janine Carden informed Group Manager Nankivell that NWFC was in the middle of a call with NWAS Control.

15.519 In the call between NWFC and NWAS Control, NWAS Control said, “I’ve got a request from our Gold Commander at the scene.” This was a reference to Stephen Hynes, who was a qualified Strategic/Gold Commander, but was acting as Operational/Bronze Commander. NWAS Control went on, “Can we have 12 firefighters, equivalent to 3 pumps and one officer … To support the movement of casualties. If possible,
trauma technicians … And we want them to go to Victoria Station.”

15.520 In her call with Group Manager Nankivell at 00:21, Janine Carden relayed the substance of what NWAS Control was asking for. This included raising the fact that trauma technicians were being requested “if possible”.

15.521 Group Manager Nankivell, in evidence, explained what a trauma technician was. He said:

“Trauma technicians are trained to the same level as a firefighter but then they go on a hospital placement or out with a paramedic and they learn the slightly more technical things to do with life-saving interventions.”

15.522 Group Manager Nankivell stated: “[W]e tried to have one [a trauma technician] on every appliance, but it didn’t always work out that way.”

15.523 After this call, Group Manager Nankivell drew Chief Fire Officer O’Reilly’s attention to the request for trauma technicians. Chief Fire Officer O’Reilly’s recollection of his response to this was that he said: “[E]ven if we wanted to, we wouldn’t
be able to get 12 trauma technicians on the one fire engine.”

15.524 Chief Fire Officer O’Reilly should have paused at this stage to reflect. Again, he had new information. The substance of what he was being asked for was firefighters with greater first aid skills than standard firefighters possessed. It would have been acceptable for him to have telephoned Stephen Hynes to clarify the request that had been made. It would also have been acceptable for him to have deployed the Specialist Response Team, on the basis that they would bring additional first aid skills above those of a trauma technician. What he should not have done is continue on as planned.

15.525 Chief Fire Officer O’Reilly accepted during his evidence that he “should have acknowledged” the representations made by Group Manager Nankivell “better”. He also stated that he “should have made a decision to include an element of the specialist response team in that response to the arena”.

661 132/204/19-205/3
662 132/104/15-17
663 132/104/3-22
Mobilisation to Victoria Exchange Complex (00:19 onwards)

Call to NWFC (00:19)

15.526 At 00:19, Group Manager Levy called NWFC. He spoke to David Ellis. Group Manager Levy notified NWFC that “Station Manager Berry proceeding to … Rendezvous point … At Corporation Street with [three fire appliances] … All of the resources remaining stand by at Thompson Street [Manchester Central Fire Station].”

15.527 Group Manager Levy spoke to Station Manager Berry shortly after this call. He did so just as Station Manager Berry was setting off. Group Manager Levy is likely to have learned of the Operation Plato declaration either over the NILO radio broadcast made by Station Manager Lawlor or from a call he had with Group Manager Fletcher at 00:20.

15.528 Group Manager Levy informed Station Manager Berry that Operation Plato had been declared. Group Manager Levy asked Station Manager Berry to wait. Group Manager Levy instructed Station Manager Berry not to deploy with the
standard fire appliances because of the Operation Plato declaration.  

Call from Assistant Chief Fire Officer (00:25)

15.529 Assistant Chief Fire Officer Harris stated that Group Manager Nankivell, Group Manager Levy and Group Manager Fletcher continued to discuss the potential to mobilise the Marauding Terrorist Firearms Attack capability. Assistant Chief Fire Officer Harris considered that this conversation was not taking into account the information received from Stephen Hynes.

15.530 At 00:25, Assistant Chief Fire Officer Harris called Group Manager Levy. Assistant Chief Fire Officer Harris said words to the effect of, “I’ve heard you on the radio, Ben. I know you are trying to be helpful, but we don’t need anything else from you now.” Group Manager Levy interpreted this as effectively relieving him of command. Assistant Chief Fire Officer Harris’s evidence was that he did not intend it in this way.

15.531 By this stage, the pressure that all GMFRS personnel felt under meant that the risk of misunderstanding was high. It was the responsibility of both of these senior officers to

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667 120/78/19-25
668 130/137/20-138/15, 130/122/1-128/5
669 122/40/12-14
670 122/40/4-17, 130/134/12-23
guard against this. Both should have expressed themselves with greater clarity and ensured that they had been understood correctly. In particular, if Group Manager Levy considered that he was being relieved of command, he should have asked directly whether this was what was happening. As it was, Assistant Chief Fire Officer Harris was unaware that Group Manager Levy had appointed himself as Incident Commander.

15.532 Following the conversation with Assistant Chief Fire Officer Harris, three non-specialist fire appliances deployed to Station Approach.671

15.533 Group Manager Levy’s initial countermand of the mobilisation instruction was a product of the chaotic position GMFRS was in by this stage. It caused further delay. The lack of clarity around whether Group Manager Levy or Chief Fire Officer O’Reilly was in command meant that conflicting orders were given.

15.534 By this stage, the errors that I have identified above had compounded to create an impossible situation for Group Manager Levy. He had rightly put himself in command in an effort to get the response moving. He was also right to recognise that the Operation Plato declaration meant that the Specialist Response Team were the right team to deploy because of their ability to operate

671 INQ041473/75
in the warm zone. The Specialist Response Team’s enhanced first aid skills were also likely to be an asset.

15.535 Simultaneously, Chief Fire Officer O’Reilly was right to regard himself as the person in the best position to make command decisions. However, he failed to adjust his thinking in light of the new information. This led to an impasse with Group Manager Levy.

15.536 The situation was resolved by Assistant Chief Fire Officer Harris instructing Group Manager Levy to defer to Chief Fire Officer O’Reilly’s decision. At this point, Group Manager Levy was left with no real choice. He knew that he did not have the full picture. Two more senior officers, including the head of GMFRS, were insistent on the non-specialist deployment. That decision was not so obviously wrong as to justify additional protest, which would only delay the GMFRS response further. As a result, I have concluded that Group Manager Levy was correct to adopt the position he did and acquiesce on the deployment of non-specialists.

Arrival on Station Approach (00:36)

15.537 Station Manager Berry travelled to the scene in a GMFRS car in convoy with the fire appliances.
He made telephone calls during the period between 00:27 and 00:33, involving the Command Support Room, Group Manager Levy and NWFC. Station Manager Berry also spoke to NWAS, in order to establish where the ambulances were located at the scene. The answer from NWAS Control was that the RVP was Manchester Central Fire Station.  

15.538 Station Manager Berry had been directed to travel to the corner of Miller Street and Corporation Street. Station Manager Berry did not find the ambulances he expected at this location. At 00:33, he spoke to Group Manager Nankivell who told him to go to Hunts Bank.  

15.539 At 00:36:59, the first fire appliances arrived on Station Approach near the junction with Hunts Bank. Station Manager Berry arrived seconds later.

Entry to Victoria Exchange Complex (00:43)

15.540 At 00:39, Station Manager Berry approached Stephen Hynes outside the War Memorial entrance to Manchester Victoria Railway Station. Also present was CI Dexter. It was apparent to Station Manager Berry that emergency service personnel were operating in that area without
ballistic protection. In Station Manager Berry’s mind, this “didn’t add up” with the Operation Plato declaration.677

15.541 Station Manager Berry asked Stephen Hynes what GMFRS could do to help. Stephen Hynes asked for blankets to be collected and for any GMFRS staff not dealing with that to help with P3 casualties, those who were ‘walking wounded’.678 Stephen Hynes informed Station Manager Berry that inside the Victoria Exchange Complex was a “warm zone”.679

15.542 When Stephen Hynes told Station Manager Berry this, Stephen Hynes did not know that Operation Plato had been declared. What Stephen Hynes was seeking to communicate was that the inside of the Victoria Exchange Complex was an NWAS Major Incident warm zone.680 Because Station Manager Berry knew about the Operation Plato declaration, he interpreted it as being an Operation Plato warm zone.681 This is a clear example of why the use of hot, warm and cold zones for two different emergency responses can create problems.
15.543 Station Manager Berry issued an instruction not to go into the Victoria Exchange Complex. He stated in evidence that he did so because what he was seeing in terms of unprotected responders did not add up with an Operation Plato declaration.\textsuperscript{682} This was unduly risk averse and overly cautious in light of the circumstances.

15.544 At 00:43, an NWAS paramedic directed a firefighter carrying an oxygen bottle into the railway station through the War Memorial entrance.\textsuperscript{683} One minute later, GMFRS personnel were spoken to by the NWAS Advanced Paramedic Patrick Ennis on Station Approach outside the War Memorial entrance.\textsuperscript{684} At 00:46, firefighters walked past the War Memorial entrance on Station Approach, carrying an oxygen bottle and a first aid kit.\textsuperscript{685} At 00:47, firefighters were captured on CCTV pulling casualty trolleys along Station Approach in the direction of the War Memorial entrance.\textsuperscript{686} Two minutes later, they wheeled the casualty trolley through the War Memorial entrance into the Victoria Exchange Complex.\textsuperscript{687} By 00:54:39, firefighters were present in the Casualty Clearing

\begin{itemize}
\item \textsuperscript{682} INQ035612/509
\item \textsuperscript{683} INQ035612/504
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\item \textsuperscript{687} INQ035612/509
\end{itemize}
Station, near the bottom of the staircase to the raised walkway. They had understandably decided to enter the complex, notwithstanding Station Manager Berry’s instruction.

15.545 At 00:53, Chief Fire Officer O’Reilly telephoned Station Manager Berry. It is not clear whether that call connected. Later in the same minute, Station Manager Berry called Chief Fire Officer O’Reilly back. The call lasted for just under five minutes. In the initial part of the call, Station Manager Berry informed Chief Fire Officer O’Reilly that he was trying to get information about where he could deploy firefighters. Chief Fire Officer O’Reilly stated that he was surprised at this. His evidence was:

“It came as a real surprise to me that I was getting a phone call at all with regards to the deployment of resources. My expectation would have been that an officer arriving on scene would have spoken to the other two Bronze Commanders on scene, that they would have had a full debrief to give Andy … It would have been my expectation then that what Andy would have done as a result of that … he would have done what we always do in the Fire Service … contacted North West Fire Control … asked for additional resources,
based on the hazards and risk that he had
been identified to and what the tactical plan
was.”

15.546 In light of the fact that Chief Fire Officer O’Reilly
called Station Manager Berry first, Chief Fire
Officer O’Reilly’s evidence that he was surprised
to get a call was probably a mis-recollection on
his part. However, the substance of what Chief
Fire Officer O’Reilly was saying was that he did
not expect an Incident Commander on the
incident ground to be asking him about the
deployment of resources.

15.547 I am less surprised. Chief Fire Officer O’Reilly
had intervened to make the mobilisation decision.
He had overruled a senior NILO about which
resources should be deployed. While I am not
critical of him for his initial intervention, his
subsequent overruling of Group Manager Levy
when the Operation Plato declaration was known
created a situation in which Station Manager
Berry had resources at the scene that were not
suited for all parts of the scene as Station
Manager Berry understood it to be.

15.548 At 00:54:55, Station Manager Berry approached
CI Dexter on Station Approach. CI Dexter had his
Dictaphone on, so what was said was recorded.
Station Manager Berry asked, “Are you the GMP
Bronze?” CI Dexter answered, “Ground Assigned TFC [Tactical Firearms Commander].” Station Manager Berry said, “Sorry, I’ve got the Chief on the phone … We haven’t got ballistic gear on, I need authorisation off our Chief.” CI Dexter responded, “To do what?” Station Manager Berry explained, “To go in the warm zone.” CI Dexter responded: “It’s warm going cold.” 691

15.549 Following this exchange, Station Manager Berry offered the phone to CI Dexter so he could speak to Chief Fire Officer O’Reilly. CI Dexter then proceeded to give Chief Fire Officer O’Reilly a briefing, which included:

“[I]t’s purely IED [Improvised Explosive Device] there is no ongoing firearms threat that we are aware of, I’m not going to object to them wearing ballistic protection if that’s what they need to wear but at the minute I would say that, that risk is probably quite low.” 692

15.550 A little later in the call with Chief Fire Officer O’Reilly, CI Dexter said: “Yeah, I would say there is potential for a second IED albeit it is diminishing so yeah if you go with it, from a firearms point of view at the moment its low.” 693
15.551 After the conversation ended, Station Manager Berry asked CI Dexter what was said. CI Dexter replied, “He’s on about ballistic protection – I said if you want to wear ballistic protection, wear ballistic protection but there is no firearms threat at the moment.” Station Manager Berry asked, “Was he happy with that?” CI Dexter responded, “God knows.”

15.552 This conversation demonstrates why Chief Fire Officer O’Reilly was wrong not to send specialists when he discovered that Operation Plato had been declared. The whole point of Operation Plato is to declare zones. This is what keeps the emergency personnel as safe as possible. If Station Manager Berry had had the Specialist Response Team with him, he could have deployed them straight into the “warm zone” when informed of it by Stephen Hynes.

15.553 Before Station Manager Berry began to speak to Chief Fire Officer O’Reilly at 00:53, firefighters had already gone into the Victoria Exchange Complex. I found it extraordinary that they had not been directed to do this very shortly after their arrival. The firefighters were less concerned for their own safety than their commanders were. The conversation about entering the railway station with ballistic gear was, by then, academic:
most, if not all, of the firefighters were already in the Casualty Clearing Station, despite the instruction that had been given by Station Manager Berry. The firefighters disobeyed the instruction to remain on Station Approach and entered the Victoria Exchange Complex to try to help.

**Contribution to emergency response**

15.554 The firefighters provided support to the paramedics in the Casualty Clearing Station. At 00:43 on 23rd May 2017, the first firefighter was captured on CCTV assisting NWAS.695 By this time, over an hour had passed since the final casualty had been moved from the City Room. By this time, GMFRS could make no contribution to the extraction of casualties from the City Room to the Casualty Clearing Station.

15.555 There were still 28 casualties in the Casualty Clearing Station at 00:43 on 23rd May 2017.696 The 13 firefighters were able to make a contribution to support NWAS, despite arriving so late on the scene.

15.556 They were too late to offer any assistance to those who died.

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695 INQ035612/495
696 INQ041266/1
15.557 I am critical of Chief Fire Officer O’Reilly’s decision not to send the Specialist Response Team to the Victoria Exchange Complex. However, it is important that I acknowledge the fact that, even though those who were sent were non-specialists, it did not prevent them from going where they needed to go at the Victoria Exchange Complex, other than for a short period of time immediately after they arrived.

15.558 I am not able to say whether the enhanced first aid capabilities of the Specialist Response Team would have made a difference to those in the Casualty Clearing Station. By 00:50 on 23rd May 2017, there were 21 ambulances at the scene. By 01:40 on 23rd May 2017, this had risen to 32 ambulances. 697

15.559 However, it took more than two hours from the arrival of GMFRS at the Victoria Exchange Complex for some of those in the Casualty Clearing Station to be moved to hospital. 698 It is possible that having firefighters with enhanced first aid skills would have freed up NWAS staff to take people to hospital faster. In saying this, I recognise that no additional request for firefighters beyond the initial 13 was made by NWAS.

697 INQ041992/1
698 INQ041266/1
Conclusion: why it went so wrong for GMFRS

15.560 As I stated at the beginning of this section, GMFRS made a frank concession in its closing statement that it would be fair to describe GMFRS as risk averse on 22nd May 2017. Having heard the accounts of the GMFRS officers, it is important that I acknowledge that none of them was risk averse in relation to their own personal safety. I have no doubt that every single member of GMFRS who responded on the night was a person possessing significant personal courage.

15.561 There is no doubt that GMFRS personnel wanted to join the emergency response. All GMFRS personnel who gave evidence expressed how unhappy they were, and how unsatisfactory they thought the GMFRS response was. There was a substantial quantity of evidence that this dissatisfaction during the period of inertia was being raised passionately by frontline firefighters on the night of the Attack. In the early hours of the morning of 23rd May 2017, many frontline firefighters turned their backs to Assistant Chief Fire Officer Harris when he came to debrief them.

699 INQ042436/36 at paragraph 133
700 69/114/19-115/13
15.562 The apparent aversion to risk lay principally with Station Manager Berry. He had been best placed to get the GMFRS response moving in the right direction, but the effect of his first decision was to direct some resources away from the scene. He assumed at an early stage that GMFRS was responding to marauding terrorists with firearms. His attitude was that, until he received positive evidence to the contrary, he was proceeding on that basis. I have no doubt that he would have given that impression to everyone to whom he spoke.

15.563 The NILO training Station Manager Berry received had focused on incidents similar to the Paris 2015 attacks. It was right to do so, as undoubtedly such attacks are the most complex and dangerous to respond to. I have no doubt that Station Manager Berry’s inability to contact the FDO also contributed to his sense that an event of extraordinary proportions was taking place. It was, however, in an information vacuum, that Station Manager Berry overestimated the risk.

15.564 The length of Station Manager Berry’s journey compromised his ability to re-evaluate initial decisions and consider alternative options. It would have been better if Station Manager Berry had discharged his responsibilities from home.
There was an apparent unwillingness by other senior officers to intervene as time passed. This was a different sort of aversion to risk. It was an aversion not to danger but to stepping outside of their role.

The unavailability of the FDO played a very significant role. Even allowing for this, the response of an entire fire and rescue service should not stall just because one person does not answer the telephone. The lack of the use of an alternative route to getting key information was striking. GMFRS should have identified multiple alternative routes before the night of the Attack. Speaking to the GMP Tactical/Silver Commander or the GMP Strategic/Gold Commander should have been well established as a means of communicating. Even if they were not the subject of pre-planning, these routes should have occurred to someone from GMFRS on the night of the Attack. They did not.

When the FDO was unavailable, obtaining information from GMFRS’s partner agencies should have been a previously well-used route to gaining situational awareness. It did not occur to anyone from GMFRS to find out whether NWAS or BTP had spoken to the FDO. Nor did it occur to anyone at GMFRS to find out where BTP and NWAS were sending their personnel. If this latter question had been asked, GMFRS would quickly
have realised that it should mobilise resources to the Victoria Exchange Complex.

15.568 Finally, the approach to the appointment of the Incident Commander was exposed as being flawed in these circumstances. Relying on arrival at the incident ground as a trigger to appointment is a system that works well for GMFRS’s daily activity. It is extraordinary that no one in GMFRS prior to 22nd May 2017 thought to ask how GMFRS would respond if it did not mobilise to the scene. It meant that, until Group Manager Levy’s intervention at around 23:45, no one from GMFRS regarded themselves as being in command of the incident response. This meant that all momentum was lost.
Part 16
The Victoria Exchange Complex

Introduction

16.1 The Inquiry’s terms of reference require me to consider the adequacy of the preparedness for and response to the Attack by organisations beyond the emergency services.

16.2 Three principal organisations had staff present at the Arena for the Ariana Grande concert: SMG, Showsec and Emergency Training UK (ETUK). In Part 2 in Volume 1, I set out in detail the arrangements between SMG and Showsec. Both organisations had staff at the Victoria Exchange Complex when the bomb was detonated. In the case of Showsec, some of those staff were in the City Room at that moment. The employees of both SMG and Showsec did what they could to help casualties of the explosion. Staff from ETUK went to the City Room to offer assistance.

16.3 In addition to staff directly related to activity at the Arena, there were employees of Northern Rail and TravelSafe present within the Victoria
Exchange Complex in connection with the railway and tram stop.

16.4 There were also many members of the public within the Victoria Exchange Complex when the explosion occurred. Some were in the City Room at that moment. Many more event-goers were within the Arena. Additionally, there were people in the travel areas of the Victoria Exchange Complex: the railway platforms, the tram stop, the station concourse and the NCP car park. A number of these people made important contributions to the effort to save lives. At least one member of the public came to help at the scene from outside the Victoria Exchange Complex.

16.5 In this Part, I deal with those organisations and individuals. Where appropriate, I examine the issue of how prepared the organisations in question were for a Major Incident.
SMG and Emergency Training UK
preparedness

Key findings

• SMG had an obligation under the premises’ licence to ensure that an adequate number of staff trained in first aid were present at every event.

• SMG was responsible for ensuring adequate healthcare services to event-goers and visitors to the City Room.

• In 2007, SMG and Emergency Training UK (ETUK) reached a contractual agreement that ETUK would supply healthcare services at the Arena.

• The SMG–ETUK contract required attendance at every event by a person from ETUK qualified in Major Incident response.

• The SMG–ETUK contract required information about the training and qualification level of ETUK staff to be provided for every event. ETUK did not provide this information. For reasons that were not satisfactorily explained, SMG did not insist on its provision.
- The SMG Operational Procedures document was not provided to North West Ambulance Service (NWAS) as it should have been.

- The ETUK Major Incident Plan anticipated that a METHANE message would be passed to NWAS in the event of a Major Incident.

- SMG’s event healthcare provision document anticipated that the number of healthcare staff would be determined by an event-specific risk assessment. No adequate risk assessment was carried out for the Ariana Grande concert on 22nd May 2017.

- ETUK Director Ian Parry presented himself as having a Major Incident management qualification and an Advanced Life Support qualification. He had obtained such qualifications. However, both had expired six or more years prior to the Attack. He had not undertaken the required refresher training.

- Ian Parry did not require a sufficiently high standard of skill from ETUK staff members. It was his, not the staff’s, responsibility to ensure that there was a sufficient skill level across the staff for every event at the Arena.

- Not all ETUK staff on duty on the night of 22nd May 2017 were trained in the application of tourniquets.
• The arrangement between SMG and ETUK in relation to equipment was unsatisfactory. It led to individual members of staff providing their own first aid equipment.

• ETUK engaged in exercising prior to the Attack. However, this engagement was inadequate. As a result, staff were not adequately prepared for a real-world mass casualty incident.

• ETUK and NWAS had not developed a sufficiently close relationship prior to the Attack.

• Neither SMG nor ETUK took an adequate approach to considering how the healthcare service at the Arena would respond to a mass casualty incident.

Introduction

16.6 SMG had an obligation under the Arena’s premises’ licence to “ensure that an adequate number of staff trained in First Aid is present at every event”. The premises’ licence also imposed other relevant obligations. These included: the requirement for a contingency plan formulated in conjunction with the emergency services; provision of a first aid room; ensuring that all crowd stewards had received basic training in first aid; making checks before every
event in relation to “first aid rooms and equipment”; and ensuring that “the necessary first aiders are present and in post”.2

16.7 James Allen, Arena General Manager for SMG, rightly accepted that SMG was responsible for ensuring adequate healthcare services to event-goers and visitors to the City Room.3 He also accepted that he had a personal responsibility for the adequacy of that provision as Arena General Manager.4

16.8 ETUK was incorporated in 2005.5 From the start, ETUK was run by Ian Parry, who owned the shares in it.6 At first, its sole director was Ian Parry’s daughter. In due course, Ian Parry’s wife also became a director. Neither Ian Parry’s daughter or his wife had any involvement with the operation of the company.7

16.9 By a contract with SMG dated 1st June 2007 (the SMG–ETUK contract), ETUK agreed “to provide overall management of medical and first aid services at an event”.8 From that date, ETUK provided healthcare services at the Arena on a

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2 INQ035447/5, INQ035447/9, INQ035447/12
3 90/33/17-20
4 90/33/13-16
5 133/64/6-14, 133/65/18-20
6 133/65/15-17
7 133/66/16-67/7
8 INQ040492/1, INQ040492/25
continuous basis up to and including the night of the Attack.

16.10 As I set out in Part 11, guidance on how to make adequate provision for healthcare services at events was provided in *The Purple Guide to Health, Safety and Welfare at Music and Other Events*, known as the Purple Guide.  \(^9\)

16.11 I recognise that, in a mass casualty incident, an event healthcare organisation will not be able to provide the level of care that is provided by the combination of an ambulance service and hospital staff. However, such an organisation has an extremely important role to play in keeping the injured alive while the ambulance service get to the scene. I will address this further in Part 20 in Volume 2-II when I consider ‘the Care Gap’.

**SMG and Emergency Training UK’s contract**

16.12 Ian Parry’s relationship with SMG did not begin on 1\(^{st}\) June 2007. He had worked at the Arena since 1999, initially as part of AAA Training and Technology, then as part of Emergency Training Limited. ETUK was set up when, in 2005, Emergency Training Limited was dissolved, and ETUK continued to provide healthcare services on the same basis.  \(^{10}\)
16.13 The SMG–ETUK contract was signed following a tender process. James Allen stated that the tender process was triggered, in part, by his concern about the behaviour of ETUK. The concern was based around allegations that ETUK had failed to pay its staff promptly, and that there had been a refusal to treat people in areas outside the Arena bowl and concourse, such as the City Room, as ETUK staff were concerned that insurance would not extend to that area.

16.14 The tender was based upon a document prepared by James Allen. James Allen did not have any healthcare expertise. SMG did not seek the support of anyone with healthcare expertise when creating the tender document or when considering the three submissions made to it. Expertise was required because of the size of the Arena and the number of people attending events. Three organisations, including ETUK, tendered for the work. James Allen’s review of the tender submissions described ETUK as “the easy option”. By contrast, James Allen described one of the other organisations who tendered as “the safe option”.

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11 90/42/23-43/5
12 90/42/23-45/10
13 90/39/12-15
14 90/69/12-70/12
15 90/69/18-70/12
16.15 As part of his internal report on the tender process, James Allen noted of the ETUK submission: “Ian Parry is the only one qualified to deal with emergency situations. A lot of EMT [Emergency Medical Technician] technically proficient staff have left to setup their own company leaving Ian as lone highly experienced medical figure.” James Allen agreed that the situation he was describing was not an ideal state of affairs.

16.16 Shortly after the SMG–ETUK contract was signed, James Allen prepared a note, the content of which he said he put in an email. In the note, he recorded:

“[P]art of the reason for the changes in the contract … is a concern we have records that in 2 or 3 years’ time we can pinpoint members of staff that were on duty and the minimum qualifications that person had at that time … I need to be confident that everyone on every show has reached this minimum level and that someone as part of your event team has the ability to deal with a major incident, ie is MIMMS qualified.”
16.17 ‘MIMMS’ stands for Major Incident Medical Management and Support and was a qualification provided by the Advanced Life Support Group.\textsuperscript{19}

16.18 James Allen said that the content of this note was sent in an email to Ian Parry. Ian Parry denied having received it.\textsuperscript{20} I do not need to resolve this dispute, given the terms of the agreement and what occurred after it was signed. It is relevant, though, to James Allen’s and SMG’s state of mind about ETUK.

16.19 The SMG–ETUK contract required ETUK to “\textit{provide full training, qualifications and experience of first aiders and EMTs on duty which must be submitted to the venue Duty Manager for all events as part of their pre-event checks}”.\textsuperscript{21} ‘EMTs’ stands for Emergency Medical Technicians. The title ‘EMT’ was not a protected title within the healthcare regulatory framework. This means that the qualifications for this role were not specified by law, and a person claiming such a title was not necessarily regulated by any professional body.

16.20 I do not doubt James Allen’s evidence that he was unhappy about the practices of ETUK towards its staff before 2007. His

\textsuperscript{19} 133/72/13-73/17
\textsuperscript{20} 133/82/8-84/17
\textsuperscript{21} INQ040492/26
contemporaneous note shows that, before entering into a new contract in June 2007, he was also worried about the standard of the training of ETUK staff and whether there would be someone present from ETUK able to respond to a Major Incident.

16.21 Despite the pre-contract concerns and the terms of the SMG–ETUK contract, SMG did not require the training, qualifications and experience of the ETUK staff to be disclosed before each event. James Allen’s explanation was vague when asked why this was. He suggested that the contract had been amended, potentially for confidentiality reasons. He stated that there was nothing in writing to this effect. James Allen agreed that the requirement would have been a “very sensible” idea.

16.22 This is unsatisfactory. No adequate reason was advanced for why SMG did not operate the safeguard it had built into its agreement with ETUK. SMG should have done so.

16.23 A further aspect of SMG’s failure towards ETUK was the lack of any formal review of ETUK’s preparedness and performance, whether internally or by obtaining the opinion of anyone.

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22 90/51/2-15
23 90/50/14-51/5, 90/52/5-12
24 90/51/6-10
independent with relevant expertise. Over the ten years between the agreement being signed and the Attack, SMG took its reassurance from its day-to-day experience of ETUK. This was insufficient, as SMG should have realised. Judging ETUK solely by reference to past events was incapable of providing any reassurance about how prepared ETUK was to respond to an event like the Attack, as nothing like it had occurred.

16.24 If SMG had conducted proper checks on ETUK’s performance, it would have discovered that ETUK was not meeting an adequate standard, particularly in relation to preparedness for a mass casualty incident. This was a significant failure by SMG. I will examine in paragraphs 16.43 to 16.53 how the level of training of ETUK staff who were present on the night of the Attack had an impact upon the adequacy of the response.

Plans

SMG Operational Procedures document

16.25 In Part 6 in Volume 1, I considered SMG’s written risk assessment document, *Operational Procedures: Emergency and Contingency Plans* (the Operational Procedures document). This contained inadequate risk assessments in
relation to the threat of terrorism. It included a generic risk assessment entitled “First Aid Injuries: Multiple and Major Injuries” “Caused by Explosions”. The event risk assessment was driven by the risk from the attendees, not to them. It produced the same total score regardless of the size of the audience.

16.26 James Allen accepted that the approach taken in this risk assessment was “nonsense”. In the event, this inadequate generic risk assessment made no difference, as SMG did not use this part of the Operational Procedures document.

16.27 Two other parts of the Operational Procedures document were directly relevant to the response to an attack. The first was entitled “Bomb and Terrorist Threats”. This set out the response plan in the event of a bomb detonation at the Victoria Exchange Complex. It envisaged a controlled evacuation via appropriate exits. It also provided for a handover process to the emergency services by “the most senior member of staff onsite” using a form in the appendices.
16.28 The second was entitled “Medical Incidents”. This stated: “In the event of a Major Medical Emergency Medic 1, having completed an Internationally recognised Major Incident Training course, will assume overall control until the arrival of the Statutory Emergency Services.”

The ‘Medical Incidents’ part continued by setting out a “Major incident medical emergency plan”.

16.29 This plan anticipated a number of steps. These included: “Medic One will allocate Medic Two to alert team to rendezvous point”; and “Once a major medical incident has been identified Medic One will notify Greater Manchester Ambulance Service and assume overall control until arrival of first unit.”

16.30 SMG has no record of the Operational Procedures document being sent to North West Ambulance Service (NWAS). NWAS has no record of receiving it. This is unsurprising. The circulation list of the Operational Procedures document records that the consultation copy and final copy should be sent to “Greater Manchester Ambulance Service”, the predecessor ambulance
service to NWAS in the Greater Manchester area. Whether or not this occurred, it should have been sent to NWAS when NWAS came into being. It was a significant failure on the part of SMG not to share its plan with NWAS. This failure forms part of a wider problem in terms of co-operation and communication between staff working at the Arena and NWAS. I recommend SMG review its processes to ensure that it has shared with Greater Manchester Police (GMP), Greater Manchester Fire and Rescue Service (GMFRS), BTP and NWAS the most current emergency response plans and policies for dealing with an incident at the Arena. It should also apply this approach more generally to its operations.

Emergency Training UK’s Major Incident Plan

16.31 ETUK had a document entitled ‘Emergency & Contingency Plans’ (the ETUK Major Incident Plan). This was drafted by Ian Parry and mirrored, in substantial part, the SMG Operational Procedures document. Ian Parry copied the content of the ETUK Major Incident Plan from a document given to him by a person at Greater Manchester Ambulance Service.
16.32 The ETUK Major Incident Plan stated: “Once a major medical incident has been identified Medic One will notify North West Ambulance Service and assume overall control until arrival of first unit.” It anticipated that a METHANE message would be passed on by Medic 1. In Part 11, I set out in detail what a METHANE message is and its importance. ETUK’s Major Incident Plan anticipated that Medic 1 would liaise with NWAS personnel and ensure a smooth handover.

16.33 In all three of these respects, the ETUK Major Incident Plan reflected the expectation of the Purple Guide. On the night of the Attack, Ian Parry, in the position of Medic 1, did not do any of these things. Nor did Ian Parry allocate particular roles, such as “Safety Officer” and “Medical Teams”, as was envisaged by the ETUK Major Incident Plan. This should have been done by Medic 1 in conjunction with Medic 2.

16.34 The ETUK Major Incident Plan indicated that “Medical Teams” will “provide basic first aid … following triage”. On the night of the Attack, a number of ETUK staff present in the City Room

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40 INQ024430/3 at paragraph 3
41 INQ024430/4
42 INQ024430/4
43 INQ024430/3 at paragraph 4
44 INQ024430/5
were not “versed” in triage and needed the support of a colleague. 45

16.35 The ETUK Major Incident Plan stated that, in the event of a “Wilful Terrorist/Criminal Act – … no entry will be made into the primary area of this type of incident until agreed by the Senior Fire Officer/Police. Fire Brigade have absolute control of the forward aspect of this type of incident. Control of the overall scene is the responsibility of the Police.” 46 This is not consistent with the approach to terrorist incidents that would generally be taken by emergency services. Other than in the most exceptional circumstances, the police will be the lead agency in the event of a terrorist attack.

16.36 On the night of the Attack, Ian Parry did not make any enquiry of any emergency service personnel about the safety of the area on behalf of the ETUK staff. He should have done so. In the event, this failure did not have an impact upon the response or result in any adverse consequence to ETUK staff. It does show that Ian Parry had little regard for the plan he wrote. When directed by Miriam Stone, Event Manager at SMG on the night of the Attack, to send his staff into the City Room, Ian Parry did enquire of her whether it was safe for his staff to go in.

45 91/19/2-7, 91/19/25-20/12
46 INQ024430/6
Miriam Stone, who could see the City Room on her monitor, responded that it was as far as she could tell. I will set out more detail of this conversation at paragraphs 16.122 to 16.123.

16.37 Ian Parry said that his failure to follow the plan was because “in the real world you don’t expect these things to happen”.\(^{47}\) He also stated that, “in the heat of a real-life situation”, none of the requirements of the ETUK Major Incident Plan were followed.\(^{48}\) He went on to say, “For want of a better word, the whole system fell apart that night.”\(^{49}\) He was wrong to say that there can be no expectation that a plan will be followed. The plan should have been followed, but it required proper preparation by ETUK. While Ian Parry did not expect there to be an explosion caused by a bomb, he should have been aware of, and prepared for, the possibility that this might happen.

16.38 While it is inevitable that not every aspect of a plan will necessarily be followed, as the Ambulance Service Experts stated, “[T]he whole idea of developing the plan is that, in extremis, you turn to the plan and follow the concepts in the plan.”\(^{50}\) If Ian Parry had engaged in

\(^{47}\) 133/152/21-153/7
\(^{48}\) 133/120/17-23
\(^{49}\) 133/120/17-23
\(^{50}\) 145/79/12-80/8
adequate Major Incident training, planning and exercising, it is likely that he would have remembered what his role was: the basic requirements of the plan would have been followed.

SMG event healthcare provision document

16.39 The number of ETUK staff for any particular event was determined by SMG. The procedure involved SMG notifying ETUK of the number of staff required. Staff were then allocated by ETUK.

16.40 In 2003, James Allen created a document entitled ‘Event Medical Provision at the Manchester Evening News Arena’ (the SMG event healthcare provision document). The purpose of the SMG event healthcare provision document was to determine the number of healthcare staff required for any given event. James Allen did not seek any external advice or assistance from someone with healthcare qualifications when drawing it up. It was not reviewed in light of the reissue of the Purple Guide in 2015. Both of these things should have occurred.

16.41 The SMG event healthcare provision document provided for three levels of staff: EMT-A, EMT-B
and first aider. EMT-A stands for ‘Emergency Medical Technician – Advanced’. EMT-B stands for ‘Emergency Medical Technician – Basic’.\textsuperscript{55} For an event the size of the Ariana Grande concert, it specified one “EMT-A/MIMMS”, a second EMT-A and ten first aiders.\textsuperscript{56} This is described as “a base provision”, which was said to be subject to an individual event risk assessment.\textsuperscript{57}

16.42 As I set out in Part 6 in Volume 1, SMG’s individual event risk assessment process was flawed. It was a box-ticking exercise, which did not include any assessment of the threat of a terrorist attack. This meant that the “base provision” was unaffected by any increased risk of a mass casualty incident caused by a terrorist.

**Emergency Training UK staff training**

16.43 The SMG–ETUK contract expected at least one “EMT-A” and one “EMT-B” “on a typical show”.\textsuperscript{58} The EMT-A was expected to act as Team Leader and “must be MIMMS trained”.\textsuperscript{59} The EMT-B was expected “on all shows normally above 5000 or depending on event risk assessment”.\textsuperscript{60}
16.44 According to the SMG–ETUK contract, the EMT-A was also expected to have an Advanced Life Support qualification and be able to administer prescription-only medications, including cardiac drugs following Advanced Life Support protocols. The Ambulance Service Experts considered that some of the activities the SMG–ETUK contract expected the EMT-A to undertake would require professional registration.

16.45 Ian Parry’s evidence was that, around 2012 to 2013, the Advanced Life Support Group, the company responsible for the Advanced Life Support qualification, required a person to be a registered medical, nurse or healthcare practitioner in order to undertake the Major Incident Medical Management and Support and Advanced Life Support courses. Ian Parry was not a registered practitioner in any of those categories. This meant that he was no longer eligible to undertake either of those courses or any refresher training in them from 2013.

16.46 Ian Parry’s initial Major Incident Medical Management and Support qualification was
gained in 2002. It was valid for four years. He renewed it, after it had expired, in 2007. The renewal expired in 2011, but was not renewed again. In 2002, Ian Parry obtained his Advanced Life Support qualification. In 2005, he renewed this. It expired in 2009, but it was not renewed again. His explanation for not renewing these qualifications was the change in requirement by the Advanced Life Support Group.

16.47 In the CV he drafted in 2015, Ian Parry described himself as “EMT.ALS.PLS.MIMMS”. He wrote “ALS MIMMS” next to his name on SMG sign-in sheets in 2017. An ordinary reading of these entries is misleading to a reader. Ian Parry’s evidence was that he had told James Allen or Miriam Stone about the Advanced Life Support Group’s change in requirement. He asserted that because he had undertaken the Major Incident Medical Management and Support and Advanced Life Support training, he was entitled to describe himself in that way.

16.48 James Allen stated that he did not know Ian Parry could not re-accredit with the Advanced Life Support Group. I accept James Allen’s evidence on this point. It is clear that SMG regarded the

66 INQ041774/2
67 133/68/20-70/4, 133/71/5-73/17
68 INQ041774/1
69 INQ041977/3-4
Advanced Life Support Group qualifications as important: they were specified in the SMG–ETUK contract. SMG was misled by Ian Parry. As a result, SMG wrongly believed that Ian Parry had a current qualification in Major Incident management and Advanced Life Support, when he did not.

16.49 There was no evidence that any of the other ETUK staff had undertaken the Major Incident Medical Management and Support or Advanced Life Support training specified in the SMG–ETUK contract. The training they received had varied. The only formal qualification some had was the first aid at work certificate. Others had undertaken further courses. Some had received training through the university courses they were undertaking.

16.50 Ian Parry accepted that a first aid at work qualification was insufficient on its own for any of his staff to be regarded as competent to discharge the role of event first aider. He stated that he provided training for the staff. Ryan Billington, an ETUK member of staff, also provided some training.
16.51 One member of staff, who had been working at the Arena for nine years by the time of the Attack, characterised “in-house training” at ETUK as “ad hoc sessions, things like observation taking. They weren’t regular, but I do remember there were some on occasions.”75 Another member of staff described doing her “oxygen and Entonox training, defibrillation through ETUK”.76 A third member of staff stated: “I don’t believe I did [receive any training], certainly not medically.”77

16.52 Given the evidence of staff from ETUK, I accept that some training was provided to some staff while they were at ETUK. However, there were no records available to the Inquiry that permitted a proper assessment of the extent, regularity and adequacy of any training provided to staff by ETUK. Ian Parry said that ETUK records had been disposed of following the repossession of the ETUK offices after the Attack.78

16.53 In light of all the evidence about the level of training received by ETUK staff, I am satisfied that Ian Parry did not require a sufficiently high standard for those staff members he used at events. This was not the staff members’ fault. Responsibility for this lies with Ian Parry. I shall

75 154/54/21-55/1
76 174/213/17-24
77 91/8/13-15
78 INQ041566/5-6, 133/85/8-86/3, 137/135/22-136/10
return to the issue of ETUK training when considering those staff members on duty on the night of the Attack.

Equipment

16.54 The premises’ licence required a check to be made on the “first aid rooms and equipment”\(^79\). There was one first aid room at the Arena. No inventory was maintained of the content of that room.\(^80\)

16.55 The SMG–ETUK contract specified that “5 wheelchairs and 4 medical stretchers and evac. chairs are on site”.\(^81\) James Allen stated that two of the four trolley-style stretchers had been damaged.\(^82\) He said that, in addition to the remaining two trolley-style stretchers, there were at least two or three canvas pole stretchers, one orthopaedic spine board, three or four carry-chairs and seven or eight wheelchairs.\(^83\) A number of these items were stored in the first aid room.\(^84\) Ian Parry broadly agreed with James Allen’s evidence, although he suggested

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\(^79\) INQ035447/12
\(^80\) 90/96/20-97/5
\(^81\) INQ040492/29
\(^82\) 90/102/25-103/25
\(^83\) 90/106/14-25
\(^84\) 90/106/14-25
that there was only one basic stretcher in the first aid room.\textsuperscript{85}

16.56 Tourniquets were not issued to staff as part of the first aid bags provided by ETUK.\textsuperscript{86} Ian Parry claimed that all staff were trained in the application of a tourniquet.\textsuperscript{87} In fact, many staff were not trained in their use.\textsuperscript{88} The events of 22\textsuperscript{nd} May 2017 tragically demonstrate that at a mass casualty incident there is likely to be a need for tourniquets. In future, all event healthcare staff should be trained in and have immediate access to tourniquets.

16.57 I recommend that the Department of Health and Social Care (DHSC) consider introducing guidelines to ensure that all event healthcare staff are trained in how to use tourniquets and other basic life-saving techniques for treating blast, bullet and knife wounds.

16.58 Tourniquets were included among the trauma equipment that was stored in the cupboard in the first aid room.\textsuperscript{89}

16.59 Regarding first aid and medical equipment, the SMG–ETUK contract stated: \textit{“An agreement should be reached during the planning stage...”}
about who will provide such items.” 90 There was no evidence of an agreement in writing. According to James Allen, SMG put some equipment in the first aid room, and it was for ETUK to add “to that to ensure they had what they needed” 91 Ian Parry stated that the costs of any items ETUK contributed were only reimbursed when they were used. 92 He observed that if an item did not get used then it was down to him “as an expense”. 93

16.60 The consequence of SMG’s approach was that Ian Parry was reluctant to buy first aid equipment in case it did not get used and resulted in an uncompensated expense to ETUK. This led to individual ETUK members of staff providing their own equipment because that provided by SMG and ETUK was inadequate. 94

16.61 This was an unacceptable state of affairs. It resulted in financial considerations being placed ahead of patient welfare. It gave rise to a risk to patient safety. It placed the burden on individual members of staff to determine what might be required. It put those members of staff in a position where they had to purchase equipment
in the hope of being reimbursed if they used it. Its effect was to pass on the initial cost SMG should have borne to individuals in low-paid positions.

16.62 SMG should have purchased whatever medical equipment ETUK recommended, provided the recommendations were reasonable. This would have required ETUK to take a more proactive approach than it did as to what equipment was needed. Particular consideration should have been given to making sure there was sufficient equipment for a mass casualty incident, should one occur. If there was a query about the justification for any particular item, SMG could have taken external advice. SMG had an obligation to ensure adequate equipment under the premises’ licence. While SMG could have sought to discharge this through ETUK, a more robust system, which removed financial considerations and ensured ETUK’s competence, was required.

16.63 I recommend that the DHSC and, if appropriate, the Home Office consider issuing guidance on the first aid equipment that event providers are expected to have available on their premises, as well as where that equipment should be stored to ensure that it is readily accessible when required and how often it should be checked to ensure that it is up to date and in good working order.
It may be that a minimum standard of first aid equipment forms part of the Protect Duty.

Exercising

16.64 As I set out in Part 6 in Volume 1, SMG had a programme of exercises created by Miriam Stone of SMG and Thomas Bailey of Showsec. An exercise on 17th December 2014 was designed around the scenario of a terrorist attack in the City Room. It was attended by “Medic Supervisors – from our first aid contractors, Emergency Training Ltd”. This was one of a number of exercises.

16.65 Ian Parry stated: “There were a number of desktop exercises over the years involving NWAS, the Fire Service, the police, ourselves.” Of these, he said: “[I]n desktop exercises, medical was right at the bottom of the pile. You’d spend 95% of the time talking about police, security and traffic management. So rightly or wrongly, yeah, I should be planning for a major incident, but when it comes across that your role is right at the bottom of the pile.” As I have emphasised elsewhere, full participation in well-run exercises is essential.

95 INQ001444/1
96 INQ001444/2
97 133/99/9-21, 133/155/20-156/1
16.66 Ian Parry also invited ETUK staff to attend “workshops and tabletop exercises” in their spare time. These occurred approximately every six months and included Major Incident response as a topic. They were not attended by all ETUK staff. As events on the night were to prove, these activities failed to instil the necessary knowledge and understanding in the ETUK staff who had attended. Aside from the issue of the quality of the training Ian Parry provided, staff should have been paid to attend important training such as this. A responsible organisation would make them compulsory.

16.67 ETUK’s participation in exercising did not lead to the learning and development that needed to occur in order for its staff to be adequately prepared for a mass casualty incident. Responsibility for this failure lies with Ian Parry.

16.68 I recommend that the DHSC consider introducing compulsory minimum standards of training for event healthcare staff to ensure that they are familiar with how to assist those injured in a terrorist attack and what will be expected of them in the golden hour, the first hour of the emergency response; see Part 10.
16.69 When asked about the requirement to pass a METHANE message to NWAS, Ian Parry asserted: “It was made quite clear that NWAS would refuse to accept a major incident declaration from us.” He later suggested that the organisation who told him this may have been Greater Manchester Ambulance Service, NWAS’s predecessor in the Greater Manchester area. On the basis of what he had been told, he said that any further conversations on the subject would have been pointless. He stated that he had been told that a private healthcare provider’s METHANE message would not be accepted by the ambulance service.

16.70 While the ‘M’ in METHANE does relate to whether or not a Major Incident had been declared, the remaining letters relate to other important information. I do not accept Ian Parry’s evidence that he was told that an ambulance service would not accept a METHANE message from a private healthcare provider. Such a statement is at odds with the national guidance in the Purple Guide. The Ambulance Service Experts stated that event healthcare providers can reasonably be expected to pass a METHANE
message.\textsuperscript{103} ETUK’s Major Incident Plan envisaged that this would occur.

16.71 I am prepared to accept, as Ian Parry said in his answer when first asked about this topic, that the ambulance service in question told him that they would not accept a Major Incident declaration from a private healthcare provider. But that is not the same thing as saying it would not accept any part of a METHANE message.

16.72 If Ian Parry had taken a diligent approach to his own Major Incident training and had engaged with NWAS more constructively than he did prior to the Attack, this would have been apparent to him. As it was, he was in error. His error denied NWAS a METHANE message before Patrick Ennis, Advanced Paramedic with NWAS, arrived at the Victoria Exchange Complex.

16.73 The Purple Guide envisaged a substantial degree of liaison between the event healthcare provider and the local ambulance service.\textsuperscript{104} It expected a communication plan to have been drafted and shared. It expected Rendezvous Points (RVPs) to have been identified, shared with staff and provided to ambulance control rooms and other emergency services. It expected the medical plan

\textsuperscript{103} 144/53/14-16, 145/63/18-64/6
\textsuperscript{104} INQ041126
to have been shared with the local ambulance service and local authority.

16.74 Responsibility for the lack of a more developed relationship between NWAS and ETUK lies on both sides. \(^{105}\) Had there been proper communication between them, a stronger relationship could have developed. ETUK and NWAS never jointly agreed or rehearsed what was expected of each in the event of a Major Incident. A closer relationship would have led to the discussion of such matters.

16.75 For an organisation like NWAS, which covers a large geographical area, it is not necessarily going to be possible for it to develop a strong relationship with every event first aid provider in their area. However, ETUK had been established as the sole healthcare provider at the Arena for over a decade. \(^{106}\) The Arena is one of the largest and busiest events venues in Europe. It could host events of up to 21,000 people. \(^{107}\) ETUK was regularly responsible for the healthcare of thousands of people. On its own, simply attending the six-monthly meetings hosted by SMG was insufficient engagement by NWAS. Each meeting provided the opportunity to develop the relationship and to have further

\(^{105}\) 145/81/6-11
\(^{106}\) 133/64/15-65/14
\(^{107}\) 1/22/3-10
exchanges as to how an emergency would be managed. It is surprising that this did not happen.

SMG and Emergency Training UK preparedness conclusions

16.76 An issue was raised in the course of questioning as to whether SMG’s approach to ETUK was driven by a money before safety attitude. The same issue arose in relation to SMG’s approach to preventative safety measures. I addressed that concern in Part 2 in Volume 1.

16.77 James Allen denied that SMG put money before safety.\(^{108}\) When put to him in evidence, Ian Parry agreed with the suggestion that SMG took a “bargain basement” approach.\(^ {109}\) He stated that SMG “would not pay for the level of cover that the Purple Guide mandated”.\(^ {110}\) He claimed that he had asked for more stretchers and been given an answer that he regarded as unsatisfactory as it related to cost.\(^ {111}\) He said that he had got to the point “of don’t bother asking”.\(^ {112}\) In many respects, I did not find Ian Parry to be a reliable witness and have been cautious about accepting any part of his evidence.

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\(^{108}\) 90/116/14-23
\(^{109}\) 137/175/2-7, 137/190/10-12
\(^{110}\) 137/159/9-11
\(^{111}\) 137/159/9-11, 137/190/1-12, 137/200/18-201/12
\(^{112}\) 133/153/17-25
16.78 Looking at the evidence as a whole, I am satisfied that SMG took an unacceptable approach to ensuring that there were adequate healthcare services at the Arena. SMG failed to carry out basic checks that would have revealed major deficiencies in ETUK’s approach.

16.79 I accept that Ian Parry perceived that SMG would not sanction substantial additional expenditure. However, he lacked sufficient understanding of the required standards to be capable of making a cogent case to SMG for an increase in funding to an acceptable level. Given the importance of healthcare services, SMG should have given him the opposite impression to the one he held.

16.80 Whether SMG would have refused if Ian Parry had made a cogent case for a significant increase in funding, I am not able to say. There was no clear example of them doing so. What is clear is that the relationship did not operate as it should have. In relation to healthcare, inadequate consideration was given to the welfare of the event-goers. SMG was content to leave ETUK to run itself.

113 137/159/9-11, 137/190/1-12, 137/200/18-201/12
16.81 SMG should have been checking ETUK was meeting an adequate standard. SMG should have brought in external expertise to make this scrutiny meaningful. The effect of doing neither was that SMG saved money. SMG should have emphasised that it was open to further expenditure, if justified.

16.82 Ian Parry should have informed himself of the minimum standard of healthcare services and had the courage to persist in asserting the need for additional funding for staff and equipment, even if it meant souring the relationship. His failure to raise issues was a product of concern for his own self-interest and a lack of understanding of what was required.

16.83 Neither SMG nor ETUK gave adequate thought to how the healthcare services that were in place would cope with an event such as occurred on 22\textsuperscript{nd} May 2017. As a result, ETUK was not adequately prepared to respond.
SMG and Emergency Training UK response

Key findings

• The healthcare service provided by Emergency Training UK (ETUK) on the night of the Attack was inadequate.

• The combined skill level of those on duty from ETUK on 22\textsuperscript{nd} May 2017 was too low. It was a long way short of the guidance provided by the Purple Guide.

• Contrary to the requirement of the SMG–ETUK contract, there was no one on duty that night with a Major Incident qualification.

• Within 15 minutes of the explosion, 6 members of ETUK staff had made their way to the City Room.

• Contrary to the ETUK Major Incident Plan, no METHANE message was sent to North West Ambulance Service (NWAS) before paramedics arrived.

• The ETUK Director, Ian Parry, did not liaise with NWAS in the way the ETUK Major Incident Plan, which he had written, identified that he would. This role was carried out by a more junior member of staff.
• The ETUK staff did their best to help those injured by the explosion.

• There was a failure to provide any adequate standard of care by ETUK. This was as a result of a lack of preparedness and inadequate staff skill level. Responsibility for this lies with ETUK and Ian Parry.

• Shortly after the explosion, the SMG Event Manager made a request over the radio for all SMG first aid trained staff to make their way to the City Room.

• Members of SMG staff went to the City Room and offered what help they could to those affected by the explosion.

Emergency Training UK staff on duty

16.84 Taking the evidence as a whole, the healthcare service provided by ETUK on the night of 22\textsuperscript{nd} May 2017 was inadequate. While the number of staff may have been adequate, they did not have anything like the necessary skill level for a concert of this size.\textsuperscript{114} This was for three reasons: first, because SMG’s specification of the level that was required was too low; second, because ETUK and Ian Parry provided an even lower mix of skills than SMG thought it

\textsuperscript{114} 144/59/14-60/10
was receiving; and third, because the minimum standard Ian Parry and ETUK set for its first aiders was too low.

16.85 As set out in Part 11, the Purple Guide indicated that for an event such as the Ariana Grande concert on 22nd May 2017, the following healthcare services should be present on site: 1–2 doctors; 2–4 nurses or Extended Nurse Practitioners; 2–4 paramedics or Emergency Care Practitioners; and 10–11 first aiders. First aiders were required to have more than just a first aid at work qualification. It also indicated a minimum of one ambulance and crew and one rapid response vehicle.

16.86 For the night of 22nd May 2017, SMG required 2 Emergency Medical Technicians and 12 first aiders from ETUK.\(^{115}\) The ambulance ETUK owned had not been booked for the event and was not at the Victoria Exchange Complex.\(^{116}\) ETUK also owned a response vehicle. This was at the Victoria Exchange Complex that night, but it was not used.\(^{117}\)

16.87 Ian Parry claimed the healthcare provision made by ETUK at the venue was in excess of the Purple Guide requirement.\(^{118}\) This claim was

\(^{115}\) 133/90/11-15, INQ001599/1
\(^{116}\) 137/112/19-113/9
\(^{117}\) 137/113/10-114/17
\(^{118}\) 133/89/18-90/19
wrong. The reason he made it was because he had not read the relevant part of the 2015 Purple Guide.\textsuperscript{119} Ian Parry’s lack of knowledge of which guidance was in force is concerning.

16.88 James Allen stated that the healthcare staff numbers were decided by reference to the Purple Guide and by SMG’s “experience of doing shows and also the data that we’d collected over the previous years”.\textsuperscript{120} The flaw in this approach, as SMG should have realised, was that the Arena had not previously been the subject of a mass casualty incident. Consequently, none of the data in the past was capable of informing the cover that would be required for such an eventuality.

16.89 Explaining why SMG’s requirements were not aligned with the Purple Guide, James Allen asserted that “when you read” the Purple Guide, “it is very much focused on festivals and one-off events”.\textsuperscript{121} I disagree. While such events receive substantial attention, the part dealing with resources at an event does not have an exclusive focus.\textsuperscript{122} Instead, it provides “some outline guidance” and “is not intended to be prescriptive in any way”.\textsuperscript{123} It encourages a risk-driven
approach.\textsuperscript{124} It provides a non-exhaustive list of factors to be included in the risk assessment. Some of these, such as “Overnight camping” and “Time of year”, are irrelevant to the Arena, but several factors are relevant.\textsuperscript{125}

16.90 The 14 staff ETUK had on duty\textsuperscript{126} on the night of the Attack fell a long way short of the Purple Guide expectation in terms of relevant skills.\textsuperscript{127} None of those present was qualified in any of the protected title professions listed in the Purple Guide. While there were two trainee doctors and a trainee paramedic among those on duty, these members of staff had not completed their training and were not fully registered in those professions.\textsuperscript{128}

16.91 Ian Parry asserted that there was also a trainee nurse among the ETUK staff.\textsuperscript{129} That was not correct. The person in question had not started the nursing course at the time of the Attack.\textsuperscript{130}

16.92 According to the SMG–ETUK contract, the EMT-A role required Major Incident Medical Management and Support and Advanced Life
Support qualifications. As explained in paragraphs 16.43 to 16.49, none of the ETUK staff on duty on the night of the Attack had these qualifications. Ian Parry had misled SMG in relation to the state of his own qualifications. This meant that, within the terms of the SMG–ETUK contract, Ian Parry was not able to act as more than EMT-B. Ian Parry stated that he was acting as EMT-B on the night of the Attack.

Also acting as EMT-B was Ryan Billington, according to his evidence. He was a second-year student paramedic and 20 years old. Ian Parry claimed Ryan Billington was in the role of EMT-A. I reject this evidence. The confirmation email Ryan Billington received booking him for the shift identifies his role as EMT-B.

As a result, there was no one acting in the EMT-A role, as defined in the SMG–ETUK contract.

So far as the other ETUK staff were concerned, they were all retained that night as first aiders. They had a mix of qualifications. At one end of
the spectrum, one staff member was weeks away from qualifying as a medical doctor. At the other, several did not have formal qualifications beyond a first aid at work course. To take one example at the latter end of that spectrum, one member of staff had only undertaken a three-day course in 2012/13, followed by a one-day refresher in the two years before the Attack.

Before the concert

16.96 Ian Parry provided the ETUK staff with a briefing before the concert began. The briefing was “generic”. In the briefing, he informed ETUK staff of the crowd profile, crowd numbers, event timings and how many ETUK staff were on duty. The risk of a terrorist attack was not mentioned. It should have been. Ian Parry was not aware of the threat level at the time. He should have been.

16.97 Ian Parry paired the ETUK staff. Each pair was given a radio. One member of ETUK staff was allocated to the Sierra Control Room in the
As Medic 1, Ian Parry was not paired with anyone.\textsuperscript{147}  

Response by Emergency Training UK’s Emergency Medical Technicians  

Ian Parry  

Shortly after the explosion, Miriam Stone spoke to Ian Parry over the radio. She informed him that his staff were needed in the City Room.\textsuperscript{149}  ETUK staff made their way to the City Room. Ian Parry entered the City Room at 22:36.\textsuperscript{150}  Six minutes after Ian Parry, Ryan Billington entered the City Room.\textsuperscript{151}  Ryan Billington’s arrival brought the total number of ETUK staff in the City Room to six.  

Ian Parry’s explanation for not sending a METHANE message was, “I was sent out there to look after the patients. The idea of a METHANE message just went out the window. The system fell apart.”\textsuperscript{152}  This evidence was in contrast with his claim at another stage of his evidence that no METHANE message was sent because he believed NWAS would not accept...
it. He stated that his “assumption” was that SMG staff were informing NWAS.

16.100 As Medic 1, it was Ian Parry’s responsibility to carry out the command functions envisaged by the SMG and ETUK plans. His role was to “assume overall control until the arrival of the Statutory Emergency Services”. He stated that the ETUK first aiders acted under his direction and that of Ryan Billington and Elizabeth Woodcock. He stated that the ETUK staff knew their roles but did not follow them on the night of the Attack.

16.101 Ian Parry did not discharge his command role to an adequate standard. Had he attended to Major Incident training and exercising more diligently, he would have been much better placed to do so. Ian Parry did not liaise with NWAS, although there was at least one point when he was close to Patrick Ennis. He stated that he left Ryan Billington to do this as he was “probably the best-placed person to do the handover because he knew specifically how NWAS work and he

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153 133/100/6-24
154 137/94/1-22
155 INQ024430/1
156 INQ024430/1
157 133/122/14-19
158 133/122/9-13, 133/123/7-10
159 137/99/13-23, 137/102/10-24
would know their policies”.  

He went on to say he did not make a call to NWAS because, “I was busy doing what I was told to do and couldn’t have got through anyway, probably.”

16.102 Ian Parry went around the City Room. He informed ETUK staff that if a person was not responding they should move on. Of his own approach to triage, he stated in evidence: “[N]o breathing, move on to somebody else, leave them alone and move on to somebody else – or catastrophic bleeding.” He described his role as “doing the assessment of those who we couldn’t do any more for and … eventually I was directing others who to treat and how to deal with them”.

16.103 Ian Parry checked Kelly Brewster. He spoke to those assisting Jane Tweddle and Megan Hurley. He covered Michelle Kiss and re-covered Martyn Hett. He assisted in moving John Atkinson from the City Room. Ian Parry
had a tourniquet in his pocket. He did not use it as he forgot he had it on him. In his evidence, he said that he covered one or two people whom he thought were dead.

**Ryan Billington**

16.104 Shortly after Ryan Billington entered the City Room, he broadcast a message over the ETUK radio channel. He requested that all trauma equipment be brought to the City Room. He then made a broadcast, stating: “This is a major incident. Follow major incident protocol. If people have no pulse, we can’t help; treat catastrophic bleeding.”

16.105 I can understand that some reading it will find this message upsetting. It was fortunate that Ryan Billington took control as he did. In a mass casualty situation, an approach that focuses on those with catastrophic bleeding is established to be the most likely to save lives. Ryan Billington’s message was in accordance with NWAS’s triage tool. The message he sent was an important reminder to the ETUK staff of how to approach a mass casualty incident.
16.106 At 22:57, Ryan Billington approached NWAS Advanced Paramedic Patrick Ennis and GMP Inspector Michael Smith. The conversation with Patrick Ennis continued for over a minute. Ryan Billington provided an initial handover to Patrick Ennis. He told Patrick Ennis how many dead and injured there were. Patrick Ennis informed Ryan Billington that ETUK staff should not perform CPR and should focus on those who were bleeding. Ryan Billington relayed this message over the ETUK radio channel.

16.107 Ryan Billington became aware that there were no stretchers immediately to hand. He instructed people nearby that they should use whatever they could find in order to get people out of the City Room. SMG accepted in its oral closing statement that insufficient equipment was brought into the City Room.

16.108 Patrick Ennis left the City Room after he had spoken to Ryan Billington. Having spoken to Daniel Smith, Consultant Paramedic and Operational Commander for NWAS, on the
station concourse,\textsuperscript{185} Patrick Ennis returned to the City Room at 23:05.\textsuperscript{186} Upon his return, Ryan Billington spoke to him again.\textsuperscript{187}

16.109 By speaking to Patrick Ennis, Ryan Billington undertook the important liaison role between ETUK and NWAS. Ryan Billington had had some Major Incident training as part of the paramedic undergraduate course he was undertaking.\textsuperscript{188} He had not completed that course at the time of the Attack.\textsuperscript{189} He had not undertaken the Major Incident Medical Management and Support training.\textsuperscript{190}

16.110 It should not have fallen to Ryan Billington to undertake this role. It was not the role he was retained to undertake on the night.\textsuperscript{191} He did not hold the qualification SMG expected him to hold for this purpose. In saying this, I am not critical of Ryan Billington for engaging with NWAS. On the contrary, it is commendable that he stepped into the void created by Ian Parry. However, relying upon people in the midst of a serious incident to act as Ryan Billington did is not an appropriate

\begin{itemize}
\item \textsuperscript{185} INQ035612/183
\item \textsuperscript{186} INQ035612/200
\item \textsuperscript{187} INQ035612/225, INQ035612/237
\item \textsuperscript{188} 91/10/3-13, 91/45/25-46/2
\item \textsuperscript{189} 91/1/20-25
\item \textsuperscript{190} 137/134/15-17
\item \textsuperscript{191} 91/37/9-20
\end{itemize}
way to prepare for and respond to a mass casualty incident.

16.111 In the course of the critical period of the response, by which I mean the period up to the removal of the final living casualty from the City Room at 23:39, Ryan Billington went on to be involved in the care of Megan Hurley, Kelly Brewster, Martyn Hett and John Atkinson.

Emergency Training UK’s Emergency Medical Technicians conclusions

16.112 ETUK lacked highly skilled staff on the night of 22nd May 2017. Had ETUK adhered more closely to the guidance provided by the Purple Guide, there would have been more highly skilled members of ETUK staff on hand to help. Two EMT-Bs, of the standard defined by the SMG–ETUK contract, were insufficient for an event such as the Ariana Grande concert.

16.113 This lack of highly skilled staff resulted in a lower standard of care being provided to the injured during the period before NWAS could arrive. The timing and number of NWAS paramedics entering

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192 153/42/9-45/19
193 154/50/19-53/11, 154/9/18-24
194 156/29/20-35/24
195 158/96/11-150/5, 158/18/7-12, 158/21/21-22/24
196 91/70/20-71/4, 137/134/18-136/2
197 144/59/14-60/10
the City Room meant that the impact of this continued longer than it would have done had more paramedics been committed to the City Room.

Response by Emergency Training UK’s first aiders

16.114 Elizabeth Woodcock was designated “Medic 2” by Ian Parry for that shift. She had received very little Major Incident training. She stated that the training was that ETUK staff should evacuate; that they should only enter when told it was safe; and that someone would take the clinical lead and advise them what to do.

16.115 She was aware of the ETUK Major Incident Plan. She stated: “[W]e didn’t use that plan on the night.” She stated the use of tourniquets did not form part of that training. Her evidence was that some staff were happy to use them, had been shown how to use them, “but we did not carry them on us”. This is consistent with Ryan Billington’s evidence on tourniquets.

16.116 Elizabeth Woodcock entered the City Room at 22:34. She attended to Saffie-Rose
Roussos, Wendy Fawell, Sorrell Leczkowski, Kelly Brewster and Georgina Callander.

16.117 Marianne Gibson entered the City Room at 22:40. She attended to Saffie-Rose Roussos, Jane Tweddle, Kelly Brewster, Alison Howe, Sorrell Leczkowski, Megan Hurley and John Atkinson.

16.118 Other ETUK first aiders in the City Room had involvement with those who died. Kristina Deakin checked Martyn Hett and attended to Georgina Callander. Sarah Broadbent checked Wendy Fawell. Craig Seddon assisted in the treatment received by Jane Tweddle. Zak Warburton checked Angelika
Klis\textsuperscript{221} and Kelly Brewster.\textsuperscript{222} Ken O’Connor knelt beside Saffie-Rose Roussos,\textsuperscript{223} covered Angelika Klis\textsuperscript{224} and checked Philip Tron.\textsuperscript{225}

16.119 ETUK staff did what they could for members of the public in or around the City Room. This included assisting with transporting a casualty to hospital,\textsuperscript{226} and transporting the child of another ETUK staff member away from the scene.\textsuperscript{227} A number of ETUK staff also offered assistance in the Casualty Clearing Station.\textsuperscript{228}

16.120 I am not critical of the individual ETUK first aiders for what they did or did not do. Those that went into the City Room showed courage in doing so. Any failure to provide a reasonable standard of care for an event healthcare service was as a result of failures by ETUK and Ian Parry. ETUK and Ian Parry did not adequately prepare the ETUK first aiders. In the case of some ETUK first aiders, they did not have sufficient qualifications or skills to perform to the standard that should be required of an event healthcare service.

\textsuperscript{221} 150/106/25-107/6
\textsuperscript{222} 154/9/4-15
\textsuperscript{223} 174/18/1-6
\textsuperscript{224} 150/107/18-20
\textsuperscript{225} 151/9/3-13
\textsuperscript{226} INQ007047/1-2
\textsuperscript{227} INQ005027/1-3
\textsuperscript{228} 137/102/10-24, 137/111/25-112/15
16.121 I accept that this standard of care will not be as high as that provided by an ambulance service.\textsuperscript{229} However, the minimum requirement expected by Ian Parry of event first aiders was too low. The first aiders were not supported by sufficient ETUK staff who had a high level of qualifications and skills.

Response by SMG staff

16.122 At 22:31, Miriam Stone was watching the CCTV monitors in the Sierra Control Room.\textsuperscript{230} Those relating to the City Room “\textit{went white}”. After a few seconds the monitors cleared. It was apparent to her that there was white smoke in the City Room. She stated: “\textit{As the view became clearer I could see the scene of devastation and carnage}.”\textsuperscript{231} It was obvious to Miriam Stone that an explosion had occurred.\textsuperscript{232}

16.123 Miriam Stone instructed Thomas Rigby, the Showsec Head of Security, to close the City Room.\textsuperscript{233} She contacted Ian Parry and informed him that ETUK staff needed to go to the City Room. Ian Parry raised the issue of whether it was safe for his staff to enter the City Room. Miriam Stone replied that there was “\textit{no obvious}...
visible threat and very little movement in the area and it appeared to be safe visually”.\textsuperscript{234} She stated: “[A]s far as I can tell, it is safe.”\textsuperscript{235}

16.124 Jacqueline Day was Head of Merchandising from SMG. She was in the City Room when the bomb detonated. She briefly left, before returning. She approached Saffie-Rose Roussos. She went to find help.\textsuperscript{236}

16.125 Paul Johnson, the SMG Fire Safety Officer, was in the Whisky Control Room when the bomb detonated. He saw the City Room through the CCTV monitors. He immediately telephoned 999.\textsuperscript{237} At 22:34, he spoke to a GMP operator. He reported that a “bomb” had detonated in the City Room. He informed GMP that there were “a lot of casualties on the floor”.\textsuperscript{238}

16.126 Once she had spoken to Ian Parry, Miriam Stone made a broadcast on the SMG radio channel for any first aid trained staff to make their way to the City Room.\textsuperscript{239}

16.127 John Clarkson was employed by SMG as a Senior Event Technician. His role was to build and dismantle stages for Arena events. He had
held a basic first aid qualification since 2004 and undertaken a refresher course in February 2017. Paul Worsley worked for SMG as a Senior Engineer. His duties included setting up equipment and managing the electrical systems.

16.128 Upon hearing the explosion, they immediately made their way towards the City Room. Miriam Stone warned John Clarkson of the “horrific” scene and stressed that he did not have to go there. She recalled that he “replied to me very determinedly ‘I’m going!’”.

16.129 In the hours that followed, John Clarkson and Paul Worsley worked together to assist a young and seriously injured casualty. They transported her to the Casualty Clearing Station, where they stayed with her until an ambulance arrived.

16.130 They used a trolley-style stretcher to move this casualty to the Casualty Clearing Station. This trolley-style stretcher had been brought from the first aid room by two members of SMG staff. This was the only trolley-style stretcher used on the night of the Attack to evacuate anyone from the City Room.

240 INQ005525/1
241 INQ006925/1
242 INQ005683/6
243 INQ005525/2-3
244 INQ022455/2-3
16.131 At 22:55, James Allen, the Arena General Manager, arrived at the Victoria Exchange Complex. He went to the Whisky Control Room. Once there, he liaised with firearms officers in relation to their search of the Arena.\footnote{90/108/13-109/13, INQ029788/13 at paragraph 60}
Showsec

**Key findings**

- There were members of Showsec staff in the City Room who were injured by the explosion.
- Immediately after the explosion, the Showsec Head of Security instructed Showsec staff to divert people away from the City Room.
- A radio message was broadcast shortly after the explosion requesting any Showsec staff with first aid skills to go to the City Room.
- Members of Showsec staff, including those who had been injured by the bomb, did their best to help those affected by the explosion.

Sierra Control Room

16.132 The Showsec Head of Security, Thomas Rigby, was with Miriam Stone in the Sierra Control Room when the bomb exploded. He heard a loud bang and saw the CCTV monitors go white. When the video feed returned, he could see seriously injured people on the floor in the City Room.
16.133 Thomas Rigby radioed those Showsec staff not in the City Room.\textsuperscript{247} He instructed them to divert people away from the City Room and to use every alternative exit.\textsuperscript{248}

16.134 Miriam Stone asked Thomas Rigby if there were any Showsec staff who were first aid trained.\textsuperscript{249} The Showsec radio log records that, at 22:42, a message was broadcast as follows: “Requested for any staff from Showsec that has any first aid skills to City Rooms [sic].”\textsuperscript{250} Thomas Rigby believes that at least five Showsec staff responded to this request.\textsuperscript{251}

In the City Room

16.135 David Middleton was the senior Showsec staff member in the City Room at the time of the explosion.\textsuperscript{252} He was knocked to the floor. A colleague picked him up and dragged him through the Arena doors. David Middleton then began diverting people away from the doors that led back into the City Room.\textsuperscript{253}

16.136 Daniel Perry initially assisted David Middleton out of the City Room immediately after the blast. He
then helped organise “a staff line in [order] to divert people away from the arena”.254

16.137 Jordan Beak was a Showsec Supervisor.255 He was standing with David Middleton facing the grey doors when he saw a “really bright flash of light”. He was temporarily blinded. When his vision returned, he was standing on the Arena concourse.256 He did not know how he had got there.

16.138 He went back into the City Room. He grabbed T-shirts from the merchandise stall to cover people up and to be applied as dressings.257 He did what he could to help the injured. He covered Michelle Kiss.258 He later assisted people away from the City Room.259

16.139 Robert Atkinson, a Showsec Steward, was on the raised walkway with Kyle Lawler when the bomb detonated.260 He went to the City Room. While in the City Room, he did what he could to assist the casualties,261 one of whom was Sorrell Leczkowski.262

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254 117/89/12-17
255 INQ011960/6, 117/88/6-25
256 INQ011960/6
257 117/88/17-21
258 151/24/13-25/3
259 117/88/6-16
260 INQ033776/55
261 INQ006565/3
262 153/73/22-74/25
16.140 Megan Balmer, a Showsec Supervisor, was by the doors into the Arena facing the concourse.\textsuperscript{263} The explosion forced her through the doors. Initially, she ran in the direction of Hunts Bank.\textsuperscript{264} She was instructed by a colleague to evacuate people through that exit and released a set of doors to allow this. She heard a request for first aiders who were willing to help.\textsuperscript{265} Having requalified in first aid 18 months earlier, she made her way to the City Room.\textsuperscript{266}

16.141 Once in the City Room, Megan Balmer did what she could to help the casualties, including applying tourniquets, dressing wounds and offering reassurance.\textsuperscript{267} She checked on Wendy Fawell, but found there was nothing she could do to help.\textsuperscript{268} She sought to provide assistance to Kelly Brewster.\textsuperscript{269} She also helped a casualty down to the Casualty Clearing Station.\textsuperscript{270}

16.142 Amy Barratt, a Showsec Door Supervisor, was in the Arena bowl when she heard “\textit{a loud bang}”.\textsuperscript{271} She heard an instruction over the radio to open the barriers and let people exit out of the back
gate of the Victoria Exchange Complex. Having done this, she made her way towards the City Room. She heard a request for people with first aid training. She had done a first aid at work course some years before. Wanting to help, she made her way to the City Room.272

16.143 Once in the City Room, she did what she could for those who were injured,273 including checking Saffie-Rose Roussos274 and Wendy Fawell.275

16.144 Other Showsec staff members tried to help those who were killed by the explosion. Usman Ahmed and Jade Samuels sought to assist Alison Howe.276 Jade Samuels also bent down next to John Atkinson for a short time.277 Akeel Butt was with those helping John Atkinson.278
TravelSafe

Key findings

- There were three TravelSafe officers on duty at the Victoria Exchange Complex on the evening of 22\textsuperscript{nd} May 2017.
- Having heard the explosion, they immediately made their way in the direction of the City Room.
- In the City Room, each of them did their best to help those affected by the explosion.

16.145 TravelSafe officers were employed by a company called STM. STM contracted its staff to Northern Rail.\textsuperscript{279} The role of STM staff was to provide a visible security presence on the railway network, and to ensure the safety of train passengers and staff.\textsuperscript{280}

16.146 On 22\textsuperscript{nd} May 2017, three TravelSafe officers, Philip Clegg, Niall Pentony and Reece McKay, were on duty at the Victoria Exchange Complex.\textsuperscript{281}

16.147 At 22:31, Philip Clegg and Niall Pentony were standing on the station concourse\textsuperscript{282} when they heard “a loud bang” from the direction of the

\textsuperscript{279}156/59/2-7
\textsuperscript{280}INQ022500/2
\textsuperscript{281}INQ035612/12
\textsuperscript{282}INQ035612/4
Arena. Without apparent concern for their own safety, they immediately made their way towards the scene of the explosion, entering the City Room from the Fifty Pence staircase at 22:32. Each of them did what they could for the casualties in the City Room.

16.148 Philip Clegg checked Kelly Brewster at the request of her sister, Claire Booth. He also checked Nell Jones, Elaine McIver, Martyn Hett, Wendy Fawell, Sorrell Leczkowski, Chloe Rutherford and Liam Curry. In the Casualty Clearing Station, Philip Clegg assisted paramedics with John Atkinson.
Northern Rail

Key findings

- Northern Rail was a Category 2 responder under the Civil Contingencies Act 2004.
- Staff from Northern Rail went to the aid of those who had been affected by the explosion. They did their best to help.
- There were no stretchers available to Northern Rail staff in the Manchester Victoria Railway Station.
- Staff from Northern Rail carried large NHS first aid bags from Manchester Victoria Railway Station onto the raised walkway and into the City Room.

Introduction

16.149 Manchester Victoria Railway Station was operated, managed and controlled by Northern Rail. Northern Rail held the lease as tenant and was the Station Facility Operator.  

16.150 Network Rail retained responsibility for the operational railway network and responding to accidents, incidents and other emergencies to the extent that they affected the operation of the
railway network. Network Rail also managed the infrastructure.¹

16.151 Network Rail and Northern Rail were Category 2 responders under the Civil Contingencies Act 2004.² At the time of the Attack, the evacuation procedures at Manchester Victoria were governed by Northern Rail’s Emergency Evacuation Plan. Station security was governed by Northern Rail’s Station Security Plan.³

16.152 Northern Rail staff attended the City Room following the explosion and were actively involved in assisting casualties.⁴ They did their best to help those affected.

16.153 Emergency responders used equipment located at Manchester Victoria Railway Station on 22nd May 2017.⁵ At the time of the Attack, there were no stretchers in the railway station part of the Victoria Exchange Complex.⁶

Response by staff

16.154 Owen Sanderson was the Northern Rail Station Supervisor on the night of 22nd May 2017.⁷

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1 16/38/19-24, INQ025591/4, INQ025592/2 at paragraph 7
2 16/40/13-17, INQ025579/5 at paragraphs 24 and 25, Civil Contingencies Act 2004, Schedule 1, Section 24
3 37/81/15-82/14, INQ000683/1-2, INQ025579/7 at paragraph 32
4 INQ025579/13 at paragraphs 63 and 64
5 INQ025579/13 at paragraph 66
6 INQ025579/13 at paragraph 67
7 INQ029439/1
He was the on-duty Team Leader and Bronze on site. This meant that he was responsible for managing the operational response by Northern Rail staff to an incident. He heard the noise of the explosion and heard something on the Arena radio about an explosion. Instinctively, he activated the station alarm.

16.155 At 22:38, Owen Sanderson spoke to Police Constable (PC) Carl Roach of BTP on the station concourse. Other members of station staff, including Barry Chaudry, were also present. PC Roach asked Owen Sanderson to fetch all the station’s first aid equipment.

16.156 Northern Rail Train Dispatcher Stuart Craig was on the station concourse when he heard the explosion and saw a flash. He realised a bomb had gone off. He began to help direct people from the station. Owen Sanderson told him to get a first aid kit and defibrillator.

16.157 At 22:39, Stuart Craig carried medical equipment into the City Room via the raised walkway. Once in the City Room, he put the equipment

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8 INQ025579/12 at paragraph 61
9 INQ029439/2
10 INQ035612/54
11 74/91/15-92/20
12 INQ024863/1-2
13 INQ024863/2
14 INQ035612/57
down and sought to help the injured.\textsuperscript{15} He assisted in the evacuation of John Atkinson from the City Room.\textsuperscript{16}

16.158 By 22:40, Owen Sanderson and a Northern Rail colleague each had a large NHS first aid bag on the station concourse.\textsuperscript{17} This is shown in Figure 39.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure39.png}
\caption{Northern Rail staff with large NHS first aid bags\textsuperscript{18}}
\end{figure}
16.159 With the help of STM employee Steven Hawksworth, they carried these bags up the staircase to the raised walkway.¹⁹

16.160 Once on the raised walkway, Owen Sanderson and Steven Hawksworth carried one bag between them to the City Room. Barry Chaudry stopped on the raised walkway with the bag he was carrying to tend to a casualty.²⁰

16.161 Owen Sanderson had undertaken a basic first aid at work refresher course not long before the Attack.²¹ On the night, he spoke to a number of the injured, seeking to reassure them.²²

16.162 Other Northern Rail staff who have been identified as helping in the response to the Attack include Andrew Lowe, Luke Westall, Ian Johnson and Matthew Greenhalgh.²³

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¹⁹ INQ035612/70
²⁰ INQ035612/80
²¹ INQ029439/3 and 8
²² INQ029439/4-6
²³ INQ029439/6, INQ024754/4
Members of the public

Key findings

- Members of the public in and around the City Room showed extraordinary courage and compassion in response to the Attack.
- Members of the public made an important contribution to the emergency response.
- On the night of 22nd May 2017, they represented the very best of our society.

Introduction

16.163 While the Inquiry did not receive evidence from every member of the public who provided assistance in the City Room, evidence was received from a significant number of people. What follows are just some of the accounts the Inquiry received.

16.164 In relation to each of these individuals, it is important to record that every one of them acted heroically and selflessly. None of them had any form of protective equipment. Many were dressed for a night out or were in casual clothing. I accept that, in the case of each and every person I heard from, they were doing the very best they could that night. The circumstances with which
they were presented were appalling. That night they represented the very best of our society.

16.165 In Part 17 in Volume 2-II, I will identify some of those who were helped by the people listed in paragraphs 16.166 to 16.194. In Part 18, I will deal with those they helped who were killed by the explosion. Some of the people whose experience I summarise below responded to the incident, despite having been in the City Room when the bomb detonated.

Members of the public in the City Room at 22:31

Jonathan Woods

16.166 Jonathan Woods was waiting on the mezzanine to collect his wife and daughter from the concert in the City Room. He recalled seeing people start to come into the City Room. He described the atmosphere as being “good”.24 When the bomb detonated, he saw “an incredible flash being red black and purple in colour”.25 He felt the shock wave. He was struck in the knee, and his leg buckled. He believes that he was lifted off the ground and deposited in front of the JD Williams entrance. Despite this, he did what he could to

24 INQ029396/5
25 INQ029396/6
assist those affected by the explosion.\textsuperscript{26} He tried to help Michelle Kiss.\textsuperscript{27}

**Michael Byrne**

16.167 Michael Byrne was waiting in the City Room to collect his daughters.\textsuperscript{28} After the explosion, he stayed and assisted casualties in the City Room, including Alison Howe\textsuperscript{29} and Lisa Lees.\textsuperscript{30}

**Ronald Blake**

16.168 Ronald and Lesley Blake were in the City Room at the time of the detonation, waiting to collect their daughter and her friend after the concert.\textsuperscript{31} Ronald Blake described seeing a large orange flash about four car lengths away from where he was standing, followed by a loud bang.\textsuperscript{32} He felt something hit his right inner thigh. He found himself lying on the floor looking up towards his wife, Lesley.\textsuperscript{33}

16.169 Having checked that his wife was uninjured, Ronald Blake noticed John Atkinson lying on the floor covered in blood. He approached John Atkinson and made a 999 call.\textsuperscript{34} With the

\textsuperscript{26} INQ029396/7  
\textsuperscript{27} 151/23/14-20  
\textsuperscript{28} INQ006321/1  
\textsuperscript{29} 152/11/21-12/2  
\textsuperscript{30} 152/4/23-5/19  
\textsuperscript{31} 158/60/22-61/11, 158/8/6-12  
\textsuperscript{32} 158/8/6-12  
\textsuperscript{33} 158/8/13-15  
\textsuperscript{34} 158/61/21-62/18
encouragement of the operator, he applied his wife’s belt to John Atkinson’s right leg as a tourniquet.\textsuperscript{35} Colonel Professor Jonathan Clasper, a member of the Blast Wave Panel of Experts who considered John Atkinson’s care, gave evidence that Ronald Blake “did brilliantly”.\textsuperscript{36} Ronald Blake stayed with John Atkinson until 23:29, at which point John Atkinson was evacuated to the Casualty Clearing Station and was being treated by a paramedic.\textsuperscript{37}

16.170 Ronald Blake helped others injured outside Manchester Victoria Railway Station.\textsuperscript{38} He had no previous first aid training.\textsuperscript{39} He provided help while he himself was injured. He further injured himself when carrying down the stairs the makeshift stretcher bearing John Atkinson.\textsuperscript{40}

Philip and Kim Dick

16.171 Philip and Kim Dick were in the City Room waiting to collect their daughter and granddaughter at the time of the explosion.\textsuperscript{41} They immediately went to help an injured girl and, later, a second injured girl in the City Room. They assisted with those children’s

\textsuperscript{35} 158/63/1-17
\textsuperscript{36} 161/88/8-17
\textsuperscript{37} 158/57/2-25
\textsuperscript{38} 158/58/1-3
\textsuperscript{39} 158/60/4-7
\textsuperscript{40} 158/71/2-5
\textsuperscript{41} 90/1/14-24, 88/32/15-23
evacuation from the City Room to the Casualty Clearing Station.⁴²

16.172 They stayed with the two injured girls until Philip and Kim Dick were reunited with their daughter and granddaughter around midnight.⁴³ Kim Dick expressed her “upset that it took in excess of an hour before any paramedic or medically trained person attended to the girls”.⁴⁴

Members of the public who went to the City Room to help

Bethany Crook

16.173 Bethany Crook, a nurse, had been at the concert with her daughter, Hope, who was 13 years old at the time.⁴⁵ They were in the Arena bowl when the bomb was detonated. On entering the Arena concourse and seeing the injured there, Bethany Crook was encouraged by her daughter to help, which she did.⁴⁶ She left her daughter with staff at the Arena and was taken by another member of staff to the City Room. She entered the City Room at 22:52.⁴⁷

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⁴² 88/34/7-19, 90/3/14-5/4
⁴³ 88/39/25-40/12
⁴⁴ 88/41/6-15
⁴⁵ 155/97/9-98/25
⁴⁶ 155/99/6-100/8
⁴⁷ 155/96/23-125/6, 175/56/22-105/20
16.174 Bethany Crook went on to assist many in the City Room, including Saffie-Rose Roussos and Georgina Callander. Having given assistance in the City Room, Bethany Crook also continued to help many in the Casualty Clearing Station into the early hours of 23rd May 2017.

16.175 Bethany Crook described her experience in this way:

“Never had I felt so helpless, lost or alone. All I had before me were my two bare hands, no equipment, some skills, my faith and hope that somewhere there were people trying to get to us to help. But this wasn’t the case. No one was coming and what may have been seconds to you all felt like minutes for me, what were minutes felt like hours, and what were hours felt like an eternity, alone with people and children’s lives literally in my bare hands.”

Daren Buckley

16.176 Daren Buckley attended the concert with his son, who loved music. His son enjoyed the concert: he sang every word.
16.177 The bomb detonated as they were walking towards the City Room. There was a huge flash, and the doors to the City Room slammed shut. 53

16.178 Daren Buckley left his son with a member of staff and went into the City Room to help. 54 The CCTV showed he was in there for over 21 minutes. 55 Armed police officers told him to leave. 56 Daren Buckley initially refused. He said: “[N]obody’s helping, so somebody’s got to help.” 57 He stated that the police said it was a crime scene and he had to leave. 58

16.179 Daren Buckley collected his son from the Arena. 59 They were directed to go back through the City Room. They were told it was the safest place to go: the area had been checked. 60

Darron Coster

16.180 Darron Coster served with the Royal Military Police for 22 years. 61 He retired in 2008. 62 Through his military service, he was familiar with the aftermath of a bomb explosion. This enabled
him to stay calm in a crisis. He had basic battlefield first aid training. This included how to apply pressure and, subject to the guidance in force at the time, the use of tourniquets.

16.181 Darron Coster had arranged to collect his son, his son’s girlfriend and a friend from the concert. As he arrived at the steps of the raised walkway, he heard an explosion. He stated that it was “a little flash of dust and light”. He walked towards it and saw a cloud of dust coming out of the doors leading into the City Room. People were evacuating quickly across the raised walkway. He received a text message from his son to say they were safe.

16.182 The first action Darron Coster took in the City Room was to shut the doors so that no one else could see in. It was an upsetting scene, and he was aware of the possibility of secondary shooters or explosions. He then spoke to various people wearing tabards. They were, he said, in “quite a state”; they did not know what to do and did not seem to have any first aid resources available.
training. Darron Coster told them to get water and check on people. He said to leave those who were not responsive, but to stay with anyone who could communicate and to provide them with reassurance.\textsuperscript{72}

16.183 Darron Coster walked around the City Room several times.\textsuperscript{73} He provided care to a number of people. He applied a tourniquet to a person with a leg injury.\textsuperscript{74} He used a belt and a handbag strap.\textsuperscript{75} Another casualty had injuries to his torso and face. Darron Coster spoke to the casualty’s mother on the phone. He provided reassurance that everything would be ok.\textsuperscript{76} A third casualty was lying on a table by the merchandise stand. That person was already receiving first aid from a police officer. Darron Coster again spoke on the phone. He reassured the casualty’s mother that they looked like they would survive.\textsuperscript{77} He attempted to assist a man with serious leg injuries, who was sitting down. When they tried to move him, the casualty was in considerable pain, and it was not possible to evacuate him. He stated that they did not have a stretcher.\textsuperscript{78}

\begin{itemize}
\item \textsuperscript{72} 88/10/10-12/22
\item \textsuperscript{73} 88/12/23-13/7
\item \textsuperscript{74} 88/13/17-14/2
\item \textsuperscript{75} 88/14/3-6
\item \textsuperscript{76} 88/15/17-17/4
\item \textsuperscript{77} 88/17/9-18/5
\item \textsuperscript{78} 88/19/14-20/17, 88/21/22-22/8
\end{itemize}
16.184 After about ten minutes, Darron Coster saw a BTP officer arrive. Darron Coster thought that the police officer identified himself as the Bronze Commander. They spoke and Darron Coster offered any help that was needed. He felt that the police officer was effective and took charge of the situation. 79 Four or five further police officers arrived at about the same time, followed shortly afterwards by a medic, with three pips on his shoulder. 80 This was the Advanced Paramedic Patrick Ennis. At that point, he thought the “cavalry had arrived”. 81

16.185 Darron Coster stayed in the City Room helping casualties until between 23:10 and 23:30. 82 He provided assistance to many in the City Room. He covered Nell Jones with a jumper. 83

Gareth Chapman

16.186 Gareth Chapman, a T-shirt seller, was on Victoria Station concourse when the bomb detonated. His child and the mother of his child were attending the concert. 84 As shown in Figure 40, 52 seconds after the explosion, he is captured on the station concourse CCTV running to the City Room.

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79 88/22/14-24/7
80 88/24/17-25/11
81 88/25/14-17
82 88/26/11-19
83 152/27/5-13
84 153/26/10-21
16.187 Gareth Chapman entered the City Room via the Fifty Pence staircase less than two minutes later.\textsuperscript{86} He covered Megan Hurley, Chloe Rutherford and Liam Curry with T-shirts.\textsuperscript{87} He gave what assistance he could to others.\textsuperscript{88} He assisted in carrying John Atkinson to the Casualty Clearing Station.\textsuperscript{89}
Michael Buckley

16.188 Off-duty police officer Michael Buckley was waiting in his car near the Arena to collect his daughter when he heard a “loudb hollow booming sound”. He made his way to the City Room. He provided assistance to injured people. He sought to provide treatment to Sorrell Leczkowski. He also sought to provide treatment to Kelly Brewster, with whom he remained for over half an hour.

Paul Reid

16.189 Paul Reid, a poster seller, was outside the City Room just off the Trinity Way link tunnel when he heard the blast. He had completed first aid at work training through his employer and had received refresher training about one year prior to the Attack. He made a 999 call before he entered the City Room. He helped Saffie-Rose Roussos for over 30 minutes. He returned to the City Room and assisted others.
Robert Grew

16.190 Robert Grew lived in a flat that overlooks the Arena. He was standing outside his flat at the time of the detonation.\(^{97}\) He heard a loud bang from the direction of the Victoria Exchange Complex. He thought it was a train crashing into the buffers at the station. He started to jog over to the station in case people were hurt and there was something he could do to help.\(^{98}\)

16.191 Robert Grew was an experienced climber and had previous experience with serious fall-type injuries. He described himself as a “competent first aider” so hoped he might be able to assist.\(^{99}\) On entering the City Room, he described being “not remotely prepared [for] the scene I encountered at the top of the stairs and within the foyer … It was total and utter carnage.”\(^{100}\)

\(^{97}\) INQ007013/1
\(^{98}\) INQ007013/1
\(^{99}\) INQ007013/1-2
\(^{100}\) INQ007013/2
16.192 Robert Grew sought to help those he could in the City Room, including Lisa Lees\textsuperscript{101} and Courtney Boyle.\textsuperscript{102} When she gave evidence, Claire Booth mentioned Robert Grew and the help he gave to her and her daughter Hollie.\textsuperscript{103} Robert Grew also spoke to John Atkinson in the City Room.\textsuperscript{104}

Sean Gardner

16.193 Sean Gardner was waiting to collect his daughter outside the City Room at the time of the detonation.\textsuperscript{105} He sought to provide assistance to Jane Tweddle.\textsuperscript{106} It was not until after he had given what assistance he could to Jane Tweddle that he was reunited with his daughter.\textsuperscript{107}

Thomas Owen

16.194 Thomas Owen heard the bomb go off when he was with his girlfriend in the Arena bowl.\textsuperscript{108} They agreed she should go to his home address. He made his way to the City Room along the concourse. Once there, he assisted the injured, including Georgina Callander.\textsuperscript{109}

\begin{itemize}
\item \textsuperscript{101} 152/5/24-6/3
\item \textsuperscript{102} 150/118/18-25
\item \textsuperscript{103} 138/84/15-25
\item \textsuperscript{104} 158/16/21-25
\item \textsuperscript{105} INQ007087/1-2
\item \textsuperscript{106} 151/29/15-18
\item \textsuperscript{107} INQ007087/1-2, INQ007087/7
\item \textsuperscript{108} INQ041648/1 at paragraph 4
\item \textsuperscript{109} 155/9/5-10/14
\end{itemize}
Conclusion

16.195 I have considered above the responses of those organisations based within the Victoria Exchange Complex, and the individuals who found themselves in and around the Victoria Exchange Complex on the night of the Attack. I have pointed out where there were failings in relation to SMG and ETUK’s preparedness and response. Similarly, I have noted the courageous actions taken by members of the public, as well as Northern Rail and TravelSafe staff, present on the night of the Attack.
Manchester Arena Inquiry
Volume 2: Emergency Response

Volume 2-II

Report of the Public Inquiry into the Attack on Manchester Arena on 22\textsuperscript{nd} May 2017

Chairman: The Hon Sir John Saunders

November 2022
Manchester Arena Inquiry
Volume 2: Emergency Response

Volume 2-II

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Chairman: The Hon Sir John Saunders

Presented to Parliament pursuant to section 26 of the Inquiries Act 2005

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HC 757-II
The twenty-two who died

Alison Howe
Angelika Klis  Marcin Klis
Chloe Rutherford  Liam Curry
Courtney Boyle
Eilidh MacLeod
Elaine McIver
Georgina Bethany Callander
Jane Tweddle
John Atkinson
Kelly Brewster
Lisa Lees
Martyn Hakan Hett
Megan Joanne Hurley
Michelle Kiss
Nell Jones
Olivia Paige Campbell-Hardy
Philip Tron
Saffie-Rose Roussos
Sorrell Leczkowski
Wendy Fawell
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Part 17
The explosion

THE CONTENT OF PART 17 IS PARTICULARLY DISTRESSING. IT CONTAINS DETAIL IN RELATION TO THE EFFECT OF AN EXPLOSION AND THE IMPACT ON THOSE WHO SURVIVED

Introduction

17.1 The Improvised Explosive Device detonated by SA had a devastating effect. In Volume 3, I will describe its construction in greater detail. At this stage, it is sufficient to record that it comprised a high explosive element, triacetone triperoxide,¹ which was surrounded by a large number of small metal items. Those metal items comprised 29.26kg of metal nuts and 1.47kg of screws or cross dowels. It is estimated that there were approximately 3,000 such items in total.²

17.2 Those numbers give some idea of the terrible intent of SA and HA. They planned to cause as much harm to as many people as they could. In this Part, I deal with the effects of the explosion and the experience of some of the members of the public who were in the City Room and

¹ 44/49/23-50/8
² 44/110/11-111/8
survived the Attack. This cannot be a complete summary of all of the effects of the Attack on each person who was in the City Room. It would be impossible to cover that in my Report. Rather, this Part sets out the accounts I heard from some of those most seriously affected by the events that night.

17.3 In Part 18, I will consider what happened to each of those who died following the detonation of the bomb. I will also consider whether any of those who were killed could have survived the Attack had the emergency response been different.

**Effect of an explosion**

17.4 I was assisted in understanding the effects of an explosion by a Blast Wave Panel of Experts, led by Professor Anthony Bull from the Centre for Blast Injury Studies.

17.5 When an explosion occurs, it causes a blast wave. A blast wave has two component parts. The first is the shock wave. This is a high-pressure wave of energy, which transmits through material. Behind the shock wave is the blast wind. This follows the shock wave and carries material with it. The material moved by the blast wind comprises ‘primary fragments’, which come
from the device itself, and ‘secondary fragments’, which come from the environment. ³

17.6 Blast injuries fall into five main categories. ⁴

17.7 Primary blast injuries result from the contact of the shock wave with the body. The shock wave transmits through the structures of the body. Where there are spaces between those structures, it causes a tearing or separation. This is particularly significant where the two structures are of different densities, such as in a lung. The shock wave is capable of causing very serious injury. ⁵

17.8 Secondary blast injuries are caused by objects moved by the blast wind. When they make contact with the body, they can disrupt the anatomy. Being struck by a fragment from a blast has been likened to being shot with a bullet. However, the fragment typically causes more devastation as the energy around the object does not travel in a straight line, rather it is tumbling. This means a small wound from a secondary blast injury can cause devastating internal injuries. ⁶

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3 150/10/3-18/23
4 150/21/18-20, INQ025364/9
5 150/21/15-24/8
6 150/25/15-27/11
17.9 Tertiary blast injuries are the damage caused when the body is thrown against an object or a large object strikes against the body. This commonly occurs when a person is pushed to the floor or against a wall by the force of the blast wind, causing crush injuries. The energy involved is often far higher than in a road traffic collision. This can result in very severe injury. 7

17.10 Quaternary blast injuries are those not due to primary, secondary or tertiary blast injuries. Any part of the body can be affected. Often they are burn or inhalation injuries. 8

17.11 Quinary blast injuries are caused by contaminants in the explosion, such as biological or radiological contaminants. 9

17.12 The first four types of blast injury were caused to those present in the City Room by SA’s detonation. Figure 41 provides a pictorial representation of the way in which blast injuries occur.
Figure 41: Types of blast injury

- **Primary blast injury** (shock wave and reflecting shock waves)
- **Secondary blast injury** (primary and secondary fragments)
- **Tertiary blast injury** (bodily displacement)
- **Quaternary blast injury** (other explosive effects, including burns)
- **Quinary blast injury** (environmental contaminants)

10 INQ025364/9
Those who survived

Introduction

17.13 In 2019, Greater Manchester Police (GMP) estimated that there were 940 victims of the Attack who survived. Of those 940 victims, 337 people were in the City Room at the time of the explosion and a further 92 people were in the immediate vicinity. Of the victims, 237 people were physically injured. A total of 111 people required hospitalisation. A total of 91 people were categorised as being seriously or very seriously injured. 11

17.14 This section of the Report will describe the experience of some of those who were present in the City Room in the aftermath of the explosion and their recollection of the moment the bomb detonated. It will set out their views of the emergency response that followed, where it was effective and where it failed.

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11 138/58/4-59/15
17.15 These accounts, which are harrowing, show the courage of the human spirit in adversity. For most, if not all, the Attack is something they will never forget. The physical and mental scars will always be there. The testimony each person gave to the Inquiry was moving and powerful. It forms an important part of the record of the events that night. I am very grateful to all those who provided evidence to the Inquiry and for the courage they showed in doing so.

17.16 In this section, I summarise and quote from the evidence given, largely without comment. This is to convey the experiences of each witness, through their words and their perspective. This section does not seek to review the experience of every person who was a victim of the Attack. Nor is it a record of the most seriously injured people. It provides the accounts of some of the members of the public in the City Room, many of whom were severely injured. Part 16 in Volume 2-I contained evidence from others in the City Room, viewed from the perspective of their contribution to the emergency response. Some of those I mentioned in Part 16 in Volume 2-I were also casualties themselves.

17.17 At the end of this section, I consider the experience of those who were present in the City Room and survived the explosion but whose loved ones died in the Attack.
17.18 Where appropriate, I have included references to occasions on which a survivor saw SA prior to the explosion.

**Before the Attack**

17.19 Many people described their excitement, and that of their children, at the thought of attending the Ariana Grande concert. For a large number, this was their first ever concert. For many, the ticket was a Christmas or birthday present, often purchased with a second ticket so that a friend could also attend.

17.20 In the moments immediately prior to the explosion, the atmosphere in the City Room was described as joyful. Josephine Howarth described a “family atmosphere”, with “lots of parents and grandparents around waiting to pick up children”. She said: “Everybody seemed to be enjoying themselves.”

17.21 Sarah Gullick described the atmosphere in the City Room as “good natured”. She recalled: “You could hear the music playing and people were coming out of the arena excited with happy faces.”

17.22 Janet Capper remembered standing in the City Room, looking back to the main doors to the
Manchester Arena. She could still hear the music playing. The staff had opened the doors as there were people leaving. She said: “I vividly recall seeing how happy all the children looked as they were leaving.”

David Robson recalled spotting his daughter and her friend. He started waving at them. He stated: “I looked at them and they had spotted us and they were running towards us, excitedly.”

What happened next is in stark contrast to those positive emotions. Witnesses heard a loud bang and saw a bright orange flash. Some were knocked to the ground. It was, many said, like nothing they had ever experienced before. Witnesses went on to describe a scene of chaos and devastation in the City Room in the immediate aftermath of the explosion.

After the Attack

Amelia Tomlinson and Lucy Jarvis

Amelia Tomlinson, known as Millie, went to watch the concert with her friend Lucy Jarvis. They left just as the encore ended. They walked across the City Room arm in arm. Millie Tomlinson felt a rush of warm air. She said it was like when you

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14 87/31/24-32/4
15 85/19/2-5
16 86/3/5-10
17 86/6/12-15
18 86/7/18-23
jump in a pool and feel water in your ears. 19 Lucy Jarvis did not hear the explosion but recalled it being “really hot”. 20

17.25 Millie Tomlinson and Lucy Jarvis were separated by the force of the blast. 21 They were able to get up and run back into the Arena bowl. 22 Lucy Jarvis fell over. She could not walk due to an ankle injury. 23 She was losing a lot of blood. 24 Millie Tomlinson tied her jacket around Lucy’s leg to try to stop the bleeding. 25 Lucy Jarvis described having holes in her jeans from the shrapnel and an injury to her arm. 26

17.26 Millie Tomlinson and Lucy Jarvis were helped out of the Arena bowl by SMG and Showsec staff. 27 Lucy Jarvis was evacuated first, 28 and recalled that she was taken to the Arena concourse, where two SMG staff cared for her and bandages were applied. After about 30 minutes, she was put on a stretcher. 29 The two SMG staff stayed with her, even though firearms officers told them

19 86/7/1-9
20 86/54/19-24
21 86/7/17-20
22 86/8/19-9/7
23 86/9/24-10/1, 86/55/25-56/2
24 86/10/23-11/2
25 86/11/23-12/2
26 86/61/2-5
27 86/59/11-62/10
28 86/12/13-14/2
29 86/61/22-24
to leave. ³⁰ Lucy Jarvis was evacuated over the raised walkway and down in the lift. ³¹

17.27 A Showsec first aider stayed with Millie Tomlinson while she waited for her family and then drove Millie Tomlinson and her family to Manchester Royal Infirmary. ³² She had injuries to her hand and foot. ³³

17.28 Lucy was assessed in the Casualty Clearing Station. Initially, she was triaged as ‘orange’ and wondered what that meant. ³⁴ She had to wait on the station concourse floor for two hours. During that time she vomited. Her status became ‘red’ and she was taken to an ambulance immediately. ³⁵ Lucy described her experience of waiting as “quite stressful” and “scary”. ³⁶ People all around her were injured, but she did her best to remain calm. ³⁷ Lucy Jarvis gave evidence to the Inquiry and set out the extent of her injuries. ³⁸ She underwent a 14-hour operation and was in hospital for eight weeks. ³⁹
Andrea Bradbury

17.29 Andrea Bradbury is a retired counter-terrorism police officer. She served for 30 years in the police and retired two months before the Attack. She drove her 15-year-old daughter with her friend, and her friend’s mother, Barbara Whittaker, to the concert. Andrea Bradbury described her daughter, like so many of those who went, as an Ariana Grande “addict”, who loved watching her on television and wearing cat ears. Andrea Bradbury texted her daughter throughout the concert. She said she had “an absolute ball”.

17.30 At 21:52, Andrea Bradbury and Barbara Whittaker can be seen on CCTV on the raised walkway, walking towards the City Room. They had arranged to meet their daughters on the McDonald’s staircase after the concert. At the time of the explosion, they were near to the merchandise stall, facing the doors to the Arena. There was a massive blast from behind them. Andrea Bradbury described a “big white
“flash” and said it felt like her legs had been hit by a garden strimmer.47

17.31 Andrea Bradbury said, as a former counter-terrorism police officer, it was immediately obvious to her that it was a bomb explosion.48 She did not think at any point that a firearm was involved, nor that it was an active shooter incident.49 She was concerned about a secondary device and said to Barbara Whittaker that they needed to leave to get to a place of safety.50 They were confident they had not seen the children come into the City Room before the explosion and crawled to the Arena bowl to find them.51 In the period of time she was in the City Room, Andrea Bradbury did not see any members of the emergency services.52

17.32 It was loud inside the Arena, with tannoy messages and alarms.53 They were able to speak to their children on the phone.54 The children had left the Arena via Hunts Bank.55 Andrea Bradbury said she went back through the City Room. She was only there a very short time. She saw three

47 89/124/9-23
48 89/126/4-13
49 89/127/1-21
50 89/128/3-22
51 89/128/19-130/24
52 89/130/19-24
53 89/133/4-7
54 89/133/4-16
55 89/133/17-19
police officers run in but no wider emergency response at that stage. Andrea Bradbury said she telephoned the on-call counter-terrorism officer in Lancashire to provide an account from the scene. She did this three times. She felt it was important for senior officers to know what had happened and that there had been a single explosion.

17.33 Later that evening, once reunited with her daughter, Andrea Bradbury went to GMP Headquarters (GMP HQ). She went there to tell them what had happened. She spoke to an officer at the security gatehouse and then a police officer who said she was “Gold”. Assistant Chief Constable Deborah Ford, who was duty Strategic/Gold Commander for GMP on the night, said that this was not her. Andrea Bradbury made concerted efforts, despite her own injuries, to give the police information about the Attack.

17.34 Andrea Bradbury required medical treatment and arrived at hospital at 00:48 on 23rd May 2017.
She has suffered permanent nerve damage to her legs.62

**Darah Burke**

17.35 Dr Darah Burke is a general practitioner.63 He went to the concert with his wife, Ann, and their 10-year-old daughter.64 They left the concert as Ariana Grande was singing the last song of her encore.65 They made their way towards the railway station.66

17.36 Dr Burke described a sudden, very loud bang as the family made its way through the City Room. He was thrown forwards slightly.67 His daughter was on the floor, screaming.68 They were about halfway to the doorway leading out to the raised walkway.69

17.37 His daughter could not stand up. Dr Burke and his wife carried her out to the raised walkway.70 Dr Burke and his wife were bleeding from their legs.71 Dr Burke had shrapnel injuries to his right leg and left buttock. His wife had shrapnel injuries

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62 89/147/12-17  
63 85/49/17-21  
64 85/50/3-11, 85/52/13-14  
65 85/52/9-15  
66 85/53/2-11  
67 85/55/13-16  
68 85/56/1  
69 85/56/8-17  
70 85/57/16-58/6  
71 85/58/9-10
to her thigh and heel. His daughter’s right arm and leg were bleeding heavily, as was the right side of her head. Dr Burke took off his shirt and tied a tourniquet around his daughter’s arm and a coat around her leg.

17.38 Dr Burke assessed that his daughter was not in immediate danger and went back into the City Room. Due to his own injuries, he was not able to provide assistance, but described how he saw “shadows and people were starting to stand and ... provide assistance”. Dr Burke returned to the raised walkway where he ensured that an injured person was not in “immediate danger”. He described how emergency responders arrived. He stated that as he and his family were “relatively stable, not in immediate danger”, he directed emergency responders onto the City Room. He recalled police firearms officers pointing their guns at him and his family.

17.39 He and his family were on the raised walkway for an hour. At some point, they were given a trauma pack with bandages. They were small.
There were no major trauma dressings. A doctor in plain clothes re-dressed his daughter’s wounds. A police officer told them they needed to leave the area. The officer carried his daughter off the raised walkway in his arms. No one triaged them when they were on the walkway or in the station.

17.40 His daughter was carried to an area outside Chetham’s School of Music. After about 15 or 20 minutes, they were triaged as a family as P3 casualties. ‘P3’ refers to priority three casualties and means casualties whose treatment may be safely delayed for beyond four hours. Dr Burke could not remember anyone giving his daughter a full medical examination.

17.41 The family waited at Chetham’s School of Music until about 02:00 on 23rd May 2017. By then, his daughter’s situation had deteriorated. She was cold, shivering and light-headed. A decision was made to take her to hospital by ambulance. She was reassessed as a P2 casualty. ‘P2’ refers to priority two casualties and means casualties who

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81 85/65/15-20
82 85/65/4-23
83 85/67/2-68/1
84 85/67/10-17, 85/69/10-15
85 85/70/3-16
86 INQ022339/5-7
87 85/70/17-22
88 85/75/10-77/15
89 85/78/9-13
require surgical or other interventions within 2–4 hours.

17.42 Ann Burke accompanied her daughter in the ambulance.\(^90\) Dr Burke went to a different hospital on a bus transporting casualties to hospital. Apart from Dr Burke, there were no medical practitioners on the bus.\(^91\) He arrived at hospital at about 03:00.\(^92\) His daughter arrived at hospital by ambulance at about 02:15.\(^93\)

17.43 Dr Burke stated that the response from bystanders and first responders was “rapid, highly professional”.\(^94\) He stated that there were, however, very few stretchers available and that the dressings in packs were inadequate.\(^95\) He stated that they were reassessed frequently, it was slightly chaotic and they were asked the same questions. He stated that new dressings were removed unnecessarily\(^96\) and not everyone seemed to be aware of the triage system.\(^97\)

Janet Senior and Josephine Howarth

17.44 Janet Senior drove her sister, Josephine Howarth, and her two young nieces to the
The girls were really excited. Janet Senior and her sister arranged to meet the girls in the City Room after the concert.

17.45 Janet Senior and Josephine Howarth returned to the City Room shortly before 22:00. They initially sat on the JD Williams staircase and then moved to sit at the top of the McDonald’s staircase. They can be seen on CCTV appearing from those steps and making their way across the City Room at 22:30.

17.46 Janet Senior recalled a petrol-like smell and then the explosion happened. She described it as a “crack bang” with a flash and that there was pink-coloured smoke. Janet Senior felt a horrendous impact on her chest and neck. In common with others, she said it was similar to being underwater. She said: “Everything seemed to move in slow motion for a few minutes.” Shrapnel was “buzzing around.”

17.47 Josephine Howarth described seeing the merchandise stall turn “to shreds”. She knew
instantly it was a bomb. She described rolling, orange flames. The explosion was “very bright, very loud”, and debris struck her.\textsuperscript{107} Her leg was badly injured, and there was blood gushing from it.\textsuperscript{108}

17.48 Janet Senior had the presence of mind to telephone 999. She told the operator that there had been an explosion, people had died and they needed help.\textsuperscript{109} The connection was lost. Janet Senior later found a voicemail from the emergency services asking for her to call back. The voicemail was timed at 22:44.\textsuperscript{110} At about this time, Janet Senior’s nieces also left voicemails saying they were OK.

17.49 Janet Senior and Josephine Howarth were both seriously injured.\textsuperscript{111} Josephine Howarth told her sister to use her handbag strap as a tourniquet.\textsuperscript{112} They both had knowledge of first aid. Janet Senior had done a course as part of her role as a horse-riding coach. They had both been taught about tourniquets and how to use them to stem severe bleeding.\textsuperscript{113}
17.50 The CCTV confirms that they were both evacuated from the City Room at 23:14.\textsuperscript{114} Janet Senior arrived in the Casualty Clearing Station at 23:18.\textsuperscript{115} She was placed in an ambulance at 00:42 and arrived at hospital an hour later at 01:40.\textsuperscript{116} Josephine Howarth left the Casualty Clearing Station at 01:34. She was placed in an ambulance at 01:41 and arrived at hospital at 02:08.\textsuperscript{117}

17.51 Janet Senior said that when she was in the City Room, she was praying for more people to come: “time was clocking on”, people were dying and the room was getting quieter.\textsuperscript{118} She vividly recalled seeing a dog and hearing it panting. It was at that point she realised that a bomb had exploded and thought she and her sister were not going to make it home.\textsuperscript{119} She said that help was very slow in coming. People were “dotted about”, but she did not think anyone was actually doing a lot.\textsuperscript{120} Her experience of the Casualty Clearing Station was that it was “organised chaos”.\textsuperscript{121} She felt that no one regularly checked on her, even

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\item \textsuperscript{115} 89/24/19-20
\item \textsuperscript{116} 89/44/23-45/8
\item \textsuperscript{117} 89/74/5-14
\item \textsuperscript{118} 89/33/3-9
\item \textsuperscript{119} 89/32/17-34/19
\item \textsuperscript{120} 89/38/7-18
\item \textsuperscript{121} 89/41/1-8
\end{itemize}
though she was a P2 casualty. No one gave her pain relief. When the ambulance drove her to hospital, it had to turn around because of road blocks. The satnav did not work.

17.52 Josephine Howarth said she slipped in and out of consciousness and only had short clips of memory. She did recall seeing three people giving first aid in the City Room and thinking, “[O]h my God, there’s only three for all these people, where are the paramedics?” She also recalls being very cold, lying on a marble floor without any blankets.

Martin Hibbert

17.53 Martin Hibbert went to the concert with his daughter, Eve. It was, he said, “daddy and daughter time”: a happy occasion. The sun was shining. It was a beautiful day. Martin Hibbert said that the concert was amazing. They were in a VIP box.
17.54 On CCTV, they can be seen walking into the City Room, from the Arena bowl, at 22:30.\textsuperscript{132} They were between five and six metres from SA.\textsuperscript{133} Martin Hibbert said that he heard an “\textit{almighty bang}”. There was a high-pitched, piercing sound.\textsuperscript{134} Then it felt like a ten-tonne truck had hit him.\textsuperscript{135} He immediately felt he could not breathe and noticed he was losing a lot of blood.\textsuperscript{136}

17.55 At that point, he saw how seriously injured Eve was. It was \textit{“like she had been shot through the head”}. She was bleeding and gasping for breath.\textsuperscript{137} He had shielded Eve from much of the blast, but one bolt got through. Eve suffered a very significant brain injury.\textsuperscript{138}

17.56 Martin Hibbert said he thought he was watching Eve die. He was not in pain. He did not panic. He had a job to do: make sure Eve survived.\textsuperscript{139} He could feel his body shutting down, but fought to stay awake to ensure that Eve got out.\textsuperscript{140} He kept asking: \textit{“Where is everybody? Where are the paramedics?”} He got fed up of being told that

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\item 132 138/6/8-14
\item 133 138/6/19-7/5
\item 134 138/7/11-23
\item 135 138/7/18-19
\item 136 138/7/18-8/5
\item 137 138/8/6-13
\item 138 138/9/17-10/3
\item 139 138/8/6-19
\item 140 138/10/4-18
\end{itemize}
they were on the way.\textsuperscript{141} He said it seemed like forever.\textsuperscript{142}

17.57 He saw Eve covered up twice with T-shirts and posters. People thought she had died.\textsuperscript{143} Martin Hibbert said he could see she was gasping for breath. Her lips were quivering.\textsuperscript{144} People thought her injury was non-survivable. They were going to cover her up and leave her. It was a “big frustration”, as he felt that if he had lost consciousness, Eve would have died.\textsuperscript{145} He thought that unqualified people were being left to make a life or death choice.\textsuperscript{146}

17.58 Martin Hibbert was taken out of the City Room at 23:21. Eve was taken out at 23:25.\textsuperscript{147} They were both taken to the Casualty Clearing Station. Eve left by ambulance at 00:18.\textsuperscript{148} He found it “baffling” that she was not put straight into an ambulance. In those circumstances, he thought it was a miracle that she was still alive. He said he had “just no words for it”.\textsuperscript{149}

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141 138/10/18-22
142 138/14/9-17
143 138/11/8-12/19
144 138/12/20-13/1
145 138/13/2-12
146 138/24/4-25/7
147 138/15/11-16/1
148 138/17/5-7
149 138/16/8-17/1
\end{verbatim}
17.59 Martin Hibbert left for hospital at 00:24, 1 hour and 53 minutes after the detonation. When he was placed in an ambulance, he was going to be taken to Wythenshawe Hospital. This was a 25- to 30-minute journey. The paramedic, however, went to Salford Royal Hospital, 10 minutes’ away. Martin Hibbert said that decision was “life saving”. A different paramedic might have made a different decision. That was another frustration for him.

17.60 Martin Hibbert noted that the equipment that was available, such as plasters, scissors and bandages, was inadequate and that the responders didn’t have “the right equipment”. He has reflected on whether Eve’s treatment would have been different with more strategic planning and marshalling of vehicles; whether it might have shortened the period to get to hospital.

17.61 Martin Hibbert described the life-changing impact of his injuries. He suffered 22 shrapnel wounds, one to the centre of the back which severed his spinal cord. He has been left paralysed from the waist down. Sometimes, he said, the post-
traumatic stress disorder is a greater battle than the spinal injury.\textsuperscript{156} He tries to motivate and inspire people. He does everything he had done before and more and is thankful to be alive.\textsuperscript{157} Eve was in hospital for ten months. Initially, her family were told that Eve would probably remain in a vegetative state, but she can now eat, talk and walk unassisted. Martin Hibbert said she would “\textit{inspire the world}”.\textsuperscript{158}

Sarah Nellist

17.62 Sarah Nellist was in the City Room to collect her daughter and niece. She arrived at about 21:50 and waited by the box office, near to the exit doors from the Arena. This is where she was at the time of the explosion.\textsuperscript{159} She described seeing SA a couple of minutes before the explosion. She thought he looked “a \textit{bit odd}”.\textsuperscript{160}

17.63 She saw the bomb detonate. It was, she said, like “\textit{black powder paint}”.\textsuperscript{161} There was a high-pitched noise. The heat was “\textit{unbelievable}”.\textsuperscript{162} The force of the blast knocked her over.\textsuperscript{163} Sarah Nellist
was able to get up. She ran onto the Arena concourse and was then directed outside. She was able to find her daughter and niece, and they went to their car. They did not see any paramedics but were assisted by members of the public.

Suzanne Atkins

Suzanne Atkins took her daughter and her daughter’s friend to the concert. She described how the children were happy and excited as they went into the Arena. They arranged to meet at the doors to the City Room after the concert. Suzanne Atkins went back to the City Room with her mother at about 22:20 to collect the children. At the time of the explosion, she was standing against railings by the merchandise stall.

She described seeing SA walk across the City Room. He was about a metre in front of her. She said he was “stooped and had a bit of a swagger about him”. He looked out of place in a crowd.
of young girls and families.\textsuperscript{173} She said that SA looked like he was going somewhere, but from the direction he was going, he could not have been going anywhere.\textsuperscript{174}

17.66 Suzanne Atkins described seeing an orange flash from the explosion. It felt like something had rolled into her that was burning her legs. The impact sent her backwards.\textsuperscript{175} She found her mother on the floor and quickly took her out to the raised walkway.\textsuperscript{176} Suzanne Atkins said she went onto autopilot. She went to find her daughter.\textsuperscript{177} She recalled someone saying there had been another explosion.\textsuperscript{178} She thought she had lost her daughter and needed to get into the Arena to find her.\textsuperscript{179} She scoured the City Room.\textsuperscript{180}

17.67 After some time, she was able to contact her daughter by mobile phone, but it kept cutting out.\textsuperscript{181} She was trying to escort her mother away from the City Room and speak to her daughter.\textsuperscript{182} It was a frightening situation. Suzanne Atkins

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\item \textsuperscript{175} 86/37/14-38/2
\item \textsuperscript{176} 86/38/13-39/2
\item \textsuperscript{177} 86/38/24-39/15
\item \textsuperscript{178} 86/39/20-40/4
\item \textsuperscript{179} 86/41/5-17
\item \textsuperscript{180} 86/42/12-19
\item \textsuperscript{181} 86/43/9-14
\item \textsuperscript{182} 86/44/6-12
\end{itemize}
\end{footnotesize}
explained: “It felt like no one was coming ... and we had to deal with it ourselves.” Suzanne Atkins saw a police officer, who told her to drive her mother to hospital. The police officer said people had been shot. Suzanne Atkins said to the officer that it was an explosion.184

17.68 Eventually, Suzanne Atkins was reunited with her daughter outside the station.185

Family of those who died

17.69 I heard oral evidence from a number of those bereaved by this atrocity who were at or near the City Room at 22:31. I am extremely grateful to them for the courage and dignity that they displayed when recounting their terrible experience of the Attack and its aftermath. What follows is a summary of that evidence.

Paul Price, partner of Elaine McIver

17.70 Paul Price and Elaine McIver were in the City Room to collect his daughter and her friend. As the concert ended, he recalled that a wave of people came out of the exit doors into the City Room. He was seriously injured by the explosion. He saw Elaine McIver lying about three or four metres away from him, but he could not reach

183 86/43/22-44/5
184 86/45/23-47/11
185 86/47/15-48/2
her because of his own injuries. Paul Price was evacuated from the City Room at 23:18.\textsuperscript{186}

**Claire Booth, sister of Kelly Brewster**

17.71 Claire Booth went to the concert with her daughter, Hollie, and her sister, Kelly.\textsuperscript{187} Claire Booth said the drive to Manchester was a lovely one. Kelly and Kelly’s partner Ian had just had an offer accepted on a house. Kelly and Kelly’s partner Ian talked about all the plans for the move, the layout for a future nursery and a holiday they were planning to Disneyland.\textsuperscript{188}

17.72 It was a good concert. They all enjoyed it. Claire Booth described “loads of little girls just dancing”.\textsuperscript{189} They left their seats as the last song ended, walking in a line. Claire Booth was at the front, Hollie in the middle and Kelly at the back.\textsuperscript{190} They went into the City Room and started to walk towards the Trinity Way link tunnel.\textsuperscript{191}

17.73 As they passed the box office windows, there was a huge yellow flash. Claire Booth described it as like a “blowtorch”.\textsuperscript{192} It was really loud and the hottest heat she had ever felt. The force of

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\item\textsuperscript{186} 156/46/7, 156/53/19-57/24, 156/50/16-17
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\item\textsuperscript{188} 138/65/2-66/5
\item\textsuperscript{189} 138/70/6-12
\item\textsuperscript{190} 138/71/11-72/1
\item\textsuperscript{191} 138/72/6-73/1
\item\textsuperscript{192} 138/73/14-74/5
\end{enumerate}
\end{footnotesize}
the blast pushed her into the box office wall.\textsuperscript{193} Claire Booth described the room then going momentarily silent. It took a moment to focus, but then she was able to see shrapnel on the floor. At that point, she knew it was a bomb and could see some of its components.\textsuperscript{194} She was worried about a second explosion or someone shooting them.\textsuperscript{195}

17.74 Claire Booth described looking back to find Kelly and Hollie. Kelly was lying on her side. Hollie was leaning on her hands as if about to get up. Hollie called out.\textsuperscript{196} Claire Booth explained how she picked Hollie up and started to run out of the City Room, towards the Fifty Pence staircase. She called for Kelly to follow them. Claire Booth only stopped when Hollie said she was bleeding. At that point, she realised that Kelly was not with them.\textsuperscript{197}

17.75 Claire Booth described the scene as one of chaos and panic. People were screaming. Some were running and others were still on the floor. Hollie was very upset. Claire Booth was torn: she wanted to care for her daughter but also find her sister. She begged people to look after Hollie.
People kept running past. No one helped. Claire Booth realised she was on her own. She ran back into the City Room and found Kelly was still lying on the floor where they had left her, as if she were asleep. She did not look injured. Claire Booth described kicking at her legs, shouting at her to get up. Kelly did not respond at all.\textsuperscript{198}

17.76 Claire Booth went back to Hollie. She used her daughter’s mobile phone and called Hollie’s father, Dale, to tell him what had happened. He told her to go back and check on Kelly. Claire Booth went back and stood over her, screaming her name over and over. Dale said to check Kelly’s pulse. It was only at this point, as she leaned over Kelly, that Claire Booth realised she was also injured. Hollie was screaming for her. Claire Booth described her sense of hopelessness. She said “\textit{sorry}” to Kelly over and over and walked away.\textsuperscript{199}

17.77 Some help started to arrive. Someone told her to elevate Hollie’s legs. Claire Booth was by this time concerned about her own injuries. She did not know if she was dying. She asked a police officer if her throat had been cut. She was told that she had a facial injury. This made her calmer. She was then able to focus on getting help for her sister and Hollie. Claire Booth spoke to her

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\item \textsuperscript{198} 138/77/17-79/14
\item \textsuperscript{199} 138/79/20-83/11
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own mother when her mother rang Hollie’s mobile phone. Claire Booth told her mother that Kelly had died.200

17.78 Showsec staff tried to help. One person gave her a T-shirt to hold against Hollie’s leg. When she pressed it down, another part of Hollie’s jeans started to go a deeper red with more blood. She was given another T-shirt but noticed another hole. Hollie’s legs were covered in holes. Claire Booth begged the Showsec staff not to let Hollie die.201

17.79 When asked about the emergency response, Claire Booth said: “Every minute in the foyer felt like an hour.”202 She told anyone who approached her to offer their help, to go to Kelly. She could see no one was staying to give first aid, and she could not understand why. Nobody came back to tell her anything. Eventually, an off-duty police officer did stay with Kelly. He moved her and checked her pulse.203

17.80 Hollie needed urgent attention. She had started to go quiet and close her eyes. She spoke very slowly and said she wanted to sleep. Claire
Booth described calling out to Emergency Training UK staff.\textsuperscript{204}

17.81 The room suddenly seemed full of police officers, all in different uniforms. At one point, she was told that Kelly had a faint pulse but did not hear anything further after this. Someone helped to cut Hollie’s jeans, and it was clear her legs were very badly injured. Claire Booth said it felt like hours had gone by. She repeatedly asked where the ambulances were. She could hear sirens. She was told they were coming but then they would never arrive. At one point, firearms officers asked her to leave. She was asked to carry Hollie, which was impossible.\textsuperscript{205}

17.82 Claire Booth described how it did not make any sense that ambulances were not arriving. Claire Booth said she was desperate. Police officers were helping to apply pressure to Hollie’s legs. They found even more injuries at the top of her legs. She did not think Hollie was going to get out of the City Room alive. Dale telephoned and said he and Ian had arrived from Sheffield but could not get through the police cordon. He said he could see ambulances. Claire Booth said that she felt relieved because she hoped that Ian could stay with Kelly, so that Kelly would not be alone. Claire Booth said, at around this time, the

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\textsuperscript{204} 138/91/13-93/10
\textsuperscript{205} 138/93/16-101/5
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atmosphere in the room started to change: things were happening. A paramedic saw them. It was very quick. Hollie was given a card with a number two on it. Claire Booth was given a number three.\(^{206}\)

17.83 It became their turn to be taken out of the City Room to the Casualty Clearing Station. On the CCTV, this can be seen at 23:29. Hollie was put on a metal crowd barrier and Claire Booth in a wheelchair.\(^{207}\) Hollie described the experience as “very scary, incredibly painful”.\(^{208}\) She was not fastened to the barrier. She had to grip on. It felt like she would slide off. Claire Booth said it was a “horrific way” for anybody with injuries to be moved.\(^{209}\)

17.84 Claire Booth and Hollie arrived in the Casualty Clearing Station at 23:31.\(^{210}\) Claire Booth described how lost she felt there. It was cold and bright. They had no blankets, but someone gave them a curtain to wrap up in and keep warm.\(^{211}\) There were lots of injured people. She described how it felt. It was chaotic. There was no plan. It seemed that no one knew who would be treated next. It felt like a long time before anyone

\(^{206}\) 138/101/22-106/22
\(^{207}\) 138/107/14-109/20
\(^{208}\) 138/111/11-23
\(^{209}\) 138/111/23-112/7
\(^{210}\) 138/112/14-21
\(^{211}\) 138/113/24-114/3, 138/123/18-124/8
checked Hollie. Hollie was reassessed as a priority, P1 patient, but it still took a long time for her to be taken to hospital. They were taken to hospital at 01:59 on 23rd May 2017, 3 hours and 28 minutes after the explosion. Both Claire Booth and Hollie received treatment for their injuries and were in-patients for weeks after the Attack. They underwent a number of operations. Hollie had lost so much blood that she needed a blood transfusion at hospital.

17.85 Reflecting on what happened, Claire Booth said: “I remember feeling like we had been abandoned … I could hear the sirens so close by but help never came.” She stressed the need to educate the public that in a situation such as this, medical help might not always come immediately. Claire Booth said if she had known that, she would not have sat and waited for help to arrive.

Bradley Hurley, brother of Megan Hurley

17.86 Bradley Hurley attended the concert with his 15-year-old sister, Megan Hurley. His sister was a big Ariana Grande fan, and they were both excited to see the show.
described it as a “really fun night”. They left as soon as the concert finished, and as they approached the doors to the City Room Megan Hurley said: “What an experience that was.”

17.87 Bradley Hurley said they were in the City Room for about five seconds before his vision went completely white. There was a high-pitched, piercing sound. It was like a mosquito. His whole body felt extremely hot. He thought he might have collapsed or had a heart attack.

17.88 After the immediate shock, Bradley Hurley realised he was on the floor. He tried to get up but knew straightaway that his legs were broken. He lay on his back, propped up on his elbows. His legs were bent and his skin was burning all over. His vision was blurred and his hearing distorted, like being underwater.

17.89 Bradley Hurley described looking at his sister. He knew straight away that she had died. She was not breathing. He tried, but couldn’t find a pulse. Bradley Hurley said at that moment he felt strangely calm: he felt an acceptance about what had happened and that there was nothing he could do to change it.
17.90 He knew it had been a terrorist attack: a bomb with shrapnel.\textsuperscript{223} They were a few metres away from the seat of the explosion.\textsuperscript{224}

17.91 Bradley Hurley found it difficult to put things in a precise order, but he described how the City Room quickly descended into chaos. There were screams of pain from every direction. The room was dimly lit and smoky, and he had never felt so alone or helpless. He could not move and was bleeding heavily. There were other people in a similar situation lying around, but he did not have the words to speak to them. He recalled it being “the worst imaginable situation”.\textsuperscript{225}

17.92 Bradley Hurley remembered people coming over to him. One person wrapped their belt around his leg as a makeshift tourniquet. To him, it seemed like the right thing to do. Someone else later joined him and told him to take off the tourniquet. They said he could lose his leg. Bradley Hurley said he was “conflicted”, but the tourniquet was taken off.\textsuperscript{226}

17.93 Someone was handing out Ariana Grande merchandise to cover those who had died. Someone covered his sister.\textsuperscript{227}
17.94  More police arrived, and Bradley Hurley described trying to get their attention. He did not feel like anyone checked him properly. No one cut off his jeans to see how bad his injuries were.\textsuperscript{228} He felt helpless, lying in pain on the floor, unable to move. The feeling of large police boots walking around close to his face was “uncomfortable” and “scary”.\textsuperscript{229} From the CCTV, he later knew that North West Ambulance Service Advanced Paramedic Patrick Ennis assessed him at 23:06. This lasted ten seconds, but he had no memory of it.\textsuperscript{230}

17.95  The police reassured him that the paramedics were on the way, but they also seemed to be frustrated and confused that the ambulance personnel were not in the room.\textsuperscript{231} At some point, he was given a wristband with a number two on it.\textsuperscript{232}

17.96  Bradley Hurley said that at some stage he was able to speak to his parents on Megan Hurley’s mobile phone. He told his father that there had been a bomb and where he was in the City Room. He said that his sister was with him. Bradley Hurley’s father told him that he was going

\textsuperscript{228} 138/169/15-170/9
\textsuperscript{229} 138/171/12-23
\textsuperscript{230} 138/170/20-25
\textsuperscript{231} 138/172/10-25
\textsuperscript{232} 138/173/1-7
to come to the Arena and to stay there. Bradley Hurley also described speaking to his mother. He told her that Megan Hurley had died. It was the worst thing he had ever had to do. 233

Bradley Hurley’s father can be seen on the CCTV in the City Room with Bradley Hurley and Megan Hurley at 22:56. 234 At that point, some men began to assess Megan Hurley. One of them thought she had a pulse. Bradley Hurley recalled that he suggested they get a defibrillator. He thought it was “mad” that he was the first person to suggest it. 235 The people using the defibrillator seemed to be in a state of shock and panic. His father was constantly asking for medical help. Bradley Hurley said that the help they expected never came. 236 The defibrillator did not help Megan Hurley. 237 They were in a major city, and he could not fathom how few resources there seemed to be. 238

Bradley Hurley’s father left the City Room for a short time, but returned at 23:20 with his wife. Bradley Hurley described how hard it was seeing his parents confronted with what they saw. They were in shock. It was something he will never
By this time, Bradley Hurley said, although his skin was still burning, he was getting very cold. His teeth were chattering. He was covered with a green plastic sheet. His parents were continually asking where the paramedics were. There were police all around him. He was continually knocked, which was very painful. His mum asked for him to be given oxygen and pain relief.

Bradley Hurley praised an officer, Police Constable (PC) Lauren Moore, who stayed with him. She reassured him and asked him about normal life. It meant a lot.

Bradley Hurley’s parents became frustrated with the speed of the evacuation. His father found a fence panel, but passed it on to another casualty who needed it. Bradley Hurley recalled the pain and discomfort of that person as they were put onto the makeshift stretcher. It made him scared. His father found another barrier, and it was finally his turn to be moved. The pain from being moved onto the barrier was excruciating. He screamed and swore. The barrier was uncomfortable and unsteady. Every step would
send a jolt of pain. He thought he would slide off. 244

17.101 CCTV showed Bradley Hurley being taken out of the City Room at 23:39. He said he felt sick at leaving Megan. 245 Bradley Hurley explained how he struggles to understand why he was the last survivor taken out of the City Room, despite being assessed as a P2 patient. 246 He was on the floor of the City Room for one hour and eight minutes. 247

17.102 Bradley Hurley arrived at the Casualty Clearing Station at 23:42. 248 He was placed on the floor. It was freezing cold. At some point, he was covered with a foil blanket. It felt like he was back to square one, waiting for treatment again. 249 An off-duty nurse, Bethany Crook, cut off his jeans up to his thighs and took off his shoes. It was the first time it felt that someone was taking charge. She assessed him properly. 250 He had 11 large holes in his leg and a large hole in his foot. 251 He was given pain relief and the anticoagulant tranexamic acid (TXA). He recalled

244 138/191/2-192/169
245 138/192/20-193/7
246 138/173/7-174/20
247 138/174/11-17
248 138/193/25-194/3
249 138/194/4-195/20
250 138/197/16-198/15
that it did not seem to “touch the sides” and just made him sick.252

17.103 At 02:44 on 23rd May 2017, Bradley Hurley was taken from the Casualty Clearing Station to an ambulance. He arrived at hospital at 02:51, more than four hours after the detonation.253 He was taken straight to theatre for an operation. His injuries were extensive, with shrapnel injuries to his legs, feet and jaw. His legs had external braces for six months. The impact on him, physically and mentally, has been significant. The loss of his sister affects his family every day.254

17.104 As someone who experienced it, Bradley Hurley did not believe that the emergency response to the Attack worked well. If his parents had not been there, he fears that his extraction would have taken even longer.255

Lisa Roussos, mother of Saffie-Rose Roussos

17.105 Lisa Roussos described how Saffie-Rose was a big fan of Ariana Grande and was so happy to be going to the concert.256 Lisa Roussos accompanied her daughters, Saffie-Rose and

252 138/198/21-200/1
253 138/205/7-18
254 138/209/1-213/11
255 138/213/17-214/2
256 174/143/5-10, 174/145/17-146/6
Ashlee, to the concert and remembers how Saffie-Rose danced all night. 257

17.106 As the concert came to an end, Lisa Roussos said she decided to stay for the encore. She had considered leaving to miss the crowds, but did not want to do that to Saffie-Rose. After the final song of the encore, they made their way out of the Arena bowl. Ashlee was in front. Saffie-Rose was pulling her mother’s left hand, eager to see her father and brother. Lisa Roussos’s last memory of Saffie-Rose before the explosion was of being pulled along by her, their arms outstretched. 258

17.107 There was a big thud, and Lisa Roussos recalled lying on the floor. There was a muffled sound of white noise. She knew something serious had happened and that it was probably a bomb. 259 Lisa Roussos could remember trying to move her body, her arms and legs, but nothing would move. She forced herself to stay awake. She thought help would come soon, but it felt like hours before anyone approached her. When they did, she was really breathless and could only say “Saffie”. 260 Lisa Roussos said she wanted to keep her eyes open, to stay alive, so that she could
make sure someone was taking care of Saffie-Rose.261

17.108 The next thing Lisa Roussos remembers was the feeling of being moved: her body being thrown from side to side, possibly from being taken out of the City Room on a stretcher. She tried to give someone her age, but because she was so breathless she gave the wrong age. Her breathing was very shallow and she could only take short breaths. She just wanted to close her eyes and give up.262

17.109 She could then recall being at hospital, her jeans being cut off and someone removing her jewellery. That was her last memory.263 She was later told that while unconscious she had been assessed as having a very small chance of survival, and amputation had been discussed.264

17.110 Lisa Roussos was in a coma for about two-and-half weeks and underwent a number of operations as a result of the injuries she sustained.265 When she woke up from the coma, her husband Andrew was holding her hand. He asked how she was feeling. He did not mention Saffie-Rose. Lisa Roussos said her last thought

261 174/151/22-25
262 174/152/1-153/5
263 174/153/6-12
264 174/158/3-7
265 174/155/11-158/19
before she went into the coma was about Saffie-Rose, and she “just knew” when she woke up that Saffie-Rose had died. She wanted to go and be with Saffie-Rose to look after her. 266

**Andrew Roussos, father of Saffie-Rose Roussos**

17.111 Andrew Roussos went with his son, Xander, to collect his wife, Lisa, daughter, Saffie-Rose, and step-daughter, Ashlee, from the concert. He spoke to Lisa at 22:29 to check where he should wait. As Ariana Grande was about to do an encore, he decided to find a parking space. Andrew Roussos was not present in the City Room at the time of the explosion but he was in the vicinity. His evidence relates to the adequacy of the emergency response and I have therefore included a summary of his evidence in this section. 267

17.112 A few minutes later, after he parked in Cathedral Gardens, Andrew Roussos described hearing screams and seeing hysterical children running away. He tried to stop people to find out what had happened. Three women told him that either a bomb had exploded or a balloon had popped causing everyone to panic. 268
Andrew Roussos decided he needed to find his family. Together with Xander and the family dog, they walked towards the Arena. As they turned onto Hunts Bank, the first person he saw was his step-daughter, Ashlee, on the floor near to Chetham’s School of Music. She was stable, but injured and confused. He knew then that this was serious and feared that Lisa and Saffie-Rose would also be injured.\footnote{269}

There were two trainee doctors with Ashlee, who confirmed that a bomb had gone off. This was about 22:50. A police officer advised Andrew Roussos that everyone was out of the Arena and that he should go from person to person to see if he could find Saffie-Rose and his wife, Lisa. He could see hundreds of people now. Many were injured on the floor. The majority were children. He was frightened but trying to keep calm and not panic, for Xander’s sake. It took about 30 or 40 minutes for Andrew Roussos to get to the bottom end of Hunts Bank.\footnote{270}

Andrew Roussos continued to search around the perimeter of the Victoria Exchange Complex for Saffie-Rose and Lisa. Unable to find them, at around 23:45 he went back to check on Ashlee. The trainee doctors agreed to stay with her, and he contacted her boyfriend who was also
travelling to Manchester. They agreed to meet at Manchester Royal Infirmary to see how Ashlee’s boyfriend could help with finding Lisa and Saffie-Rose before he continued on to be with Ashlee.271

17.116 Andrew Roussos waited at the hospital for hours. He gave the staff the details for Saffie-Rose and Lisa and felt a growing sense of “panic”.272 Andrew Roussos said he called the helpline many times, but they were not able to give him any information. One hospital did not appear to know what was happening at another. They told him they would call back, but never did.273

17.117 At about 04:00, a friend found out that Lisa was at Salford Royal Hospital. Andrew Roussos arrived there after 04:30. He was taken into a private room and told of the extent of his wife’s injuries. Lisa had been airlifted to Wythenshawe Hospital, which was better placed to treat her, but her chances of survival were small. Salford Royal Hospital had no news about Saffie-Rose. Andrew Roussos said that knowing that Ashlee was injured, then hearing of the serious injuries suffered by his wife, but still not knowing where Saffie-Rose was, was “indescribable”.274

271 174/123/1-127/22
272 174/129/17-18
273 174/127/25-131/16, 174/137/11-14
274 174/130/12-16, 174/131/21-134/6
17.118 Andrew Roussos drove to Wythenshawe Hospital to see Lisa. It was about a 40-minute drive. Lisa was so badly injured that she was put into an induced coma. Andrew Roussos said he broke down when he saw her. At 08:00, he spoke to a police officer at the hospital and asked for help to find Saffie-Rose. He gave the police officer a photo. At about 12:30 on 23rd May 2017, the officer returned and told him that Saffie-Rose had been killed in the explosion.275

17.119 As a father, he wished he could have protected Saffie-Rose more. Andrew Roussos described the emergency response to the Attack as “shameful” and “inadequate”.276

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275 174/138/1-140/24
276 174/113/23, 174/114/12-15
Part 18
Fatal consequences of the explosion

THE CONTENT OF PART 18 IS PARTICULARLY DISTRESSING. IT CONTAINS DETAIL ABOUT THE NATURE OF THE INJURIES SUSTAINED BY THOSE WHO DIED AND THEIR CAUSE OF DEATH

Introduction

18.1 My investigation into the Attack began as twenty-two inquests. As I set out in my Preface to Volume 1, it became necessary to continue that investigation as a statutory public inquiry. This Part has been drafted with the duties of a Coroner in mind.

18.2 The purpose of this Part is to provide a summary of the evidence about what happened to each of those who died. For each individual, I heard detailed evidence about the circumstances of their death during a period of the Inquiry’s oral evidence hearings concerned exclusively with each of those who died.

18.3 The summary of that evidence within this Part is intentionally short. Its focus is on the most
relevant information about the circumstances in which they were killed. It is not necessary, and would be distressing, to repeat every aspect of the evidence heard. The transcripts of the evidence, which provide far greater detail, are available on the Inquiry’s website.¹ I have noted in this Part where some of the evidence has not been published on the Inquiry’s website due to its graphic and distressing nature. This includes post-mortem reports.

18.4 I have summarised the position in relation to each person who died separately. I made exceptions for this in the case of two couples. For each of those who died, I set out where that person was in the period immediately after detonation, what care they received, when they were confirmed as dead and their cause of death. I confirm in the case of every person who died that they were unlawfully killed.

18.5 This is the information that, as a Coroner, I would have included in the record of inquest for each person.

18.6 The evidence set out in this Part is distressing. It sets out the tragic circumstances in which each person died. It is important to remember, as the Inquiry heard during the commemorative pen portrait evidence, that each of those who died is

¹ Transcripts by hearing date, Manchester Arena Inquiry website
“not a number, each of them is not just one of the 22 who died: each was an individual, each was unique, each loss of life is a separate tragedy”.

Investigation

18.7 All of those who died were the subject of a post-mortem examination. These examinations were carried out by a team of forensic pathologists, led by Dr Philip Lumb. The post-mortem examinations were assisted by a radiology team led by Colonel Dr Iain Gibb, who was supported by Lieutenant Colonel Dr Mark Ballard and Commander Dr David Gay.

18.8 Extensive work was undertaken by Operation Manteline, the Greater Manchester Police (GMP) team who assisted my investigation. This included many hundreds of hours spent analysing the footage from 90 CCTV cameras, from 52 body-worn video cameras and from mobile phones. From that work, timelines were produced to show, as far as possible, what happened to each person who died and the individuals who interacted with them.

18.9 An important part of my investigation has been whether a different or better emergency response may have led to the survival of any of those who
died. I have been assisted in this part of my investigation by experts. These experts and their qualifications are set out in Appendix 12. Such has been the complexity of some of the issues that have arisen that it has been necessary to call upon more than one expert in certain disciplines.

18.10 First, I instructed the Blast Wave Panel of Experts to consider the relevant evidence. The Panel are a multi-disciplinary team based at Imperial College London and the Defence Science and Technology Laboratory. The Panel have considerable expertise in blast injury. The Panel comprised Professor Anthony Bull, Colonel Professor Peter Mahoney, Colonel Professor Jonathan Clasper, Lieutenant Colonel Ballard and Alan Hepper. The purpose of their review was to consider whether any of those who died may have been able to survive their injuries with different or better care.

18.11 Second, in relation to two of those who died, the complexity of the evidence surrounding their deaths led me to instruct further experts. In the case of John Atkinson, I instructed cardiology expert Surgeon Commander Dr Paul Rees. In the case of Saffie-Rose Roussos, I instructed consultants in pre-hospital care and emergency medicine, Lieutenant Colonel Dr Claire Park, Dr Gareth Davies and Mr Aswinkumar Vasireddy, and consultant radiologist Dr Richard Wellings.
18.12 Third, I instructed forensic pathologists Professor Jack Crane and Dr Lumb to review the post-mortem evidence in the light of all the medical and scientific evidence. That included a review of relevant video footage. In relation to John Atkinson’s post-mortem, Dr Naomi Carter, who carried it out, was invited to review her findings following receipt of Surgeon Commander Rees’s report.

Survivability

18.13 The Blast Wave Panel of Experts were instructed to assess the available evidence and provide their conclusions on whether each of those who died may have survived, if they had received different medical care. The Panel defined the term “unsurvivable” as “injuries so severe that even if the most comprehensive and advanced medical treatment [available in 2017] was initiated immediately after injury, survival was still deemed impossible”. I shall adopt this definition.

18.14 In the case of twenty of the twenty-two people who died, the Panel concluded that all of the evidence supports the conclusion that their injuries were unsurvivable. I accept this evidence. I record this fact in relation to each of those to
whom it applies when I address the circumstances of their death.

18.15 The evidence was less conclusive in the cases of John Atkinson and Saffie-Rose Roussos. For this reason, it required more detailed analysis, which I will provide at paragraphs 18.154 to 18.234.

Alison Howe

18.16 Alison Howe was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.17 When the bomb detonated, Alison Howe was standing near to the Arena exit doors. She was approximately three metres from the seat of the explosion.6

18.18 Following the detonation, CCTV shows that Alison Howe was lying on her back on the floor of the City Room. After a short period, she was approached by a member of the public, who placed her in the recovery position.7

18.19 At 22:55, a Showsec staff member and a British Transport Police (BTP) officer gave Alison Howe chest compressions.8

6 152/11/19-20
7 152/11/21-12/2
8 152/12/14-20
18.20 A short time later, a paramedic assessed that Alison Howe’s injuries were incompatible with life. CPR was stopped and Alison Howe was covered at 22:58.  

18.21 A tag was placed on Alison Howe at 23:34 to confirm that she was dead.  

18.22 As a result of the explosion, Alison Howe suffered multiple injuries. A post-mortem examination confirmed that Alison Howe’s death was caused by a significant head injury. Her injuries were unsurvivable.

Angelika and Marcin Klis

18.23 Angelika and Marcin Klis were unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.24 When the bomb detonated, Angelika and Marcin Klis were standing near to the Arena exit doors. Marcin Klis was approximately five metres from the seat of the explosion. Angelika Klis was approximately four metres from the seat of the explosion.
18.25 Following the detonation, Angelika and Marcin Klis were found lying on the floor of the City Room. They were together. Members of the public, Emergency Training UK (ETUK) first aiders and police officers checked on them. Both remained motionless.  

18.26 By no later than 22:50, Angelika Klis was covered. Marcin Klis was covered by no later than 22:59.  

18.27 A tag was placed on Angelika Klis at 23:39 to confirm that she was dead. A tag was placed on Marcin Klis at 23:40 to confirm that he was dead.  

18.28 A post-mortem examination confirmed that Marcin Klis’s death was caused by chest injuries. A post-mortem examination confirmed that Angelika Klis’s death was caused by multiple injuries. These injuries were sustained as a result of the explosion. Their injuries were unsurvivable.
Chloe Rutherford and Liam Curry

18.29 Chloe Rutherford and Liam Curry were unlawfully killed on 22\textsuperscript{nd} May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.30 Following the detonation, Chloe Rutherford and Liam Curry were lying side by side. Neither showed signs of life.\(^ {19}\)

18.31 They were both covered shortly after 22:42.\(^ {20}\)

18.32 A tag was placed on Chloe Rutherford at 23:40 to confirm that she was dead.\(^ {21}\) A tag was placed on Liam Curry at 23:44 to confirm that he was dead.\(^ {22}\)

18.33 Post-mortem examinations for Chloe Rutherford and Liam Curry confirmed that their deaths were caused by multiple injuries. These injuries were sustained as a result of the explosion. Their injuries were unsurvivable.\(^ {23}\)

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19 \textsuperscript{154/99/11-20}
20 \textsuperscript{154/99/18-24}
21 \textsuperscript{154/100/8-9}
22 \textsuperscript{154/100/13-15}
23 \textsuperscript{154/100/19-101/17}
Courtney Boyle

18.34 Courtney Boyle was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.35 When the bomb detonated, Courtney Boyle was approximately four metres from the seat of the explosion.24

18.36 Following the detonation, Courtney Boyle was lying on the floor of the City Room on her right side. She was not moving.25

18.37 A member of the public checked on Courtney Boyle. She did not move or show any signs of life.26

18.38 By 22:51, Courtney Boyle was covered.27

18.39 A tag was placed on Courtney Boyle at 23:38 to confirm that she was dead.28

18.40 A post-mortem examination confirmed that Courtney Boyle’s death was caused by multiple injuries. These injuries were sustained as a result of the explosion. Her injuries were unsurvivable.29
Eilidh MacLeod

18.41 Eilidh MacLeod was unlawfully killed on 22\textsuperscript{nd} May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.42 When the bomb detonated, Eilidh MacLeod was approximately four metres from the seat of the explosion.\textsuperscript{30}

18.43 Following the detonation, Eilidh MacLeod was lying on her right side on the floor of the City Room. She was motionless.\textsuperscript{31}

18.44 By 22:51, 20 minutes after the explosion, Eilidh MacLeod was covered with clothing.\textsuperscript{32} A police officer who saw Eilidh MacLeod believed she had died.\textsuperscript{33}

18.45 A tag was placed on Eilidh MacLeod at 23:45 to confirm that she was dead.\textsuperscript{34}

18.46 A post-mortem examination confirmed that Eilidh MacLeod’s death was caused by multiple injuries. These injuries were sustained as a result of the explosion. Her injuries were unsurvivable.\textsuperscript{35}

\textsuperscript{30} 153/65/18-19
\textsuperscript{31} 153/65/20-23
\textsuperscript{32} 153/65/24
\textsuperscript{33} 153/66/11-15
\textsuperscript{34} 153/66/19-21
\textsuperscript{35} 153/67/2-23
Elaine McIver

18.47  Elaine McIver was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.48  When the bomb detonated, Elaine McIver was approximately four metres from the seat of the explosion.\(^ 36 \)

18.49  Following the detonation, Elaine McIver was seen lying face down. She was not moving. A few minutes later, Elaine McIver was lying on her back.\(^ 37 \)

18.50  An emergency responder checked on Elaine McIver about six minutes after the explosion. There was a small, sharp movement of her head but she otherwise did not respond.\(^ 38 \)

18.51  At 22:50, police officers attempted CPR. One of the officers noticed some movement to her mouth. Elaine McIver did not respond to CPR.\(^ 39 \) By 22:55, she was covered.\(^ 40 \)

18.52  A tag was placed on Elaine McIver at 23:45 to confirm that she was dead.\(^ 41 \)

\(^ {36} \) 156/46/2-3  
\(^ {37} \) 156/46/4-8, 156/46/14-19  
\(^ {38} \) 156/46/20-47/1  
\(^ {39} \) 156/48/2-7, 156/49/3-50/6  
\(^ {40} \) 156/48/16-18  
\(^ {41} \) 156/50/22-25
18.53 As a result of the explosion, Elaine Mclver suffered multiple injuries. A post-mortem examination confirmed that her death was caused by chest injuries. Her injuries were unsurvivable. 42

Georgina Bethany Callander

18.54 Georgina Callander was unlawfully killed as a result of the Attack.

18.55 When the bomb detonated, Georgina Callander was approximately four metres from the seat of the explosion. 43

18.56 Georgina Callander suffered a very serious head injury in the explosion. She remained in the City Room until 23:26 when she was evacuated to the Casualty Clearing Station. 44

18.57 In the City Room, Georgina Callander was triaged as a P1 casualty, which meant that she was classified as priority one, among the most seriously injured, requiring immediate medical care. 45 She was breathing but she did not communicate with anyone who tried to help her.

18.58 Georgina Callander was carried into the Casualty Clearing Station at 23:28. 46 By this time, she was

42 156/51/11-53/5
43 155/6/20-21
44 155/28/16-18
45 155/12/10-23, 155/45/20-48/4, 155/70/11-71/18
46 155/22/7-29/11
in cardiac arrest.\textsuperscript{47} She was given CPR and a cardiac output was restored.\textsuperscript{48}

18.59 An ambulance took Georgina Callander to Manchester Royal Infirmary at 23:40.\textsuperscript{49} On the journey to hospital, initially she had a pulse but was assessed as having a very low score on the Glasgow Coma Scale.\textsuperscript{50} This indicated deep unconsciousness.

18.60 Georgina Callander’s condition deteriorated further in the ambulance. She went into cardiac arrest shortly before the ambulance arrived at Manchester Royal Infirmary at 23:48.\textsuperscript{51}

18.61 At the hospital, Advanced Life Support was given to Georgina Callander for 30 minutes.\textsuperscript{52} Georgina Callander remained in cardiac arrest. Her death was confirmed at 00:05 on 23\textsuperscript{rd} May 2017.\textsuperscript{53}

18.62 A post-mortem examination confirmed that Georgina Callander suffered multiple injuries as a result of the explosion. Her death was caused by a head injury and her injuries were unsurvivable.\textsuperscript{54}

\begin{verbatim}
47 155/29/10-32/18
48 155/32/19-33/15, 155/134/15-21
49 155/35/21-25
50 155/37/4-5
51 155/36/17-38/21, 155/142/25-145/8
52 155/39/23-40/7, 155/154/20-155/25
53 155/40/8-23, 155/155/1-11
54 155/41/13-42/19
\end{verbatim}
Jane Tweddle

18.63 Jane Tweddle was unlawfully killed on 22\textsuperscript{nd} May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.64 When the bomb detonated, Jane Tweddle was standing near to the box office. She was approximately 14 metres from the seat of the explosion.\textsuperscript{55}

18.65 Following the detonation, a friend helped Jane Tweddle across the City Room, but she collapsed on the ground near to the staircase leading towards Trinity Way.\textsuperscript{56}

18.66 A member of the public placed Jane Tweddle in the recovery position. An ETUK first aider and police officers gave CPR to Jane Tweddle for approximately 11 minutes. A defibrillator was used but could not detect any cardiac output.\textsuperscript{57}

18.67 CPR was stopped at 22:59.\textsuperscript{58} Jane was covered with clothing at 22:59.\textsuperscript{59}

18.68 A tag was placed on Jane Tweddle at 23:47 to confirm that she was dead.\textsuperscript{60}

\textsuperscript{55} 151/29/7-9
\textsuperscript{56} 151/29/10-14
\textsuperscript{57} 151/31/14-33/23
\textsuperscript{58} 151/33/24-25
\textsuperscript{59} 151/33/24-34/4
\textsuperscript{60} 151/34/10-12
18.69 A post-mortem examination confirmed that Jane Tweddle’s death was caused by neck injuries. These injuries were sustained as a result of the explosion. Her injuries were unsurvivable.\(^{61}\)

### John Atkinson

18.70 John Atkinson was unlawfully killed as a result of the Attack.

18.71 When the bomb was detonated, John Atkinson was approximately six metres from the seat of the explosion.\(^{62}\) He suffered serious injuries, principally to his legs.

18.72 Following the detonation, John Atkinson attempted to drag himself across the floor of the City Room. He left an obvious trail of blood behind him.\(^{63}\)

18.73 A member of the public assisted John Atkinson very shortly after the blast. The member of the public made the first 999 call to report the Attack.\(^{64}\) He was advised to apply a tourniquet to John Atkinson’s right leg, which he did during the call using his wife’s belt.\(^{65}\) In order to help stem blood loss, police issue “leg restraints” were also applied around the top of both of John Atkinson’s

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61 151/34/23-35/6  
62 158/7/12-13  
63 158/7/18-20  
64 158/8/25-9/19  
65 158/11/17-14/10
legs approximately 43 minutes after the explosion.\textsuperscript{66}

18.74 John Atkinson was in the City Room for 47 minutes after the explosion. He was conscious during that time and spoke to those helping him. Members of the public, Showsec employees, ETUK first aiders and police officers assisted John Atkinson. He was not triaged or treated by North West Ambulance Service (NWAS) paramedics while he was in the City Room.

18.75 It took eight minutes to move John Atkinson from the City Room to the Casualty Clearing Station. At 23:16, he was placed onto an advertising hoarding and was dragged from the City Room.\textsuperscript{67} Between 23:19 and 23:20, attempts were made to manoeuvre John Atkinson on the advertising hoarding into the lift that joined the raised walkway to the station concourse. It was realised that the hoarding would not fit. At 23:21, after the advertising hoarding had given way, John Atkinson was lifted onto a metal barrier.\textsuperscript{68} He was carried towards the Casualty Clearing Station at 23:22.\textsuperscript{69} This was 52 minutes after the detonation.

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{66} 158/33/8-34/7
\item \textsuperscript{67} 158/36/15-39/22
\item \textsuperscript{68} 158/50/8-51/8
\item \textsuperscript{69} 158/54/9-11
\end{itemize}
\end{footnotesize}
John Atkinson remained in the Casualty Clearing Station for 24 minutes. At 23:47, while still waiting in the Casualty Clearing Station, he went into cardiac arrest. NWAS paramedics and a doctor gave CPR. At 23:50, John Atkinson was placed into an NWAS ambulance. In the ambulance, the doctor performed a chest decompression upon John Atkinson. This did not change John Atkinson’s cardiac output. The ambulance left Station Approach for Manchester Royal Infirmary at 00:00 on 23rd May 2017. At approximately the same time, some degree of heart activity was detected, but it is likely that this was merely intermittent activity and was in no sense a return to normal. On the contrary, circulation was continuing to reduce. The cardiac arrest at 23:47 was, on the expert evidence to which I shall turn in paragraphs 18.165 to 18.173, the point beyond which John Atkinson was incapable of survival.

John Atkinson arrived at Manchester Royal Infirmary at 00:06. By this time, he was again in cardiac arrest. He was taken to the resuscitation room and given Advanced Life
Support. This was unsuccessful. John Atkinson was declared dead by the treating clinicians at 00:24 on 23rd May 2017.

18.78 The view of Professor Crane and Dr Lumb, which I accept, was that John Atkinson’s death was caused by the leg injuries he sustained in the explosion. I also accept the opinion of the Blast Wave Panel of Experts, which was that those were injuries from which he would have survived if given prompt and expert medical treatment. As I shall explain when dealing with survivability in paragraphs 18.174 to 18.190, such treatment should have been provided.

Kelly Brewster

18.79 Kelly Brewster was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.80 When the bomb detonated, Kelly Brewster was approximately nine metres from the seat of the explosion.
18.81 Following the detonation, Kelly Brewster was lying on the floor of the City Room. She was breathing erratically and was unconscious. Kelly Brewster’s sister, a member of the public, a TravelSafe officer, ETUK first aiders and police officers all sought to help her.

18.82 Kelly Brewster stopped breathing shortly after 23:00. She was given CPR but this was not successful. Following an assessment by a paramedic, CPR was stopped at 23:11. She was covered by 23:12.

18.83 A tag was placed on Kelly Brewster at 23:45 to confirm that she was dead.

18.84 A post-mortem examination confirmed that Kelly Brewster’s death was caused by head and abdominal injuries. These injuries were sustained as a result of the explosion. Her injuries were unsurvivable.
Lisa Lees

18.85 Lisa Lees was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.86 When the bomb detonated, Lisa Lees was standing near to the Arena exit doors. She was approximately four metres from the seat of the explosion.\(^{89}\)

18.87 Following the detonation, Lisa Lees was lying on her back on the floor of the City Room.\(^{90}\) Members of the public present in the City Room went to assist Lisa. The extent of her injuries meant that she could not be helped. At 22:43, about 12 minutes after the explosion, she was covered.\(^{91}\)

18.88 A tag was placed on Lisa Lees at 23:39 to confirm that she was dead.\(^{92}\)

18.89 A post-mortem examination confirmed that Lisa Lees’ death was caused by multiple injuries. These injuries were sustained as a result of the explosion. Her injuries were unsurvivable.\(^{93}\)

\(^{89}\) 152/4/18-19  
\(^{90}\) 152/4/20-21  
\(^{91}\) 152/6/7-9  
\(^{92}\) 152/6/22-24  
\(^{93}\) 152/7/10-24
Martyn Hakan Hett

18.90 Martyn Hett was unlawfully killed on 22\textsuperscript{nd} May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.91 When the bomb detonated, Martyn Hett was approximately four metres from the seat of the explosion.\textsuperscript{94}

18.92 Following the detonation, Martyn Hett was lying on his front on the floor of the City Room. He was motionless. A TravelSafe officer checked on him but Martyn Hett did not respond.\textsuperscript{95}

18.93 Martyn Hett was seen on video footage subsequently, lying in the same position. He had not moved. By 22:53, Martyn Hett was covered.\textsuperscript{96}

18.94 A tag was placed on Martyn Hett at 23:44 to confirm that he was dead.\textsuperscript{97}

18.95 A post-mortem examination confirmed that Martyn Hett’s death was caused by multiple injuries. These injuries were sustained as a result of the explosion. His injuries were unsurvivable.\textsuperscript{98}

\textsuperscript{94} 156/9/17-18  
\textsuperscript{95} 156/9/22-24  
\textsuperscript{96} 156/10/6-7  
\textsuperscript{97} 156/12/8-11  
\textsuperscript{98} 156/12/14-13/9
Megan Joanne Hurley

18.96 Megan Hurley was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.97 When the bomb detonated, Megan Hurley was approximately three metres from the seat of the explosion.\(^99\)

18.98 Following the detonation, Megan Hurley was lying on her front on the floor of the City Room. She was not moving.\(^100\) Efforts were made to help Megan Hurley by her family, an ETUK first aider and police officers.\(^101\)

18.99 By 22:53, she was covered.\(^102\) The covering was removed a few minutes later and, at approximately 23:00, Megan Hurley was given CPR. A defibrillator was used to check her cardiac output.\(^103\)

18.100 Following a discussion with an NWAS paramedic, CPR was stopped at about 23:06.\(^104\) Megan Hurley was covered again shortly afterwards.\(^105\)

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\(^{99}\) 153/5/8-9
\(^{100}\) 153/5/18-6/1
\(^{101}\) 153/8/1-16/22
\(^{102}\) 153/6/19-21
\(^{103}\) 153/8/14-17/12
\(^{104}\) 153/17/12-24
\(^{105}\) 153/17/23-18/1
18.101 Megan Hurley’s father remained with her in the City Room until 01:02 on 23rd May 2017. No tag was put onto Megan Hurley to record her time of death.

18.102 A post-mortem examination confirmed that Megan Hurley’s death was caused by multiple injuries. These injuries were sustained as a result of the explosion. Her injuries were unsurvivable.

Michelle Kiss

18.103 Michelle Kiss was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.104 When the bomb detonated, Michelle Kiss was standing at the top of the steps leading to JD Williams. She was approximately 20 metres from the seat of the explosion.

18.105 Following the detonation, Michelle Kiss immediately fell to the floor. She was given assistance by those present in the City Room and emergency responders. Michelle Kiss did not respond and showed no signs of life.

106 153/24/2-3
107 153/24/17-25/11
108 151/23/5-6
109 151/23/14-24/12
18.106 By 22:48, Michelle Kiss was covered.\textsuperscript{110}

18.107 A tag was placed on Michelle Kiss at 00:32 on 23\textsuperscript{rd} May 2017 to confirm that she was dead.\textsuperscript{111}

18.108 A post-mortem examination confirmed that Michelle Kiss’s death was caused by a head injury. This injury was sustained as a result of the explosion and was unsurvivable.\textsuperscript{112}

Nell Jones

18.109 Nell Jones was unlawfully killed on 22\textsuperscript{nd} May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.110 When the bomb detonated, Nell Jones was approximately two metres from the seat of the explosion.\textsuperscript{113}

18.111 Following the detonation, Nell Jones was lying on her front on the floor of the City Room. She was motionless.\textsuperscript{114}

18.112 She made no response when a TravelSafe officer checked her two times. She was unresponsive

\textsuperscript{110} 151/24/13-25 \\
\textsuperscript{111} 151/24/13-25 \\
\textsuperscript{112} 151/25/10-22 \\
\textsuperscript{113} 152/26/10-11 \\
\textsuperscript{114} 152/26/12-16
when a police officer checked on her a short time after that.  

18.113 By 22:56, Nell Jones was covered with clothing. 

18.114 A tag was placed on Nell Jones at 23:41 to confirm that she was dead. 

18.115 A post-mortem examination confirmed that Nell Jones’ death was caused by multiple injuries. These injuries were sustained as a result of the explosion. Her injuries were unsurvivable. 

Olivia Paige Campbell-Hardy 

18.116 Olivia Campbell-Hardy was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex. 

18.117 When the bomb was detonated, Olivia Campbell-Hardy was approximately five metres from the seat of the explosion. 

18.118 Following the detonation, Olivia Campbell-Hardy was lying on her left side on the floor of the City

115  152/26/17-27/3
116  152/27/4-10
117  152/27/20-22
118  152/27/25-28/20
119  151/17/2-3
Room. She appeared to be unconscious and was not moving.  

18.119 By 22:53, Olivia Campbell-Hardy remained in the same position but was covered.  

18.120 A tag was placed on Olivia Campbell-Hardy at 23:45 to confirm that she was dead.  

18.121 A post-mortem examination confirmed that Olivia Campbell-Hardy’s death was caused by head and neck injuries. These injuries were sustained as a result of the explosion. Her injuries were unsurvivable.  

Philip Tron  

18.122 Philip Tron was unlawfully killed on 22\textsuperscript{nd} May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.  

18.123 When the bomb was detonated, Philip Tron was approximately four metres from the seat of the explosion.  

\begin{flushleft}
120 151/17/4-11  
121 151/17/12-13  
122 151/17/14-17  
123 151/17/22-24  
124 151/18/2-15  
125 151/8/19-21
\end{flushleft}
18.124 Following the detonation, Philip Tron was lying on his front on the floor of the City Room. He appeared to be unconscious. 126

18.125 An ETUK first aider and a police officer checked on Philip Tron but he was unresponsive. By 22:51, Philip Tron was covered with clothing. 127

18.126 A tag was placed on Philip Tron at 23:28 to confirm that he was dead. 128

18.127 A post-mortem examination confirmed that Philip Tron’s death was caused by multiple injuries. These injuries were sustained as a result of the explosion. His injuries were unsurvivable. 129

**Saffie-Rose Roussos**

18.128 Saffie-Rose Roussos was unlawfully killed as a result of the Attack.

18.129 When the bomb was detonated, Saffie-Rose Roussos was approximately five metres from the seat of the explosion. 130

18.130 Following the detonation, Saffie-Rose Roussos was lying on the floor of the City Room. She was close to her mother. Saffie-Rose Roussos briefly

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126 151/8/22-9/2
127 151/9/5-13
128 151/9/25-10/10
129 151/10/13-22
130 174/12/14-15
pushed herself up off the floor with her arms. She also raised her left arm.\textsuperscript{131}

18.131 Saffie-Rose Roussos remained in the City Room for a period of 26 minutes.\textsuperscript{132} During that time, she drifted in and out of consciousness.\textsuperscript{133} To the first member of the public who helped her, Saffie-Rose Roussos was able to give her name.\textsuperscript{134} Members of the public, ETUK first aiders, Showsec staff and police officers helped her.\textsuperscript{135} No tourniquets or leg splints were applied to her injuries.\textsuperscript{136}

18.132 At 22:56, police officers and two members of the public placed Saffie-Rose Roussos onto an advertising hoarding.\textsuperscript{137} It was clear that she was conscious as this was done. A minute later, she was carried out of the City Room, down the stairs and through the Trinity Way link tunnel.\textsuperscript{138}

18.133 Saffie-Rose Roussos was carried onto Trinity Way at 22:58.\textsuperscript{139} An NWAS ambulance arrived on Trinity Way at 23:01.\textsuperscript{140} Five minutes later, Saffie-Rose Roussos was placed into the

\textsuperscript{131} 174/13/2-11
\textsuperscript{132} 174/34/13-16
\textsuperscript{133} 174/15/12-13
\textsuperscript{134} 174/13/23-24
\textsuperscript{135} 174/13/23-26/3
\textsuperscript{136} 174/168/14-22, 174/234/10-18
\textsuperscript{137} 174/30/10-19
\textsuperscript{138} 174/30/20-38/14
\textsuperscript{139} 174/39/2-8
\textsuperscript{140} 174/50/7-10
ambulance. Her level of consciousness fluctuated. For the next 11 minutes, Saffie-Rose Roussos was given emergency care in the back of the ambulance. At one stage, she briefly spoke.

18.134 At 23:17, 46 minutes after the detonation, the ambulance left Trinity Way for the Royal Manchester Children’s Hospital. The journey took six minutes. From approximately 23:26, Saffie-Rose Roussos was treated by a trauma team in the hospital’s resuscitation room. She went into cardiac arrest at about 23:26. Four cycles of CPR were completed but her heart was asystolic. This meant that there was no electrical activity.

18.135 Saffie-Rose Roussos was declared dead by the treating clinicians at 23:40 on 22nd May 2017.

18.136 The view of Dr Lumb and Professor Crane, which I accept, was that the death of Saffie-Rose Roussos was caused by the multiple injuries that she sustained in the explosion. Whether
those injuries made her death inevitable is a complex issue, to which I will turn in paragraphs 18.191 to 18.234.

Sorrell Leczkowski

18.137 Sorrell Leczkowski was unlawfully killed on 22\textsuperscript{nd} May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.138 When the bomb was detonated, Sorrell Leczkowski was approximately six metres from the seat of the explosion.\textsuperscript{151}

18.139 Following the detonation, Sorrell Leczkowski was lying on her right side on the floor of the City Room. She was not moving.\textsuperscript{152}

18.140 In the period that followed, efforts were made to help Sorrell Leczkowski by her mother, Showsec staff, ETUK first aiders and police officers.\textsuperscript{153}

18.141 Sorrell Leczkowski was given CPR for more than half an hour. CPR was stopped at 23:08 and Sorrell Leczkowski was covered with clothing a couple of minutes later.\textsuperscript{154}

\begin{itemize}
\item \textsuperscript{151} 153/71/23-24
\item \textsuperscript{152} 153/72/6-12
\item \textsuperscript{153} 153/72/13-77/19
\item \textsuperscript{154} 153/72/13-77/19
\end{itemize}
18.142 A tag was placed on Sorrell Leczkowski at 23:46 to confirm that she was dead.\textsuperscript{155}

18.143 A post-mortem examination confirmed that Sorrell Leczkowski’s death was caused by a neck injury. Her injuries were sustained as a result of the explosion. Her injuries were unsurvivable.\textsuperscript{156}

Wendy Fawell

18.144 Wendy Fawell was unlawfully killed on 22\textsuperscript{nd} May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.145 When the bomb was detonated, Wendy Fawell was approximately five metres from the seat of the explosion.\textsuperscript{157}

18.146 Following the detonation, Wendy Fawell was lying on her left side on the floor of the City Room. She was not moving.\textsuperscript{158}

18.147 A number of emergency responders checked on Wendy Fawell, but she was unresponsive. By 22:54, she was covered with clothing.\textsuperscript{159}

\textsuperscript{155} 153/77/25-78/5  
\textsuperscript{156} 153/78/8-18  
\textsuperscript{157} 152/18/3-4  
\textsuperscript{158} 152/18/5-7  
\textsuperscript{159} 152/20/4-5
18.148 A tag was placed on Wendy Fawell at 23:44 to confirm that she was dead.\textsuperscript{160}

18.149 A post-mortem examination confirmed that Wendy Fawell’s death was caused by a head injury. Her injuries were sustained as a result of the explosion. Her injuries were unsurvivable.\textsuperscript{161}

**Survivability**

**Key findings**

- In the case of twenty of the twenty-two who died, I am sure that their injuries were unsurvivable. I am sure that inadequacies in the response did not fail to prevent their deaths.

- In the case of John Atkinson, his injuries were survivable. Had he received the treatment and care he should have, it is likely that he would have survived. It is likely that inadequacies in the emergency response prevented his survival.

- In the case of Saffie-Rose Roussos, it is highly unlikely that she could have survived her injuries. There was only a remote possibility that she could have survived with different treatment and care.

\textsuperscript{160} 152/20/19-25
\textsuperscript{161} 152/21/3-19
Introduction

18.150 I find the following people sustained unsurvivable injuries:

- Alison Howe
- Angelika Klis
- Marcin Klis
- Chloe Rutherford
- Liam Curry
- Courtney Boyle
- Eilidh MacLeod
- Elaine McIver
- Georgina Bethany Callander
- Jane Tweddle
- Kelly Brewster
- Lisa Lees
- Martyn Hakan Hett
- Megan Joanne Hurley
- Michelle Kiss
- Nell Jones
- Olivia Paige
- Campbell-Hardy
- Philip Tron
- Sorrell Leczkowski
- Wendy Fawell

18.151 Once the explosion had occurred, it was inevitable that each would die. I have set out in Parts 13 to 16 in Volume 2-I details in relation to the treatment and evacuation of some of these individuals on the night of the Attack. Any inadequacies in the emergency response, as set out in Parts 10 to 16 in Volume 2-I, did not contribute to their deaths.
18.152 For John Atkinson and Saffie-Rose Roussos, there was evidence about the possibility of their survival had the response been different. Due to its complexity, this requires a detailed analysis of the evidence.

18.153 Readers may find what follows particularly distressing.
THE CONTENT OF WHAT FOLLOWS IS PARTICULARLY DISTRESSING. IT CONTAINS DETAIL ABOUT THE NATURE OF THE INJURIES SUSTAINED BY JOHN ATKINSON AND HIS CAUSE OF DEATH

John Atkinson

Post-mortem examination

18.154 Dr Carter is a consultant forensic pathologist on the Home Office register. She was one of the team that carried out the post-mortem examinations of the twenty-two who died in the Attack.

18.155 Dr Carter performed the post-mortem examination of John Atkinson on 28th May 2017.162 In her written report of that examination, Dr Carter listed 47 external injuries. Of those, 16 were to the right leg and foot and 14 to the left leg.163

18.156 Dr Carter concluded that John Atkinson had sustained very severe leg injuries as the result of penetration by multiple metal objects. These had shredded the musculature, damaged deep leg blood vessels and severely fractured the bones.

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162 161/21/13-16
163 INQ015996/6-13 [not published]
of the leg, particularly on the right side. While John Atkinson had suffered injuries to other parts of his body from penetrating objects, those injuries had not contributed to his death. Dr Carter’s conclusion was that John Atkinson “died principally of the effects of blood loss from his leg wounds”.  

18.157 Surgeon Commander Rees, an expert in cardiology, explained this in further detail during the oral evidence hearings. When a person suffers unchecked blood loss, their body will ultimately go into a state known as ‘hypovolaemic shock‘. This involves the body’s circulation shutting down. Organs then fail, including the heart. In simple terms, blood loss causes hypovolaemic shock which causes cardiac arrest. The view of Dr Carter was that this was the mechanism of John Atkinson’s death. The other experts agreed.

18.158 There was, however, a complicating factor identified by Dr Carter on her post-mortem examination. On her internal examination, she noted that John Atkinson had pre-existing heart disease. One of his coronary arteries contained a

164 INQ015996/17-18 [not published]
165 161/19/16-21/9
166 161/26/8-27/17
167 INQ015996/18 [not published]
168 161/92/7-10
blockage and there was also scarring to his heart that had been present for months or years. In medical terms, John Atkinson had a condition known as ‘ischaemic heart disease’. Dr Carter considered that this disease might have been a contributory factor in John Atkinson’s death, either by making his heart more likely to fail in the context of the blood loss from his leg injuries and/or by reducing the chances of successful resuscitation. Dr Carter was right to identify this as a potential issue.

Reports of the Blast Wave Panel of Experts in John Atkinson’s case

18.159 The Blast Wave Panel of Experts carried out an assessment of survivability in the case of each of the twenty-two killed, including John Atkinson.

18.160 In their first report dated 27th September 2019, the Panel expressed the view that John Atkinson had “potentially survivable” injuries. The Panel used that term to describe injuries which “could prove fatal”, but which they were aware of individuals surviving. Their assessment assumed that the right people with the right skills and right equipment would be available.

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169 INQ015996/18 [not published]
170 INQ025413/21 [not published]
171 INQ025413/20 [not published]
immediately after the injury had been sustained.  

18.161 It follows that, in their first report, the Panel considered that John Atkinson might have survived with prompt and effective treatment. However, the Panel did raise a proviso, namely the potential impact on survivability of John Atkinson’s pre-existing heart disease, as commented upon by Dr Carter.  

18.162 After preparing their first report, the Panel were provided with additional material, in particular CCTV footage and footage from the body-worn video cameras of police officers. In light of that material, they looked again at the issue of survivability and produced a second report dated 30th March 2020. Of John Atkinson, they said:

“[He] sustained multiple secondary blast injuries with an overall high burden of injury …

The PM [post-mortem] photos and medical imaging demonstrate severe leg injuries; these leg injuries were associated with severe compressible bleeding.

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172 161/3/6-4/23  
173 INQ025413/21 [not published], INQ015996/18 [not published]  
174 161/80/18-81/2  
175 INQ032039 [not published]
The video demonstrates catastrophic and continuing external bleeding; this appears amenable to treatment outside hospital.

Based on the video footage, witness statements, and the above information, we believe, John Atkinson could have potentially survived in this situation with earlier treatment (application of effective bilateral tourniquets).

However, the post-mortem noted a pre-existing cardiac condition that reportedly reduced the chances of survival given the burden of injury. This reduction in chances of survival due to the pre-existing cardiac condition is a matter not within the expertise of the panel.”

In a third report dated 24th March 2021, the Panel clarified that the change of language from “potentially survivable” in the first report to “could have potentially survived” in the second report was deliberate. They explained that it “reflects a strengthening of our opinion that timely medical intervention – the application of effective bilateral tourniquets – could have made a material difference for John Atkinson.”

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176 INQ032039/3 [not published]
177 INQ041014/13 [not published]
178 INQ041014/13 [not published]
18.164 However, the Panel’s opinion as to survivability in John Atkinson’s case continued to have a proviso. Throughout their reporting, the Panel made it plain that their opinion on survivability in his case was contingent upon the significance of his pre-existing ischaemic heart disease. In that regard, the Panel responsibly drew attention to the fact that the significance of that condition to survivability was outside their combined expertise. 

The expert cardiological opinion

18.165 For that reason, I instructed Surgeon Commander Rees to provide his opinion on the significance of John Atkinson’s pre-existing heart disease.

18.166 Surgeon Commander Rees is an expert in cardiology, general internal medicine and pre-hospital emergency medicine. He works as a consultant cardiologist within Barts Heart Centre, at St Bartholomew’s Hospital in London, and undertakes regular duties with an air ambulance service. He also has military experience, having undertaken combat deployments including working in a field hospital in Afghanistan, and worked as a consultant leading the Medical
Emergency Response Team, often treating those injured in explosions.\textsuperscript{180}

18.167 Surgeon Commander Rees gave evidence to the Inquiry.\textsuperscript{181} He agreed with Dr Carter that the problems in John Atkinson’s heart and coronary artery found in the post-mortem examination were not a consequence of the explosion but instead were pre-existing.\textsuperscript{182} John Atkinson had lived with the blockage in his artery for a substantial period prior to 22\textsuperscript{nd} May 2017, and the scarring to his heart was pre-existing and likely the result of a heart attack at some point in the past. John Atkinson’s medical records contained no reference to any history of heart problems, let alone to a heart attack. Surgeon Commander Rees found this unsurprising. He explained that cardiology recognises the concept of a silent heart attack in which the patient is wholly unaware that anything untoward has happened. Moreover, even where the patient has symptoms, they may mistake them for something trivial and make no report of them.\textsuperscript{183}

18.168 Notwithstanding that the problems in John Atkinson’s heart and coronary artery identified on the post-mortem examination appear not to have
caused him any or any significant difficulties in life, Surgeon Commander Rees agreed with Dr Carter that the findings were notable. However, he did not consider that they had made a contribution to John Atkinson’s death.\textsuperscript{184} His opinion was in three parts.

18.169 First, he did not think that the presence of ischaemic heart disease contributed to John Atkinson’s blood loss.\textsuperscript{185}

18.170 Second, he did not think that the ischaemic heart disease made any material contribution to the cardiac arrest at 23:47.\textsuperscript{186} The disease that was identified during the post-mortem was minor and was not interfering with John Atkinson’s ability to conduct a normal life. He had what Surgeon Commander Rees described as a stable “bystander” disease.\textsuperscript{187} Surgeon Commander Rees stated:

\begin{quote}
[We] also know from the post-mortem that the area of scarring is very small, so he was left with the vast majority of his heart muscle able to function perfectly normally. What we also know from the post-mortem is that his other major cardiac arteries, his main heart arteries, were entirely normal and free from disease.
\end{quote}

\begin{flushleft}
\textsuperscript{184} 161/35/21-36/13  \\
\textsuperscript{185} 161/33/4-18  \\
\textsuperscript{186} 161/33/19-35/20  \\
\textsuperscript{187} 161/34/14-35/20
\end{flushleft}
So, in all likelihood, they were functioning perfectly well. So, in the context of having a very small area of scar, a very small area of narrowing in a relatively unimportant heart artery, I think the relative contribution of ischaemic heart disease here is actually very small, and the primary contributor to his very sad deterioration is the degree of hypovolaemic shock that we outlined earlier. I think that’s by far the most significant contributor to him ending up in a state of cardiac arrest, and I think the role of ischaemic heart disease here is very small or negligible in terms of its overall contribution to deterioration to the point of cardiac arrest.”

18.171 Third, ischaemic heart disease did not contribute to the inability to resuscitate John Atkinson once he went into cardiac arrest. The deciding factor on resuscitation was John Atkinson’s state of hypovolaemic shock. Surgeon Commander Rees considered that John Atkinson’s survival after the cardiac arrest at 23:47 was “extremely unlikely”. That event marked the “point of no return”. Electrical activity detected at about 00:00 on 23rd May 2017, as John Atkinson was in
the ambulance on his way to hospital was likely to have been intermittent and not reflective of a fully functioning heart. In no sense was it a return to the activity of a normal heart.

18.172 The evidence of Surgeon Commander Rees was measured, clear and persuasive. I accept his opinion that John Atkinson’s ischaemic heart disease did not make any material contribution to his death. That removes the proviso that the Blast Wave Panel of Experts applied to their own opinion. That is of significance to the issue of survivability in the case of John Atkinson.

18.173 Surgeon Commander Rees was clear that his role was to address the cardiological aspects of the case. He recognised that the Blast Wave Panel of Experts were able to draw upon a broader range of expertise. In those circumstances, he considered that he ought to defer to them on the issue of survivability. In my view, he was right to do so.

Survivability

18.174 In respect of John Atkinson’s survivability, I heard further evidence from the pathologists and the Blast Wave Panel of Experts. They did not give evidence one after another, as is usual, but
instead concurrently in a process sometimes referred to as ‘hot-tubbing’. I used this approach on a number of occasions during the oral evidence hearings and found it an effective way of getting to the core of the expert issues.

18.175 The pathologists who gave evidence were Dr Lumb and Professor Crane. As I explained earlier in this Part, I instructed them to review the post-mortem evidence for each of the twenty-two killed in the Attack in light of all of the medical, scientific and available video evidence. Dr Lumb is a consultant forensic pathologist on the Home Office register and led the team that carried out the post-mortem examinations of those who died in the Attack.195 Professor Crane was the State Pathologist for Northern Ireland between 1990 and 2014 and is currently Professor of Forensic Medicine at Queen’s University Belfast.196

18.176 Dr Lumb and Professor Crane were clear that Dr Carter’s initial view that John Atkinson’s ischaemic heart disease might have made a contribution to a death that was principally caused by blood loss from leg wounds was entirely reasonable on the basis of what she knew.197 They were not critical of Dr Carter’s original conclusion and nor am I. Dr Carter

195 176/109/19-112/8
196 161/2/16-24
197 161/116/10-117/25
highlighted an important issue that undoubtedly required further investigation. However, Dr Lumb and Professor Crane had access to more evidence than Dr Carter, including the opinion of Surgeon Commander Rees.

18.177 In light of all of that evidence, Dr Lumb and Professor Crane had no doubt that John Atkinson’s death was caused by the leg injuries he sustained and that the pre-existing heart disease from which he suffered played no part.\(^{198}\)

18.178 I accept that evidence. It means that the issue of survivability becomes focused on whether anything more could have been done to stem the bleeding from John Atkinson’s leg injuries. It was this bleeding that led, ultimately, to his death.

18.179 Professor Bull and Colonel Clasper of the Blast Wave Panel of Experts gave evidence on the issue of John Atkinson’s survivability. They set out the views of the Panel as a whole. Professor Bull is a bioengineer. He heads the Department of Bioengineering and the Centre for Blast Injury Studies at Imperial College London. The Centre brings together experts in medicine, engineering and other areas of science to investigate blast injuries.\(^{199}\) Colonel Clasper is a consultant orthopaedic surgeon with considerable

\(^{198}\) 161/116/4-118/5
\(^{199}\) 150/3/3-4/1
experience of major injuries in both a civilian and military context. He is a Visiting Professor within Professor Bull’s department at Imperial College London and Clinical Lead for the Centre for Blast Injury Studies. 200

18.180 Colonel Clasper explained how the views of the Blast Wave Panel of Experts on the survivability of John Atkinson had developed. He confirmed that the position of the Panel in light of all of the evidence, including the opinion of Surgeon Commander Rees, was that John Atkinson “could have potentially survived” his injuries. 201

18.181 Colonel Clasper agreed with Surgeon Commander Rees that there was “no coming back from” the cardiac arrest at 23:47. 202 He explained the timeline in John Atkinson’s case by reference to the footage the Blast Wave Panel of Experts had seen. 203 A belt had been applied as a tourniquet to John Atkinson’s right leg within five to six minutes of the explosion. 204 It was the view of Colonel Clasper that the member of the public who applied this makeshift tourniquet, Ronald Blake, “did brilliantly”. 205 Nonetheless, despite the heroic efforts of Ronald Blake, John Atkinson

200 161/65/24-67/21
201 161/78/2-85/12
202 159/16/24-17/3, 161/92/7-10
203 161/85/18-89/10
204 158/13/4-23, INQ023493T/21
205 161/87/14-88/17
continued to lose blood.\(^{206}\) If additional early steps, in particular the application of bilateral tourniquets by properly qualified first responders, had been taken to stop or slow his blood loss, then that would probably have delayed John Atkinson going into a state of hypovolaemic shock and that, in turn, would probably have delayed the cardiac arrest, or even prevented it altogether.\(^{207}\) Colonel Clasper stated the following in answer to questions:

“Q. If this course had been delayed so that John had reached hospital in a state in which he was not in cardiac arrest, in your view would that have made a difference?

A. Yes.

Q. What difference do you think it would have made?

A. He had other severe injuries, but I think if he’d got to hospital without having had a cardiac arrest, given that the team were prepared for him, I think there’s a high chance he would have survived. I can’t give you an estimate of exactly how high, but I think it’s a high chance.”\(^{208}\)
18.182 The fact that there was a “high chance” that John Atkinson would have survived if he had reached hospital prior to his cardiac arrest does not mean that that necessarily could have been achieved and does not mean that survival was, on a sensible analysis of what could be achieved, probable. Colonel Clasper was pressed on this important issue. 209

18.183 In response, he described a “platinum 10 minutes” during which the best prospect of stemming significant bleeding exists. 210 However, Colonel Clasper was clear that it was not the case that intervention after ten minutes was incapable of making a difference. 211 His evidence, which represented the views of the Blast Wave Panel of Experts as a whole, was clear (with emphasis added):

“Q. … bearing in mind John goes into cardiac arrest … 1 hour and 16 minutes after the explosion and his injuries, bearing in mind that we know he was conscious and able to speak, what is your view about the window during which an intervention would have made a difference to John’s survivability?"
A. I think there was a window up to about 40 minutes after the incident."^{212}

18.184 Later, he extended that period up to 45 minutes.\textsuperscript{213}

18.185 I accept this evidence of Colonel Clasper. I therefore assess the issue of survivability on the basis that, if an intervention sufficient to slow substantially or stop bleeding had been undertaken before 23:16, that is, up to 45 minutes post-explosion, John Atkinson would probably have survived. That is because he would have arrived at hospital before his cardiac arrest.

18.186 My conclusion is that such an intervention should have occurred in one or both of two ways.

18.187 First, medical tourniquets should have been applied to both of John Atkinson’s legs and haemostatic dressings applied to his wounds\textsuperscript{214} well before 23:16. ETUK staff should all have been competent to use such treatments and equipped to do so. They were not or at least not sufficiently. Responsibility for that failure rests with the management of ETUK, namely Ian Parry, and SMG, who should have ensured that the event healthcare provider was competent. More
NWAS paramedics should have been in the City Room before 23:16, as I explained in Parts 10 and 14 in Volume 2-I. If that had occurred, it is likely that they would have identified the need for urgent treatment and/or evacuation of John Atkinson. That did not occur. Responsibility for that failure rests with NWAS. Such treatment would, I am satisfied, have enabled John Atkinson to arrive at hospital prior to having a cardiac arrest and would probably have saved his life.

18.188 Issues also arise about whether the firearms officers and unarmed police officers should have provided such treatment. In future, they should do so, where the circumstances permit. However, for reasons I will address in Part 20, I am not critical of GMP or BTP for the fact that their officers did not do so on the night of the Attack.

18.189 Second, John Atkinson should have been evacuated from the City Room promptly. His evacuation in fact started at 23:17\textsuperscript{215} and he did not arrive in the Casualty Clearing Station until 23:24,\textsuperscript{216} following an extraction which, through no fault of those engaged in it, was entirely unsatisfactory. If firefighters had been in the City Room shortly after 22:45, as I have concluded in Parts 10 and 15 in Volume 2-I ought to have
been the case, John Atkinson would have been prioritised for evacuation. If more ambulances had been present at the Victoria Exchange Complex shortly after 23:00, as I have also concluded in Parts 10 and 14 in Volume 2-I ought to have been the case, John Atkinson would have received treatment and would have been transported to hospital shortly after that time. Either way, he would have reached hospital before having a cardiac arrest and is likely to have survived.

18.190 In his opening remarks at the beginning of the oral evidence hearings, Counsel to the Inquiry explained that I would examine whether there were any inadequacies in the emergency response. I have found that there were. He went on to say that, if those inadequacies, or any one of them, led to the loss of even a single life, that would be entirely unacceptable. They did. John Atkinson would probably have survived had it not been for inadequacies in the emergency response.
THE CONTENT OF WHAT FOLLOWS IS PARTICULARLY DISTRESSING. IT CONTAINS DETAIL ABOUT THE NATURE OF THE INJURIES SUSTAINED BY SAFFIE-ROSE ROUSSOS AND HER CAUSE OF DEATH

Saffie-Rose Roussos

18.191 I heard expert evidence about the cause of the death of Saffie-Rose Roussos over the course of three days between 1\textsuperscript{st} and 3\textsuperscript{rd} December 2021. There was a significant disagreement between, on the one hand, the members of the Blast Wave Panel of Experts and, on the other hand, some of the additional experts I instructed. The former ultimately considered that there was no possibility that Saffie-Rose Roussos would have survived whatever treatment she had received. The latter felt that survival was not an impossibility with the best treatment. No one will benefit from a detailed recitation of that evidence, which was harrowing. Instead, I propose to record my conclusions, setting out the reasons for those conclusions in summary form. Even that will inevitably be distressing to read.
Dr Lumb performed the post-mortem examination on Saffie-Rose Roussos on 24th May 2017. He identified 69 external injuries in addition to internal injuries. The internal injuries involved extensive damage to the musculoskeletal and vascular systems of Saffie-Rose Roussos, injuries to her lungs and liver, and internal bleeding. In their work, the Blast Wave Panel of Experts utilised an internationally recognised system called the New Injury Severity Score. They did so by reference to the post-mortem report of Dr Lumb, the post-mortem photographs and the results of the computerised tomography (CT) scan that was undertaken, which included a reconstruction. This work ascribed a greater number of injuries to Saffie-Rose Roussos than Dr Lumb had, not because of any error on his part, but as a result of differences of description. Applying the New Injury Severity Score, the Panel identified that Saffie-Rose Roussos had suffered a total of 103 injuries that were “scorable” against that system. They stated: “Graphically, this can be described as equivalent to the energy of more than 15 handgun bullets.”
18.193 In considering the injuries that were causative of the death of Saffie-Rose Roussos, or potentially so, the experts focused on three categories of harm: the fractures to her pelvis and legs; the damage to her vascular system; and the damage to her lungs.

Fractures to the pelvis and legs

18.194 Saffie-Rose Roussos sustained extensive fractures to her pelvis and legs.\(^{221}\) These were the consequence of bolts penetrating her body and striking bone and/or bolts penetrating her body and depositing energy into the bone as they passed by.\(^{222}\) I see no value in describing these injuries further given that all of the experts agreed about the severity of the injuries sustained.\(^{223}\) Dr Lumb described the fractures as “extremely severe”.\(^{224}\) All of these fractures, the experts agreed, will have bled.\(^{225}\)

Vascular injury

18.195 The evidence identified four potential areas of significant vascular injury to Saffie-Rose Roussos: the popliteal arteries (the arteries
behind the knees which extend upwards and into the thighs); the vessels in the area of the acetabulum (hip joint) on the left side; and the femoral arteries and associated vascular structures in the left thigh and the right thigh.\textsuperscript{226}

18.196 The experts were agreed that there was vascular injury and consequent bleeding in the popliteal arteries.\textsuperscript{227} However, there was a dispute as to the existence of vascular injury and/or its severity in the area of the acetabulum and in the left and right thighs. The members of the Blast Wave Panel of Experts expressed the firm view that such injuries were present and were serious.\textsuperscript{228} They supported their opinion by reference to a presentation by Lieutenant Colonel Ballard, a consultant radiologist with considerable military and civilian experience.\textsuperscript{229} Dr Wellings, also a consultant radiologist, agreed with the Panel.\textsuperscript{230} Conversely, Lieutenant Colonel Park, Dr Davies and Mr Vasireddy, additional experts I instructed, all considered that there was no significant

\textsuperscript{228} 176/178/3-183/11, 176/183/15-185/21, 176/190/16-196/16, 176/197/6-198/25, 177/82/16-83/12
\textsuperscript{229} 176/123/10-124/14, 177/17/22-18/20, 177/131/17-132/2
\textsuperscript{230} 176/181/6-183/11, 176/183/15-184/9, 176/184/10-185/21, 176/194/24-195/9, 176/196/9-16, 176/199/20-201/11, 176/204/24-205/20
vascular injury in these areas. They did so on the basis that, in their experience, the presence of such injuries would have caused Saffie-Rose Roussos to die through blood loss much more quickly than in fact occurred. 231

18.197 On each side of this dispute were experts of high quality, each of whom had considerable relevant experience and each of whom, I have no doubt, was trying to help me to reach the right conclusion. However, both sides cannot be right.

18.198 On balance, I preferred the opinion of the Blast Wave Panel of Experts and Dr Wellings about the nature and extent of the vascular injuries. That is for the following two reasons.

18.199 First, I will consider the conclusions to be drawn from the CT scans. Computerised tomography (CT) scans combine a series of X-ray images taken from different angles around the body with computer processing, to create cross-sectional images of the body. CT scanning is of considerable diagnostic value in living patients. In the context of the Attack, CT scanning assisted the pathologists to identify where bolts had penetrated the body and the structures they had struck.
18.200 CT scanning may take a number of different forms.\textsuperscript{232} One form is known as contrast CT scanning. This involves the introduction into the body of a dye known as a contrast medium. In a living patient, this is pumped around the veins and arteries of the body by the heart, enabling the vascular system to be seen on the CT scan.\textsuperscript{233} A second form of CT scanning is known as full-body CT scanning. This does not involve the introduction of a contrast medium. It enables the musculoskeletal system to be seen on the scan but not the vascular system.\textsuperscript{234}

18.201 Dr Lumb and his team carried out full-body scans of Saffie-Rose Roussos and the others who died, rather than contrast CT scans. As the radiologists agreed, there were good reasons why this was the correct approach.\textsuperscript{235} The process of contrast CT scanning slows the post-mortem process and creates risks for those carrying it out. At the time, there were no clear indicators that it was necessary to carry out such scanning. In any event, the equipment to enable it to be done was not readily available. Even today, post-mortem contrast CT scanning is very much the exception.
and Dr Lumb described it as an area of research in forensic pathology. 236

18.202 Although I am not at all critical of the decision to carry out only a full-body CT scan, the consequence is that the CT scanning of Saffie-Rose Roussos does not show her vascular system. 237 That means that the scanning alone does not establish definitively whether she had sustained significant vascular damage in the area of her acetabulum and in the left and right thighs. 238

18.203 However, the radiologists Lieutenant Colonel Ballard and Dr Wellings considered that the CT scans were of assistance in determining whether vascular damage had occurred in those areas. They pointed out that the scans showed that Saffie-Rose Roussos had sustained penetrating injuries in each of the relevant areas with consequent fracturing. 239 It was their view that such injuries must have had cavitating effects. 240 Such effects are, as Colonel Clasper of the Blast Wave Panel of Experts explained, rarely seen in civilian practice. 241 They involve a high-velocity projectile entering the body, transferring energy...

236 176/47/10-51/15, 176/124/15-127/12
237 176/124/23-125/7
238 176/46/25-51/15, 176/112/7-114/13
239 176/117/18-221/20
240 176/117/18-221/8
241 177/58/4-59/12
into the body, tearing and distorting the tissues, and creating a cavity beyond the wound track.\textsuperscript{242} Lieutenant Colonel Ballard and Dr Wellings explained that these cavitating effects must have caused significant vascular damage to Saffie-Rose Roussos. In their view, it was not possible for such extensive damage to have been caused to the bone and soft tissue in these areas without the underlying blood vessels also having sustained significant damage.\textsuperscript{243}

18.204 I accept that analysis.

18.205 Second, I will consider the conclusions to be drawn from the post-mortem examination. At the time of that examination, Dr Lumb reported on the vascular injury to the arteries behind the knees of Saffie-Rose Roussos.\textsuperscript{244} This was a reference to the popliteal arteries, which the experts agreed were the location of vascular damage. After completing his post-mortem report, Dr Lumb was asked whether he was able to say whether there had also been vascular damage in the thighs. In response, he explained that the thighs are “richly vascular”.\textsuperscript{245} He expressed the strong view, based upon what he observed on his examination, that there was significant vascular

\textsuperscript{242} 177/59/13-23  
\textsuperscript{243} 176/180/22-185/21  
\textsuperscript{244} 176/89/3-93/12, INQ004704/18-19 [not published]  
\textsuperscript{245} 176/75/7-13
damage to both thighs, describing such damage as “inevitable” in relation to the left thigh and “almost certain” in relation to the right thigh.\textsuperscript{246} He described the injuries to Saffie-Rose Roussos’s legs as “very severe” and capable of causing death on their own.\textsuperscript{247} Professor Crane agreed that these injuries were sufficient on their own to cause death.\textsuperscript{248}

18.206 I accept the evidence of Dr Lumb as to the presence of significant vascular damage in the thighs. It comes from the expert who actually carried out the post-mortem examination, supported by the opinion of a pathologist of long experience and undoubted expertise.

18.207 I gave careful consideration to the views of the experts who expressed the competing opinion that Saffie-Rose Roussos had sustained no significant vascular damage save behind the knees.\textsuperscript{249} Their experience is substantial, and their views were expressed with force and conviction. While I accept that they may have had different experience on which to draw, the overwhelming burden of the evidence demonstrated that significant vascular injury

\begin{itemize}
\item \textsuperscript{246} 176/89/18-93/12
\item \textsuperscript{247} 176/100/11-101/7
\item \textsuperscript{248} 176/101/20-22
\item \textsuperscript{249} 178/160/1-4, 178/4/20-6/17, 178/157/4-169/13, 178/227/18-230/16
\end{itemize}
causing bleeding was present in each of the areas I have described.

18.208 The fact that Saffie-Rose Roussos did not die sooner through blood loss is explicable by reason of the following factors: she is likely to have bled rapidly in the period just after sustaining her injuries but then more slowly as her blood pressure dropped; her blood vessels may not have fully bled immediately or all of the time due to various mechanisms about which the various experts agreed; Saffie-Rose Roussos’s age will have made her more resilient; and there is real-world experience of people with serious vascular injury surviving for the same length of time Saffie-Rose Roussos remained alive.

18.209 Colonel Clasper of the Blast Wave Panel of Experts gave evidence on this final point. As I have set out, he is a consultant orthopaedic surgeon with particular knowledge and experience of injuries caused by explosions. He explained that the experience of the military is that a femoral artery injury does not always cause death swiftly. There is experience within the military of those with Saffie-Rose Roussos’s

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250 178/243/5-22, 178/240/15-242/17, 178/244/11-22
251 178/240/15-244/22
252 177/97/25-98/25, 177/218/23-220/12, 178/34/3-15, 177/154/20-156/8, 175/236/8-237/19, 175/244/19-246/13, 176/22/8-24/15
253 177/93/2-96/14, 177/155/19-156/8
254 177/93/2-96/14
burden of injury, including femoral artery injury, surviving for longer than 40 minutes, indeed for over an hour in some cases. Hence, the fact that Saffie-Rose Roussos survived for a little over one hour does not, in the view of Colonel Clasper, make her “an outlier”.\textsuperscript{255} I accept his evidence.

18.210 For these reasons, I am satisfied that Saffie-Rose Roussos sustained significant vascular damage not only to the arteries behind her knees, but also in the area of her hip joint and in both thighs. Furthermore, I consider that these injuries were extremely serious.

Injury to the lungs

18.211 The experts agreed that Saffie-Rose Roussos had suffered lung damage as a result of the explosion, significantly worse on the right side than on the left.\textsuperscript{256}

18.212 The strong view of the Blast Wave Panel of Experts was that the cause of this lung damage was a condition known as blast lung.\textsuperscript{257} They explained that an explosion has a number of effects. The first is known as the primary blast.\textsuperscript{258} This is best described as a shock wave which surges out from the seat of the explosion. The

\textsuperscript{255} 177/93/2-94/20  
\textsuperscript{256} 176/77/20-79/1, 176/85/18-87/5, 176/146/7-147/16, 176/158/18-161/17  
\textsuperscript{257} 176/215/15-218/7  
\textsuperscript{258} 177/24/8-26/5
interaction of this shock wave with the human body is capable of causing injury to the air-containing organs, such as the lungs, airway and bowel. Injury to the lungs is characteristic and, where it occurs, is known as blast lung.\textsuperscript{259} Such injury involves disruption of the structures of the lung, causing bleeding and a subsequent inflammatory reaction.\textsuperscript{260} It becomes progressively worse, is very dangerous and may be fatal, in particular where there is otherwise a high burden of injury.\textsuperscript{261}

18.213 At one stage, I had understood that there was a dispute as to whether the damage to the lungs of Saffie-Rose Roussos was the result of blast lung. As a result, I asked Professor Crane to consider that issue. He was a consultant forensic pathologist during much of the period of the Troubles in Northern Ireland and therefore has considerable experience of deaths as a result of explosions.\textsuperscript{262} He examined photographs of the lung tissue of Saffie-Rose Roussos.\textsuperscript{263} He expressed the opinion that she had sustained “severe primary blast lung injury to the right lung”.\textsuperscript{264} On the left there was also, in his view,
blast lung, but not as extensive or serious as on the right.\textsuperscript{265} Dr Lumb agreed with Professor Crane.\textsuperscript{266}

18.214 In light of the clear and unequivocal evidence of the pathologists, Dr Davies, who was on the other side of the survivability debate, realistically accepted that the damage to the right lung was severe and that a significant part of the cause was blast lung.\textsuperscript{267}

18.215 On the basis of all the evidence I heard, it is my view that Saffie-Rose Roussos had severe damage to her right lung and some, but less extensive, damage to her left lung and that the cause of both was blast lung.

18.216 Although this fact was established by the evidence, an issue remained about the severity of the consequences of this for the ability of Saffie-Rose Roussos to survive. In particular, Lieutenant Colonel Park was unconvinced that the lung injury, serious though she accepted it was, had an effect on Saffie-Rose Roussos’s ability to breathe to the extent that her life was imperilled by it.\textsuperscript{268} She and Dr Davies attached importance to the footage from the body-worn video camera of, in particular, Police Constable

\textsuperscript{265} 176/86/8-87/5
\textsuperscript{266} 176/87/22-88/5
\textsuperscript{267} 178/130/5-133/24
\textsuperscript{268} 178/134/2-135/25 (Dr Davies), 178/141/13-152/11 (Lieutenant Colonel Park)
(PC) Leon McLaughlin. They stated that they had been unable to detect in that footage any significant respiratory impairment on the part of Saffie-Rose Roussos and were of the view that the lung damage did not, therefore, have any significant physiological effect in the period before her death.

18.217 I have viewed the footage. I do not consider that it establishes the point advanced by Lieutenant Colonel Park. Furthermore, the opinion of Lieutenant Colonel Park and Dr Davies is at odds with the evidence of lay witnesses who saw Saffie-Rose Roussos in the period before she was transported to hospital. That evidence is consistent with Saffie-Rose Roussos experiencing difficulties breathing. PC McLaughlin gave evidence that, while Saffie-Rose Roussos was on the pavement on Trinity Way, her breathing was “quite shallow, quite laboured”. Bethany Crook, an off-duty nurse who was with Saffie-Rose Roussos for a 14-minute period prior to her departure for hospital, expressed her concerns about the breathing of Saffie-Rose Roussos. She explained that there were times when it was very shallow.
and times when it was “very pronounced and exacerbated … that is an indication to me medically, in my training, that tells me that she’s having difficulties breathing”. The lay witness evidence, in my view, was consistent with the effect that blast lung would generally be expected to produce, namely respiratory difficulties.

18.218 I consider that the evidence overall demonstrated that the damage to the lungs of Saffie-Rose Roussos was so severe that it must have significantly compromised her ability to get oxygen to her tissues, which was necessary for her to sustain life. This ability had already been compromised by her blood loss from the injuries to her pelvis and legs and to her vascular system.

Overall burden of injury

18.219 In all of the circumstances, I am satisfied that the views of the Blast Wave Panel of Experts about the disputed areas of injury, and about the severity of those injuries, were correct.

18.220 It is important to understand, as I explained at the beginning of this section, that these injuries formed just a part of what happened to Saffie-Rose Roussos. Overall, as all the experts agreed, she suffered an extremely high burden of injury. It is also important to recognise that all

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274 175/73/16-76/6
275 177/14/17-15/5 (Blast Wave Panel of Experts), 178/124/14-125/24 (Dr Davies)
of those injuries were affecting Saffie-Rose Roussos at the same time and, as Dr Lumb explained, will therefore have had a compounding effect upon each other.  

18.221 Alan Hepper was a member of the Blast Wave Panel of Experts. His background is in engineering. He is a Fellow with the Defence Science and Technology Laboratory, where his main responsibilities are for issues related to human vulnerability, injury assessment and injury modelling. He undertakes research on the effects of weapons, including bombs, on the human body in order to aid improvements in treatment.

18.222 Alan Hepper carried out an assessment of the burden of injury sustained by Saffie-Rose Roussos, using the New Injury Severity Score system. This allocates a score to the three principal injuries suffered by a victim of trauma. These scores are then added together to provide an overall measurement. On the basis of her three principal injuries, the New Injury Severity Score produced a result of 41 in the case of Saffie-Rose Roussos. This is in itself a high score, and those on the database used by Alan Hepper who shared the same score, and had one
or more injuries in common with Saffie-Rose Roussos, had generally, although not invariably, died.\textsuperscript{280} Alan Hepper emphasised, however, that 41 may not reflect the overall burden of Saffie-Rose Roussos’s injuries because she had sustained many more than three injuries; he explained that some of those other injuries were very serious in their own right.\textsuperscript{281}

18.223 Care needs to be taken before drawing conclusions from a statistical tool such as the New Injury Severity Score. However, the Blast Wave Panel of Experts emphasised that they had not used the New Injury Severity Score as the foundation for their opinion about Saffie-Rose Roussos’s survivability. Instead, once they had formed the view that her injuries were unsurvivable, they used the New Injury Severity Score as a check.\textsuperscript{282} In my view, that was an appropriate approach and the New Injury Severity Score result was of some, albeit limited, weight in my conclusions.

Survivability

18.224 The important question at the end of all of this evidence is whether the injuries sustained by Saffie-Rose Roussos were ones that she could have survived with different care and treatment.
18.225 In their first report, the Blast Wave Panel of Experts expressed the view that the injuries sustained by Saffie-Rose Roussos were “unlikely to be survivable” with current advanced medical treatment. The Panel explained that the term “unlikely to be survivable” described:

“… individuals whose injuries were so severe that even if that same advanced and comprehensive medical treatment was initiated immediately after injury, we would not expect that person to survive, but at that point we could not say survival was impossible.”

18.226 In their second report, the Panel reviewed their conclusion in relation to Saffie-Rose Roussos and found that her injuries were “unsurvivable”. Colonel Mahoney explained this term:

“[I]t meant that we felt the injuries were so severe that even if the most comprehensive and advanced medical treatment was initiated immediately after injury, we believe that survival was impossible.”

18.227 It follows that the Panel were initially unable to exclude the possibility of survival in the case of Saffie-Rose Roussos but then six months later
felt confident in doing so. This change was naturally of concern to her family and those who represent them and led to the instruction by me of the additional experts to whom I have referred.

18.228 The Panel were pressed in evidence on their change in opinion. They explained that their first report made clear that it was a preliminary report that was always intended to be subject to any further evidence that was received. What had changed between the first and second report was that the Panel had received the footage from the CCTV and body-worn video cameras, as was recorded in Appendix 1 to that second report. That led Colonel Mahoney to conclude that Saffie-Rose Roussos had become “very sick, very quickly” with respiratory distress that was, he believed, a combination of lung injury and blood loss. In turn, that led the Panel to conclude that Saffie-Rose Roussos had suffered from blast lung, as outlined in paragraphs 18.211 to 18.218, which conclusion I have found to be correct.

18.229 It was appropriate that the Blast Wave Panel of Experts were pressed to explain their change in position. However, having heard their evidence,
I am clear about what happened. The Panel expressed a preliminary opinion, making plain that they would review that opinion if further evidence was provided. Further evidence was provided of a type regarded by the Panel as significant. That altered the Panel’s opinion and they said so. Not only was their approach understandable, it was also entirely responsible.

18.230 That does not mean, however, that the final conclusion of the Blast Wave Panel of Experts that survival was impossible is correct.

18.231 Even though I accept that the Blast Wave Panel of Experts were right about the nature and extent of the injuries suffered by Saffie-Rose Roussos, I do not consider that the evidence enables me to say that she had absolutely no chance of survival if the most comprehensive and advanced medical treatment had been initiated immediately after injury.

18.232 Lieutenant Colonel Park, Dr Davies and Mr Vasireddy were experienced and impressive experts. Their evidence about what consultants in pre-hospital emergency medicine can achieve out of hospital was striking. 291 The evidence of their experiences means that I cannot exclude the remote possibility that Saffie-Rose Roussos would have survived, notwithstanding the severity

291 177/211/25-245/19, 178/1/1-239/17
of her injuries, if she had received treatment from an experienced consultant in pre-hospital emergency medicine immediately, followed by swift evacuation to hospital and expert treatment there.

18.233 While I have recognised the dangers involved in seeking to apply statistical data, I noted that within the database utilised by Alan Hepper, one individual who sustained blast lung of a severity comparable to that sustained by Saffie-Rose Roussos survived, notwithstanding that this person had a total New Injury Severity Score of 66, significantly higher than that given by Alan Hepper to Saffie-Rose Roussos. While I recognise that the score of 41 given to Saffie-Rose Roussos was described as conservative, this finding seems to me to underscore why I should not conclude that Saffie-Rose Roussos had no prospect of survival at all. Colonel Mahoney was asked about this example in the database. His answer did not persuade me that my analysis is flawed.

18.234 I make clear that what I am postulating is a remote possibility of survival. On the evidence that I have accepted, what happened to Saffie-Rose Roussos represents a terrible burden

292 INQ100090/3 [not published]
293 177/47/25-48/16
294 177/146/4-147/6
of injury. It is highly likely that her death was inevitable even if the most comprehensive and advanced medical treatment had been initiated immediately after injury.
Part 19
Understanding what happened and why

Introduction

19.1 During the Inquiry’s oral hearings, I heard evidence from 267 witnesses, many of whom were called during the hearings relating to the emergency response. The hearings relating to the response took place between January and October 2021. Additionally, the accounts of many other witnesses involved in the response were read out or summarised. Behind that witness evidence was a very substantial body of documentary, audio and video material which had been assembled, organised and reviewed. I also received opening and closing statements, both written and oral, on behalf of Core Participants, including each of the bereaved families and the emergency services.

19.2 Having received and considered all this information, I have been able to reconstruct what happened on the night of 22nd May 2017 and to do so in considerable detail. This has enabled me to identify what went wrong.
19.3 The complexity of this process and the necessity to await the conclusion of the criminal trial of HA, coupled with some delay to the start of the oral evidence hearings by reason of the COVID-19 pandemic, meant this has taken considerable time. Over five years will have passed since the Attack by the time that Volume 2 of my Report is published.

19.4 In the course of the oral hearings, I received evidence from a number of very senior members of the emergency services. A number of these people stated that the process of the Inquiry had caused them to identify areas for improvement that had not previously been identified and to implement or start to implement change as a result.

19.5 For example, Sarah-Jane Wilson, the Head of North West Fire Control (NWFC), began her evidence by telling me that, following her review of the Inquiry’s evidence:

“I would like the Inquiry to know that I have followed almost all of the evidence that has been given to the Inquiry. I have also worked through the documents and evidence on the Inquiry’s portal, which is something I did before the Inquiry started and have continued to do ever since …
It has become very clear to me that on the night of the Attack, North West Fire Control did not manage communications in the way that would have been expected of them by the public and by the Fire Service. The control room was responsible for significant failures in the management of information throughout that night …

I have personally asked for those failures to be fully set out in a sequence of communications which North West Fire Control has provided the Inquiry with.”

19.6 Later in Sarah-Jane Wilson’s evidence, the following exchange took place:

“Q. … has information come to light by reason of the Inquiry, which is relevant to North West Fire Control’s way of operating?

A. Yes, sir.”

19.7 Deputy Chief Constable (DCC) Ian Pilling gave evidence on behalf of Greater Manchester Police (GMP). The following exchange took place during his evidence:

“Q. … has the process of the Inquiry led to further relevant information coming to GMP’s attention?”

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1 135/3/14-4/1
2 135/94/4-8
A. Yes, it has.”³

19.8 DCC Pilling gave an example later in his evidence. He was asked about the gap in police officers’ knowledge about how other emergency services operate and why it took until February 2021 to create training materials to address this. His answer was significant: “I think it’s probably a realisation of the gravity of the problem as we started to look at the evidence from the Inquiry.”⁴

19.9 He also observed: “[O]ne of the things that I’ve taken away from this Inquiry so far is around Plato and it needing a good dose of looking at.”⁵

19.10 Assistant Chief Constable (ACC) Sean O’Callaghan gave evidence on behalf of British Transport Police (BTP). He was asked about changes which had been identified. This exchange followed:

“Q. And some of what you have already said is as a result, as I understand it, of what has come out in the Inquiry?

A. Absolutely, yes.”⁶
19.11 The Inquiry followed a number of earlier evidence-based investigations into what happened and why. Some commentators have questioned why it required a public inquiry to uncover some of these issues.

19.12 In this Part, I review why some of what went wrong only emerged as a result of the work of the Inquiry. The purpose is to show where areas for improvement in the emergency response to tragedies such as the Attack can be identified, without the need for a process as complex and lengthy as this Inquiry.

Record of events

Written notes

19.13 There was a requirement imposed by some organisations for written notes or decision logs to be kept relating to the response to the Attack. For example, firearms commanders were expected to keep a record of their decisions.\(^7\) Under the third edition of the Joint Operating Principles (JOPs 3), “decision-makers” were required to “record the rationale and information sources for their tactical decisions”.\(^8\) Police officers operated under a general expectation to keep notes in their pocket notebooks. North

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\(^7\) 108/27/4-28/5, INQ029139/35
\(^8\) INQ008372/16
West Ambulance Service (NWAS) expected its commanders to keep a decision log. Greater Manchester Fire and Rescue Service (GMFRS) expected its officers to record decisions in a log or, where this was not possible, to record notes later and within 24 hours of an incident.  

19.14 A firearms officer gave evidence that advice had been given that those officers should “just … produce duty statements at [the] time that we were there at the incident, et cetera, but not in detail. At a later date we would give a detailed statement when requested to.” This was not an assertion that I investigated in detail. However, if it accurately reflects the approach taken, it should be reviewed by GMP. The reason may be because of concern about the wellbeing of officers who had just been through a very traumatic experience, but detailed notes should normally be made as soon as is reasonably practicable.

19.15 Making accurate notes forms an important first stage in the recording of what happened and why decisions were made. The need for accuracy cannot be overstated. Inaccurate notes can be worse than no notes: they are presumed to paint an accurate picture but will have the opposite
effect. It is through the making of accurate notes that errors will be identified and improvements to what worked well noted.

19.16 The timing of record-making is critical to achieving accuracy. NWAS, for example, required a decision log to be completed within 72 hours of an incident.\textsuperscript{11} There may be good reason for this. It may be a national standard. However, in my view, this is too long a period to ensure accuracy. NWAS should reflect on this. Unless there are compelling reasons justifying a delay, such records should be completed within 24 hours of an incident.

19.17 Ideally, the making of such records should be prioritised so they are completed by the point of command handover. As JOPs 3 stated: “[D]ecision logs can be used to assist future decision-making and ensure clarity of understanding of what will be a rapidly developing and complex situation.”\textsuperscript{12} I see no reason why this statement of principle should be confined only to Major Incidents in which Operation Plato has been declared. It should be applied to all Major Incidents.

19.18 In Parts 14 and 15 in Volume 2-I, I set out occasions when inaccurate notes were made

\textsuperscript{11} INQ012848/72, INQ014791/1
\textsuperscript{12} INQ008372/16
about the content of important telephone calls. I do not repeat them here. These notes were capable of obscuring the truth of what happened on the night of the Attack. It was only the fact that recordings of the calls existed that enabled the inaccuracies to be exposed and corrected.

19.19 Investigators, judges and other decision-makers have long regarded contemporaneous notes as a more reliable source of evidence than recollections repeated after discussions with others have taken place. As a result, it is all the more essential that accurate notes are made.

19.20 I recommend that all emergency services involved in the response to the Attack reflect on their approach to note-taking during and immediately following Major Incidents with a view to improving the current practice. I recommend that the Home Office, College of Policing, National Ambulance Resilience Unit and Fire Service College ensure that all commanders responding to a Major Incident are trained on the importance of recording their key decisions and rationale.

19.21 In the case of those who are responding at the scene, the timely taking of notes will be less practicable. For people in these roles, audio and/or visual technology can provide vital support. In saying this, I am not seeking to confine the use of
audio and/or visual technology to those who attend a scene. They are the people who are likely to derive the most benefit from a recording but those remote from the scene, for example Strategic/Gold Commanders, will also see an advantage, as ACC Deborah Ford acknowledged.\(^{13}\)

### Audio and/or visual recordings

19.22 In Part 13 in Volume 2-I, I addressed the position of firearms officers and body-worn video. I will not repeat that here, but it forms an important part of what I say next.

19.23 Two of the most important pieces of evidence received by the Inquiry came from Dictaphone recordings. One was made by Chief Inspector Mark Dexter of GMP,\(^ {14}\) the other by Inspector Dale Sexton of GMP.\(^ {15}\) These recordings were an invaluable source of information for my investigation. They captured important conversations by those individuals. They allowed me to reach conclusions about how busy the people recorded on them were. They permitted me to make informed judgements about how challenging the environments were. They revealed something of the stress levels people

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13 106/20/13-23  
14 INQ025409  
15 INQ024325
were operating under. To some extent, they enabled the listener to put themselves in the situation that was being recorded.

19.24 There was inconsistency across the emergency services in relation to the use of Dictaphones. There were a number of important witnesses in command roles who had immediate access to a Dictaphone but did not use it, or used it for only a short period of time.\textsuperscript{16} There were also some in significant roles who did not have access to a Dictaphone on the night of the Attack.\textsuperscript{17}

19.25 I have considered whether those individuals or their organisations should be criticised for this. I have concluded that it is more appropriately treated as an opportunity for improvement. The lack of a recording of what individuals said and heard did not impact on the quality or nature of the response to the Attack, but it may have had an impact on the ability to learn lessons.

19.26 There was no evidence to suggest that the use of a Dictaphone would have any adverse effect on any individual’s performance. If anything, knowing that everything that is said is being recorded may lead to a person acting more deliberately and thoughtfully. It may also mean in certain circumstances that a written log is less

\begin{footnotesize}
\begin{tabular}{ll}
16 & 115/25/7-15, 121/57/17-58/11 \\
17 & 104/77/1-78/25 \\
\end{tabular}
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important, given that a complete record will be captured through an audio recording. This will free up time to focus on more important command activities.

19.27 As technology advances and costs reduce, it may be that body-worn video equipment is regarded as a viable alternative to Dictaphones. A number of police officers who responded to the Attack were issued with such equipment as part of their tour of duty that day. This audio and video footage formed a vital part of reconstructing what happened in the City Room in particular. The content was often too distressing to play publicly. I have viewed a good deal of it. It enabled me to understand better how terrible an environment the City Room was in the period immediately after the Attack. The body-worn video recordings have been the subject of very detailed analysis.

19.28 I recommend that the Home Office, College of Policing, National Ambulance Resilience Unit and Fire Service College ensure that all those who may be required to take up a command position are issued with a means to record what they say, hear and, where appropriate, see. It may also be that key personnel within control rooms would benefit from having such equipment available for activation in the event of a Major Incident. Training should be given to all who are issued
with such technology on the circumstances in which it should be used and the importance of its use. Exercises should include the use of contemporaneous recording devices in order to simulate how they will be used in practice.

19.29 It is important to make clear that I do not regard the use of audio and visual recording equipment to be a complete substitute for the timely taking of notes. A recording of what occurred will not always capture why an individual made a given decision. Accurately capturing the rationale behind commanders’ decision-making is important.

Conversations not conducted in person

19.30 Generally, radio transmissions and calls to control rooms on the night of the Attack were recorded. Collating these recordings was a substantial undertaking. Once this important work had been undertaken, these recordings formed a vital part of understanding how information moved within and between organisations.

19.31 However, as I set out in Part 15 in Volume 2-I, there were a significant number of conversations between senior GMFRS personnel which were conducted by mobile phone. The participants in these calls had different recollections as to what

18 132/167/5-25
was said in a considerable number of those discussions. This required me to resolve disputes of fact, if that was possible, before I could identify where improvements might be made.

19.32 This only serves to underline the need for audio and/or visual recordings for commanders and other key personnel.

Debriefs

19.33 A number of debriefs took place following the Attack. Some were termed “hot debriefs”. These were proximate to events and were intended to capture raw impressions of what had occurred. There were also more formal debrief processes where individuals completed questionnaires and attended debrief meetings.

19.34 The debrief process provides an invaluable opportunity for organisations to understand what may have gone wrong and how improvements in their practices can be made. They must be conducted constructively and candidly. Given the importance of joint working, the debrief process of Major Incidents involving more than one emergency service should be overseen by the local resilience forum.

19 132/167/5-25, 121/51/3-23, 121/88/4-20
20 121/131/12
21 For example, INQ000790, INQ041168, INQ022376, INQ000788
19.35 Particular care will need to be taken for debriefs following Major Incidents which may give rise to a criminal investigation. In these circumstances, the investigators will need to provide input on the management of those areas which might prejudice the investigation.

19.36 Operation Newtown was the name given by GMP to the response to the Attack. In a document dated 16th June 2017, GMFRS Deputy Chief Fire Officer Paul Argyle, Chair of the Greater Manchester Resilience Forum (GMRF), set out the principles, scope and process that were to be adopted for the Operation Newtown debrief. There were two stages. The first comprised a “strategic multi-agency debrief” undertaken by GMRF and “tactical organisational debriefs” conducted by individual GMRF member organisations. The two elements were conducted in parallel. The second stage took place at multi-agency level and aimed at testing the findings, developing the learning and making recommendations.

19.37 A large number of Operation Newtown debrief questionnaires were completed during July 2017. Each questionnaire required the person completing it to identify what aspects of the
multi-agency response did not go well, what aspects did go well and any key recommendations that they had.

19.38 Operation Manteline was the name given by GMP to the criminal investigation into the Attack. Debrief questionnaires were also completed within Operation Manteline.25

19.39 It is important that I acknowledge that an enormous amount of work went into all of the debrief processes following the Attack. I detected no lack of willingness by those who participated to get to an understanding of what went wrong, what went well and what recommendations might be made. However, I was struck by the lack of critical detail in the content of some of the debrief questionnaires prepared by witnesses who were called to give evidence. It is essential that everyone who needs to complete a debrief questionnaire is encouraged and supported to be constructive, objective, open and comprehensive.

19.40 ACC O’Callaghan was asked about the effectiveness of BTP’s debrief process and whether it was effective in revealing problems. His answer was that “[t]here’s certainly work still to be done in that area”.26 He agreed that there was a danger that a debrief process could be

25 For example, INQ041168 (Inspector Sexton’s debrief questionnaire)
26 139/62/17-63/21
defensive. This is an understandable reaction which is difficult to overcome. ACC O’Callaghan stated that BTP had retained an external consultant to ensure that BTP’s review of what has emerged from the Inquiry is robust.\textsuperscript{27}

19.41 I have a concern that the debrief processes following the Attack did not reveal several of the issues that they should have. It is beyond the scope of the Inquiry’s terms of reference for me to conduct a minute examination of why this was the case.

19.42 I recommend that each emergency service involved in the response to the Attack seek to understand why the issues considered in Volume 2 of my Report were not identified sooner. This is intended to be a constructive exercise aimed at improving the current system. I recognise that the answer to some may simply be attributable to the highly detailed and forensic process that the Inquiry has been able to undertake, but not all.

**Witness statements**

19.43 Operation Manteline took witness statements from those with evidence relevant to the criminal investigation. Inevitably, there was a substantial overlap between what was relevant to that investigation and the Inquiry’s terms of reference.
19.44 For good reason, the focus of the criminal investigation was not on command decisions on the night of the Attack. As a result, witness statements were not taken from emergency services commanders until requests were made for them by me once I had been appointed as the Coroner for the inquests. This meant that many key witnesses did not make witness statements until several years after their involvement in the Attack. This included three people whose decisions I have needed to scrutinise in detail: the GMP Force Duty Officer (FDO), the NWAS Operational Commander and the GMFRS duty National Interagency Liaison Officer (NILO).

19.45 For those witnesses who did not have recourse to comprehensive notes made at the time, this was unsatisfactory. Even where a recording exists, the rationale behind decision-making was not always captured. To take one example to illustrate this point: Inspector Sexton’s first witness statement was dated 6th December 2019. This was two and a half years after the Attack. As DCC Pilling observed, “it obviously would have been more helpful” if Inspector Sexton’s full account had been captured earlier than this.
19.46 I recommend that the Home Office, College of Policing, National Ambulance Resilience Unit and Fire Service College take steps to ensure that all emergency services understand the importance of obtaining comprehensive accounts from commanders as part of the debrief process. This will not necessarily need to occur following every Major Incident. A threshold will need to be identified for this to be triggered. As a minimum, I would expect it to occur as a result of every terrorist attack and any Major Incident which results in death.

**Kerslake Report**

19.47 In July 2017, the Mayor of Greater Manchester set up an independent review chaired by Lord Kerslake. The review was into Greater Manchester’s preparedness for and emergency response to the Attack. Participation in the work of the review was voluntary. A substantial number of people who gave evidence to me also provided accounts and information to Lord Kerslake’s team.

19.48 Lord Kerslake adopted a “*Fair Notice*” procedure before reporting. This followed the information-gathering stage. On 9th March 2018, Chief Constable Ian Hopkins wrote in response to the
Fair Notice letter which he had received on behalf of GMP. In the course of that response, Chief Constable Hopkins stated: “Relevant emergency service partners were informed of the declaration of Operation Plato.” The letter went on to assert:

“GMP can evidence that GMFRS, NWAS and the military were informed of the Plato declaration, via specified routes, within a few minutes of its declaration. These are the only partners specified in JOPS. We are not clear why this was not then communicated within these organisations, if this was the case.

…

… [the FDO] was able to complete his key tasks, including the notification of Operation Plato.”

19.49 Chief Constable Hopkins stated in evidence that the content of this letter was “a very grave error”. I agree. He explained that a team had been established run by DCC Pilling. The information had come from that team. He also pointed out that, on the next working day, an
email correcting this error was sent to Lord Kerslake by DCC Pilling.\(^{34}\)

19.50 There was no opportunity for Lord Kerslake to be misled by this error due to the timely correction. What is of more concern to me is that, more than nine months after the Attack, the senior leadership of GMP had not realised that the FDO had not communicated the Operation Plato declaration to other emergency services. That was a highly significant fact which should have been identified by GMP at an early stage. GMP should have put greater effort into understanding why it had happened. Both Chief Constable Hopkins and DCC Pilling should have immediately known the letter to Lord Kerslake was incorrect.

19.51 On 27\(^{th}\) March 2018, Lord Kerslake delivered his report.\(^ {35}\)

19.52 I am grateful to Lord Kerslake and his team for making available the material collected as part of his process. It has assisted my investigation. I see my work as building on his review. With the powers, time, evidence and assistance available to me, I have been able to examine the response in much greater detail.

\(^{34}\) 134/183/24-185/13
\(^{35}\) INQ000009
Media interviews

19.53 On 22nd May 2018, the BBC broadcast a documentary entitled *Manchester: The Night of the Bomb*.\(^{36}\) In the course of the programme, interviews given by emergency responders from BTP and NWAS setting out their account of events of the night of the Attack were played. The transcripts of the interviews were provided to the Inquiry.\(^{37}\) They formed the basis of some of the questions asked during the oral evidence hearings. I am grateful for the co-operation I received from the BBC in relation to those transcripts being made available.

19.54 Representatives of the bereaved families raised issues about *Manchester: The Night of the Bomb*. Three issues in particular were raised. First, there was concern about “the inclusion … of graphic footage of the scene of the attack, from which [bereaved families] were able to identify their loved ones as they lay dead, and about which they received no warning”.\(^ {38}\) Second, there was concern about whether it was appropriate for any emergency responder to have assisted in the making of the documentary at all. Third, there was a concern about the timing of the participation: it occurred when it was known

\(^{36}\) INQ024284T
\(^{37}\) INQ024278T/26-28
\(^{38}\) INQ042546/45-46
that an investigation into the adequacy of the response would occur.\textsuperscript{39}

19.55 ACC O’Callaghan, on behalf of BTP, apologised for the involvement of BTP in this documentary.\textsuperscript{40}

19.56 In relation to the second concern, it was submitted to me on behalf of the bereaved families: “The lesson to be learned is that greater communication with bereaved families is necessary when consideration is given to participation in documentaries and other media coverage following fatal incidents.”\textsuperscript{41}

19.57 Freedom of the press is an essential part of our democracy. It is not appropriate for me to seek to define the circumstances in which the media should interview emergency service personnel. Nor is it for me to suggest standards in relation to what material can or cannot be included. The Independent Press Standards Organisation provides some general guidance. However, having seen firsthand the upset this particular documentary caused, it is clear that consultation with bereaved families in fatality cases is capable of reducing any distress which may be caused.

\textsuperscript{39} INQ042546/46
\textsuperscript{40} 139/91/9-92/7
\textsuperscript{41} INQ042546/47
Period of the inquests and Inquiry

Introduction

19.58 In August 2018, I was appointed by the Lord Chief Justice and the Chief Coroner as the nominated judge to sit as the Coroner to conduct inquests into the deaths of the twenty-two people who died as a result of the Attack. Following a ruling I made in 2019, the Inquiry was established. The matters which were the subject of that ruling will be dealt with in Volume 3 of my Report.

19.59 Both as a Coroner and as a Public Inquiry Chairman, I was granted powers enabling me to carry out a full investigation. Paragraph 5 of the Inquiry’s terms of reference set out the scope of my investigation in this area of the Inquiry.42

Support from Operation Manteline

19.60 Supporting me in this investigation was a team of GMP officers from Operation Manteline. These officers were not involved in GMP’s response to the Attack beyond the criminal investigation. The part of the Operation Manteline team supporting the inquests and subsequently the Inquiry was headed by Detective Superintendent Teresa Lam. Detective Inspector (DI) Michael Russell was

42 Appendix 1 in Volume 1
responsible for those who gathered, collated and analysed the hundreds of hours of audio-visual material.\(^{43}\)

19.61 I am indebted to Detective Superintendent Lam, DI Russell and all those within their team. I received an extraordinary level of support and co-operation. I pay particular tribute to the work that was undertaken in reconstructing the period post-explosion. It was of a highly distressing nature. It was painstaking and protracted work. It enabled the clearest possible understanding of what happened to each of those who was killed following the detonation.

**Getting to the truth**

19.62 As I have set out above, there had been numerous reviews and debriefs aimed at identifying what happened on the night of the Attack. For that reason, some may have thought the Inquiry was going to be a re-analysis of already well-established facts. This proved not to be the case.

19.63 The forensic process of the Inquiry brought to light many new pieces of information which either had not previously been known or the importance of which had not previously been realised.
19.64 A stark example of this was in relation to the important first decision within NWFC. Based upon what the panel was told, Lord Kerslake’s report states:

“On being told on the telephone by GMP at 22:35hrs that ‘there had been an explosion and that a bomb has exploded’, the North West Fire Control operator initially acted in accordance with the action plan for ‘EXPLOSION’ and created an incident log. Following the plan’s instructions, they then opened the action plan for ‘BOMB’.”

19.65 Lord Kerslake’s report goes on to identify that the first action of the ‘Bomb’ action plan was to contact the duty NILO, which is what in fact occurred.

19.66 This account of what happened was maintained in witness statements submitted to me. On 19th August 2020, in its opening statement, NWFC stated: “Contrary to what is said in some of the material and evidence gathered, the control room operators at NWFC did not ‘open’ the action plan for ‘BOMB – GENERAL’.”

44 INQ000009/95 at paragraph 3.152
45 INQ000009/96 at paragraphs 3.153-3.154
46 INQ023881/6 at paragraph 4.9, INQ023877/31 at paragraph 7.3, INQ032856/3 at paragraph 2.2
47 INQ035485/15 at paragraph 10.1
Further witness statements were provided in support of NWFC’s position. These confirmed that the ‘Bomb’ action plan was never consulted and that the decision to contact the NILO was made without reference to any particular action plan.

It is most unfortunate that it was not until days before the oral evidence hearings began that the correct state of affairs was identified. I commend those responsible for identifying it and drawing it to the Inquiry’s attention. However, whether or not a particular action was based on an existing plan formed an important part of establishing what happened. It is remarkable that it took over three years for this misconception to be dispelled.

As I have said, the above represents what is a stark example of an important factual revelation emerging after an extended period during which the opposite had been asserted. There were many other developments which I do not rehearse here. I do not raise this particular example with a view to criticising those who had previously been wrong in their recollection. I raise it because it further underlines the importance of accurate record-keeping about what was done and why. It also demonstrates the need for early, objective analysis of the known facts.

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48 INQ035438/1-2 at paragraph 8, INQ035440/1 at paragraph 6
49 INQ037079/7-8 at paragraph 17, INQ035440/1 at paragraph 6
Post-Attack changes

19.70 On 30\textsuperscript{th} January 2020, I issued a ruling directing that each of the public body and corporate Core Participants serve a statement setting out the changes which had been made since the Attack.

19.71 Statements setting out post-Attack changes were served before the start of the oral evidence hearings, in April to June 2020.\textsuperscript{50} I found these statements instructive. They demonstrated that there was a genuine commitment to improvement on the part of each of the emergency services.

19.72 My investigation did not involve a detailed analysis of the efficacy and appropriateness of the changes that have already been made. Its focus was on what the position was in May 2017. For this reason, I have deliberately refrained from commenting on whether any of the issues I have identified have yet been addressed, whether in full or in part.

19.73 In Volume 1, I identified particular recommendations as ones which I intended to monitor. In January 2022, I heard evidence in relation to those ‘monitored recommendations’.\textsuperscript{51} This evidence provided an opportunity for those who were the subject of monitoring to share their

\begin{itemize}
  \item \textsuperscript{50} For example, INQ033298 (DCC Pilling), INQ032849 (Gerard Blezard)
  \item \textsuperscript{51} 187/1/5-239/5, 188/1/5-35/13
\end{itemize}
experience of making necessary improvements with a view to sharing their learning widely.

19.74 As I will set out in Part 21, I will adopt the same approach to particular recommendations that I make in Volume 2.

Approach to learning as a result of the Inquiry

19.75 I was particularly impressed by the evidence I heard from GMP and BTP about the structures that have been put in place in order to extract and disseminate learning as a result of the Inquiry.52

19.76 As those efforts may be of more general application to emergency services, I comment on them further below.

GMP

19.77 Towards the end of 2019, DCC Pilling set up a team within GMP whose task was to review all the recommendations identified from the Attack and from debriefs. The purpose was “to ensure [GMP] could assure [itself] that the appropriate progress had been made”.53 This team was called “the Arena Recommendations Review Team”.54 DCC Pilling identified the need for this team

52 INQ033298 (GMP), 139/1/18-106/6 (BTP)
53 131/13/2-11
54 131/13/12-16
when he began to prepare his statement for the Inquiry.

19.78 DCC Pilling stated that, out of the work of the Arena Recommendations Review Team, GMP developed what it termed the Organisational Learning Board. DCC Pilling explained:

“What I was conscious of was that given the volume of [the debriefs and reviews], that the organisation wasn’t always pulling them all together and spotting common threads. And the purpose of the organisational learning board … was twofold: first of all, to ensure that we have an effective scanning process across all those threads … The other was to have more of a lessons learning ethos within the whole organisation and encourage … an approach more towards learning lessons.”

19.79 I was impressed by DCC Pilling’s commitment to embedding learning within GMP. Establishing a structure of organisational learning officers across all districts and departments in GMP represented a step change for the better. He stated:

“[M]y ethos is that most … learning should take place at a low level, it is a localised piece of learning, but equally some learning will be
more strategic and it is issues such as that which are brought to the organisational learning board.”

19.80 I recommend that GMP share its approach with other police services through the National Police Chiefs’ Council.

**BTP**

19.81 ACC O’Callaghan gave evidence as part of the process of monitoring recommendations made in Volume 1. In January 2021, following the oral evidence hearings relevant to Volume 1, BTP created the “SABRE programme”. SABRE is an acronym which stands for “situational awareness, briefing, response and events”.

19.82 ACC O’Callaghan explained the genesis of the SABRE programme in this way:

“British Transport Police started the journey of correcting some of the wrongs as early back as when the Kerslake Inquiry was sitting and started developing some of those streams at that point. And then as further streams were picked up through this Inquiry, they were added to that programme, and those combined pieces of work are what became the SABRE programme.”

56 131/21/12-17
57 187/178/3-12
58 187/180/8-15
19.83 A number of those workstreams related to issues with BTP’s involvement in the emergency response. I take two examples from within one of those workstreams to illustrate the approach taken by BTP. First, BTP recognised that there was “a lack of familiarity” with the Major Incident Manual.\textsuperscript{59} I have set out my conclusions in relation to this in Part 13 in Volume 2-I. This led to BTP making changes in its approach.

19.84 Second, BTP developed its approach to the use of tourniquets. ACC O’Callaghan told me: “I have now changed my position on [tourniquets] having listened to or watched [Brigadier Hodgetts’] evidence and indeed watching … the video on the citizenAID website.”\textsuperscript{60} He went on to say that he had met with Brigadier Timothy Hodgetts and that BTP had recommended all frontline BTP officers be issued with, and trained in the use of, tourniquets.\textsuperscript{61} I shall return to the issue of tourniquets in Part 20.

19.85 I commend BTP’s approach to learning from the Inquiry. I was impressed by ACC O’Callaghan’s commitment to change.

\textsuperscript{59} 187/194/23-195/2
\textsuperscript{60} 139/42/4-7
\textsuperscript{61} 187/184/16-186/4
19.86 I recommend that BTP share its approach with other police services through the National Police Chiefs’ Council.

Warning letter process

19.87 I am required by Rule 13 of the Inquiry Rules 2006 to send a warning letter to any person who may be the subject of explicit or significant criticism. Rule 15 requires that a warning letter should state what the criticism or proposed criticism is; contain a statement of the facts that are considered to substantiate the criticism or proposed criticism; and refer to any evidence which supports those facts.

19.88 I was concerned at the outset of the Inquiry that the requirements of the warning letter process may impact on the timetable for publication of my Report. The requirement to identify every potential criticism and supporting evidence is onerous. It means that warning letters can only be issued when the drafting of the report is well advanced. The responses to warning letters can be lengthy and complex. All this increases the risks of delay while issues are reviewed and the Report updated. That has happened at this stage of the Inquiry.

19.89 I have nonetheless found the warning letter process a useful one. As I noted in Volume 1, I have not taken into account fresh evidence or
new arguments that were provided in warning letter responses and which could have been, but were not, put forward during the Inquiry’s evidence hearings or in written and oral submissions.

19.90 I have adopted that general approach because it is not the purpose of Rule 13 to provide those who may be criticised with an opportunity to reopen matters in order to justify their conduct or to advance submissions that could have been made openly, on notice to the Inquiry and other Core Participants and subject to submissions, but were not.

19.91 Over the course of an inquiry’s investigation, the importance of matters may change. New issues may arise. That is how inquiries work. They are not the same as an adversarial process where the issues should be clear before the hearing starts. In an inquiry, issues and proposed criticisms may come into focus only when the report is written. If they have not been explored in evidence, that is a factor I have had in mind when deciding whether or not it is fair and appropriate to make a particular finding. The warning letter process has ensured I have been able to raise matters as potential criticisms which have not been fully explored in evidence and allow an opportunity for a response before I decide whether to include them in my Report. I consider
that to be a fair process and one that is essential to enable me to prepare a comprehensive report.

19.92 I understand that any person or organisation warned that they may be criticised in a public inquiry report may be distressed by this. I also understand that, where a person does not believe they should be criticised, this distress may be greater. It is important that those subject to potential criticism have the opportunity to respond.

19.93 I have found it particularly helpful to be told in an objective, dispassionate way why a proposed criticism is said not to be justified. That is a reasonable and proper use of the warning letter process. Some of the responses to warning letters were phrased in this helpful way; others were not.

19.94 Throughout the Inquiry’s public hearings, every organisation committed to assist me in the search for the truth. I am grateful to all those who approached the warning letter process constructively. However, I am concerned that the attitude of others as expressed during a confidential process may stand in the way of further change.
I considered carefully whether to disclose the warning letter responses after the publication of this Report. I have decided not to do so but it is an important reason why I intend to monitor certain recommendations from this Report. It will ensure that everyone considers and reflects on the conclusions in the Report in a constructive manner and with the intention of ensuring that the same mistakes are not made again.
Part 20
The Care Gap

Introduction

20.1 In the event of a mass casualty incident, the public expect ambulances to travel to the scene quickly and in large numbers. The public also expect that, once on the scene, paramedics will attend to casualties immediately, with treatment starting within minutes of the incident occurring. The evidence demonstrates that, following the current approach, this is unlikely ever to be achieved. That is the case for at least four reasons.

20.2 First, the reality of the resourcing of ambulance services around the UK is that ambulances do not wait around for a Major Incident to occur. In the event of a mass casualty incident, it is inevitable that all, or at least most, ambulances in the geographical area of the incident will already be engaged in dealing with other events. That is likely to lead to a delay in the deployment to the scene of the number of ambulances and ambulance personnel needed to deal comprehensively with the incident.

20.3 Second, even when ambulance personnel begin to arrive at the scene of a mass casualty incident,
the treatment of casualties is unlikely to commence immediately. Long-established policy within the ambulance service is that the first paramedic on the scene of a Major Incident will become the acting Operational Commander.\textsuperscript{1} In that role, they are instructed not to treat casualties.\textsuperscript{2} Instead, the acting Operational Commander is expected to assess the scene and pass a METHANE message to the control room, then seek to establish command and control, before co-ordinating with incident commanders from the police and fire and rescue services.\textsuperscript{3} All of that takes time.

20.4 Third, once the command structure at the scene is in place, the expectation is that triage will commence. The nature of a mass casualty incident is that the needs of the casualties will almost certainly exceed the capacity of the paramedic resource initially available. The seriousness of the injuries may well vary considerably. Established practice is that it is vital that those in most need of medical intervention are identified quickly. This is the purpose of triage. It should be undertaken before any treatment, except for urgently required life-saving interventions. Once again, this takes time.

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{1} INQ032665/36-37, INQ032665/44
\item \textsuperscript{2} INQ013422/2
\item \textsuperscript{3} INQ032665/44
\end{enumerate}
\end{footnotesize}
20.5 Fourth, where the mass casualty incident causes the police to declare Operation Plato, that is likely to have an impact on the time it takes for the treatment of casualties in any hot or warm zone. That is so even though the current Joint Operating Principles (JOPs) provide greater flexibility for forward deployment than was the position in 2017.

20.6 Witnesses explained that the consequence of these factors is that, in a mass casualty incident, it is inevitable that there will be a delay in paramedics and/or other healthcare staff arriving at the scene and commencing treatment.\(^4\) During the Inquiry, this period was described as ‘the Care Gap’.

20.7 I heard from witnesses with the expertise and experience to assist me on two issues: first, how is the Care Gap to be made as short as possible? And, second, how are we to achieve a situation in which those who are present at the scene before professional clinical staff arrive are able to provide vital life-saving interventions?

20.8 One witness, Philip Cowburn, the Medical Advisor to the National Ambulance Resilience Unit (NARU), summarised these two issues as “narrowing the gap” and “filling the gap”.\(^5\) I will

\(^4\) 68/20/10-25, INQ041868/7 at paragraph 26, INQ042671/1 at paragraph 5

\(^5\) INQ042711/8
use these terms but I consider that there are some matters relating to treatment that do not fall neatly into either category. I will deal with the issues in the following order: matters that will narrow the gap; matters relating to treatment during the gap; and matters that will fill the gap.

Narrowing the gap

Introduction

20.9 If the Care Gap is to be made as short as possible, ambulances and specialist ambulance resources need to reach the scene of a mass casualty incident without delay. Ambulance personnel need to work collaboratively with their colleagues from the other emergency services. Specialist resources will be required and many witnesses advocated a consultant-led response. 6

20.10 Where the incident is terrorist in nature and of a type such that Operation Plato has been declared, the affected area needs to be zoned accurately and the hot and warm zones need to be shrunk as quickly as possible. All casualties, whatever zone they are in, must be triaged and treated promptly and evacuated to hospital as speedily as possible. That includes the triage, treatment and evacuation of those in the hot zone.

6 192/22/13-28/21, 192/85/11-86/19, 192/133/14-134/19, 192/137/11-140/1, 192/151/11-153/15, 192/227/7-19
Ambulance service resources generally

20.11 Getting ambulance personnel to casualties quickly in the event of a mass casualty incident is an obvious way of shortening the Care Gap. For that to happen, ambulances need to be available to deploy immediately and in sufficient numbers. Currently, that does not normally happen. That is because, around the UK, ambulance services are always “playing catch-up”: at any moment each ambulance in the country will be dealing with an incident, with other emergencies building up behind that incident in order of priority.  

20.12 Ambulance services generally do not have any spare capacity within their frontline resources. As the Ambulance Service Experts noted: “They are normally stacking emergencies with multiple emergencies waiting to be assigned to a particular ambulance.” This means that, in the event of a mass casualty incident, it is likely that the number of ambulances necessary for the care and treatment of the casualties will not be available to attend immediately or anything like immediately.

20.13 The night of the Attack on 22nd May 2017 is an example of that. Of the 319 North West Ambulance Service (NWAS) vehicles available
that night, only seven were able to deploy straightaway,\(^9\) far fewer than was needed. The Ambulance Service Experts considered that, with the existing resources available to ambulance services and current levels of demand, such a situation would almost inevitably be replicated if a similar incident were to occur again anywhere in the country. I was informed that, over the course of the last ten years, the demand on ambulance services has doubled, with the trend of increasing demand continuing.\(^{10}\) So, this problem is only going to get worse if left unchecked. That is a very concerning state of affairs.

20.14 Ensuring that ambulances reach the scene of any mass casualty incident swiftly is a critically important part of making the Care Gap as short as possible. Not only do ambulances contain the personnel and equipment able to provide many life-saving interventions, but they are also the vehicles by which casualties are best transported to hospital. If ambulances do not attend the scene quickly and in sufficient numbers, lives will be lost.

20.15 It is not for me to dictate to central government or to the NHS how finite resources should be spent. However, I consider that all ambulance service trusts should review their capacity to respond to a

\(^9\) INQ040952/1
\(^{10}\) INQ042167/5 at paragraphs 27 and 28
mass casualty incident. Having done so, they should make recommendations to their NHS commissioners about the additional and/or different resources they require in order to ensure that they are able to respond effectively to a mass casualty incident in the numbers required.\textsuperscript{11} The Department of Health and Social Care (DHSC) should give urgent consideration to any recommendations made by the trusts and the NHS commissioners.

Ambulance service specialist resources

20.16 Connected with this review is the issue of specialist ambulance service resources.

20.17 Where the mass casualty incident is the result of a terrorist attack, there may be sound reasons why only those with specialist skills and equipment should be deployed forward, at least initially. Ambulance services introduced Hazardous Area Response Team (HART) operatives to address this issue.\textsuperscript{12} As I explained in Part 14 in Volume 2-I, a HART crew comprises specially recruited personnel who are trained and equipped to provide the ambulance response to high-risk and complex emergency situations.

\textsuperscript{11} INQ042167/5-6 at paragraph 28, 188/44/13-46/16
\textsuperscript{12} 144/218/2-10
20.18 They are able to work in dangerous areas during or after a terrorist attack. They are therefore vital to making the Care Gap as short as possible in such a situation. There may be respects in which the training of HART operatives could be improved. Furthermore, strong voices have advocated the view that the clinical response to a terrorist attack should be consultant-led. I will address those issues below. None undermines the importance of HART in narrowing the gap.

20.19 Given the importance of HART in any response to a terrorist attack, it was concerning to hear evidence that this specialist resource is not always available to respond as swiftly as expected. Keith Prior is the Assistant Chief Ambulance Officer in the West Midlands. He is also a Director of NARU, which works nationally on behalf of each ambulance service trust in England to provide a co-ordinated approach to emergency preparedness, resilience and response.\(^{13}\) He gave evidence that ambulance services around the country are “struggling” to maintain the minimum levels of HART staff.\(^{14}\) He said that, of all the ambulance service trusts, only one is able to achieve that minimum level routinely.\(^{15}\)
20.20 Keith Prior’s view was that there are not sufficient numbers of HART personnel. He explained that NARU’s view is that there needs to be an increase in the membership of HART if a proper response to an incident such as the Attack is to be achieved. Also, he considered that there is currently a lack of understanding on the part of ambulance commanders about what HART can provide in the response to a terrorist attack. NARU has been taking steps to address this lack of understanding, but Keith Prior explained that more remains to be done. I accept the evidence of Keith Prior that these are real issues that need to be addressed.

20.21 The Ambulance Service Experts identified an increasing tendency in recent years for HART resources to be deployed for less serious calls. They describe this as a problem and observe that the deployment of HART to a Major Incident should be mandatory. I agree that, in the event of any Major Incident, it is highly undesirable that HART should be delayed in attendance by being engaged in another incident that does not require specialist resources.

16 190/12/22-13/1
17 190/13/2-7
18 190/14/24-16/8
19 190/17/8-18/8
20 INQ042167/9 at paragraph 33
21 INQ042167/9 at paragraph 35
20.22 I recognise that steps are being taken to increase certain other specialist resources of the ambulance service. However, HART operatives have particular skills and capabilities that would be invaluable in the event of a terrorist attack.

20.23 The review of resources I identified at paragraphs 20.11 to 20.15 should encompass an assessment of whether each ambulance service trust has an adequate number of trained specialist personnel to respond effectively to a mass casualty incident. On the evidence I heard, the numbers are currently not sufficient.

20.24 DHSC and NARU should also develop procedures to ensure that, so far as possible, each ambulance service trust is able to deploy or call upon HART resources immediately in the event of a Major Incident.

20.25 As part of that, DHSC and NARU should develop procedures to ensure that, so far as possible, each ambulance service trust can call upon cross-border support in respect of HART resources immediately in the event of a Major Incident.

20.26 NARU has developed new national standards and training courses for ambulance commanders. Their purpose is to improve
standards and standardise command competence. I welcome that.

20.27 I recommend that DHSC and NARU ensure that all ambulance commanders receive regular Major Incident training. The training should include training on HART capabilities, on all the command roles and where they will be located, on how to gain situational awareness through the deployment of sector commanders and other roles, and on the importance of getting ambulance personnel to casualties without delay.

Joint Operating Principles

20.28 At the time of the Attack, the third edition of the Responding to a Marauding Terrorist Firearms Attack and Terrorist Siege: Joint Operating Principles for the Emergency Services (JOPs 3) was in force.\(^\text{24}\) In Parts 11 and 12 in Volume 2-I, I addressed the detail of that edition of JOPs and its position in a hierarchy that involves the Joint Doctrine: The Interoperability Framework (the Joint Doctrine)\(^\text{25}\) above it, and, below it, at a national level, the Counter Terrorism Policing Headquarters (CTPHQ) Operation Plato guidance,\(^\text{26}\) and, at the local level, Greater Manchester Police’s (GMP’s) Operation Plato

\(^{24}\) INQ008372/1  
\(^{25}\) INQ004542  
\(^{26}\) INQ013767 (2012 guidance), INQ016688 (refreshed guidance)
plans.\textsuperscript{27} JOPs 3 dealt with the response to a Marauding Terrorist Firearms Attack. This addressed zoning and the fact that, as of 2017, specialist resources such as HART were able to enter the Operation Plato warm zone, but not the Operation Plato hot zone.\textsuperscript{28} For that reason, zoning is of importance to the Care Gap. Casualties will almost inevitably be present in the Operation Plato hot zone. The quicker this zone is shrunk and then reclassified to warm or cold, the quicker the casualties within it will be treated. Similar and connected considerations apply to the Operation Plato warm zone. Casualties are also likely to be in that location. Shrinking and then reducing the warm zone to cold will enable a broader range of emergency responders to enter and therefore speed up the treatment of casualties there as well.

20.29 Since the Attack, changes have been made to JOPs. The fourth edition was issued in November 2017. Then, in 2019, there was a shift away from the concept of a Marauding Terrorist Firearms Attack to the broader concept of a Marauding Terrorist Attack. That led the edition numbering to restart. In March 2019, the first edition of the Marauding Terrorist Attack Joint Operating Principles was issued. In December 2020,
a second edition was issued.\textsuperscript{29} That is the edition currently in force (the current JOPs).

\textbf{20.30} Chief Inspector (CI) Richard Thomas was the Head of Specialist and Counter Terrorism Armed Policing Capabilities at CTPHQ in 2017. He remained in that post as a civilian when he gave evidence in January 2022.\textsuperscript{30} His evidence gave rise to issues of operational sensitivity so it was necessary for some of it to be heard in a restricted session. However, CI Thomas confirmed in open evidence that the current JOPs and the current CTPHQ Operation Plato guidance simplify the description of each zone. They provide greater clarity in relation to the deployment of both non-specialist and specialist resources into zones.\textsuperscript{31} The evidence overall indicates that the current JOPs provides not just greater clarity but also greater flexibility to commanders in relation to the forward deployment of both non-specialist and specialist resources.\textsuperscript{32}

\textbf{20.31} This greater clarity and flexibility is desirable. However, the evidence revealed that some senior emergency service commanders continue to lack confidence that the approach contained in the

\begin{itemize}
\item \textsuperscript{29} 141/102/12-22
\item \textsuperscript{30} 60/1/12-2/14
\item \textsuperscript{31} 141/104/10-23
\item \textsuperscript{32} 189/56/18-57/6, 189/141/9-142/8, 190/7/3-10
\end{itemize}
current edition of JOPs will necessarily work to produce a better outcome. Mark Hardingham is Chair of the National Fire Chiefs Council, which provides advice to government about matters that have a bearing on fire and rescue services and which seeks to provide the professional voice for those services. He explained that the National Fire Chiefs Council considers that JOPs ought to include specific reference to the Care Gap and the steps commanders need to take to minimise the gap.

20.32 NARU also considers that JOPs would benefit from improvement. The substantive changes NARU considers should be made are as follows.

20.33 First, greater emphasis should be placed in JOPs on the rapid deployment forward of all emergency services to save lives. Rather than waiting for the ideal conditions to deploy forward, the presumption should be to deploy forward. In particular, the need to deploy specialist paramedics and doctors into hazardous areas, where that is necessary to assist casualties, must be prioritised.

33 189/133/23-134/21
34 189/142/13-145/13
35 190/7/11-8/6
36 INQ042707/1-2
20.34 Second, the emergency services need to work together to align their perception and understanding of risk. Overall, there needs to be a greater tolerance of risk across the emergency services.

20.35 Third, in the aftermath of a terrorist attack, the possibility of a secondary device will often, if not always, exist. The presumption should be on deployment unless there is a proper basis for believing that a real risk of a secondary device exists. JOPs should make clear that this is the position. A hypothetical chance should never prevent deployment.

20.36 NARU’s points, all of which have force, highlight an issue that featured throughout the emergency response evidence. That issue is: how is a situation in which commanders from different emergency services assess risk differently to be addressed? The Joint Doctrine and the current JOPs assume that commanders will agree both the risk and the forward deployments that are appropriate based on that risk. The evidence I heard reveals that this assumption may not be correct. The different emergency services may have different appetites for risk, and certainly individual commanders may do. The emergency response to the Attack demonstrates how this is capable of creating a problem and a delay in deploying responders forward.
20.37 To give just one example, shortly before 01:00 on 23rd May 2017, a Joint Emergency Services Interoperability Principles (JESIP) huddle took place between CI Mark Dexter, the GMP Ground Assigned Tactical Firearms Commander; Stephen Hynes, the NWAS Operational Commander; and Station Manager Andrew Berry, the Greater Manchester Fire and Rescue Service (GMFRS) National Interagency Liaison Officer. The GMFRS Chief Fire Officer, Peter O’Reilly, participated by telephone. The issue of zoning was the focus of the discussion. It is impossible to listen to the recording of that discussion without concluding that, even at that late stage, nearly two and a half hours post-detonation, there was no joint understanding of risk across the three emergency services.\(^{37}\)

20.38 In the course of the evidence, the question of whether this situation should be resolved by JOPs giving one of the commanders a trump card or casting vote was examined.\(^{38}\) I am satisfied that there would be significant problems in doing so in a formal sense. However, I am also satisfied that there should be a working assumption that in certain situations particular commanders should take the lead and that their

\(^{37}\) INQ040657/67-71

\(^{38}\) 146/36/14-43/1
views should prevail, unless there is a compelling reason not to follow them.

20.39 For example, in an Operation Plato situation, the views of the police commander about which resources can and cannot be deployed into particular areas should be followed, unless there is a compelling reason not to do so. The current JOPs has sought to achieve greater clarity in relation to this situation. However, the evidence I heard indicates that if clarity has been achieved in the document itself, that clarity has not been communicated adequately to those who will actually have to respond to events such as the Attack.

20.40 Decisions about zoning and the forward deployment of specialist and non-specialist resources will be critical to the treatment of casualties in an Operation Plato situation. They will be capable of dictating whether lives are or are not saved. In the circumstances, the Home Office, His Majesty’s Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS), the College of Policing, the Fire Service College, NARU and JESIP should review and, as necessary, update the Joint Doctrine and JOPs. The following matters should be considered in that review.
20.41 First, achieving a situation in which commanders understand that the critical decisions of the commander most directly concerned in the issue under consideration are followed, unless there is a good reason for not doing so.

20.42 Second, achieving a situation in which risk appetite, by which I mean the understanding, acceptance and management of risk, is common across the three emergency services.

20.43 Third, achieving a situation in which deployment forward of specialist resources is the presumption, to be displaced only in the presence of a properly evidenced basis for not deploying resources forward.

20.44 Fourth, achieving a situation in which the possibility of a secondary device does not delay forward deployment of resources unless there is a proper basis for believing that such a device exists.

20.45 Fifth, achieving a situation in which the three emergency services all use the same terminology to describe the Operation Plato hot, warm and cold zones and all have a common understanding of those terms. That need also arises in Major Incident situations in which Operation Plato is not declared. In the same way, a situation must be achieved in which the three emergency services
work jointly, using common terminology and sharing an understanding of those terms.

20.46 I recommend that the Home Office, HMICFRS, the College of Policing, the Fire Service College, NARU, individual police services and JESIP review what changes need to be made to the CTPHQ Operation Plato guidance and Major Incident Plans in order to achieve those aims. This calls for an urgent response.

High-fidelity training

20.47 The observations I have just made relate to the extent to which JESIP can help to reduce the Care Gap. In Part 21, I will make some further and more general recommendations in relation to JESIP, the Joint Doctrine and JOPs. However, changing policy and guidance is not, of itself, enough. The changes need to become embedded in those who may actually be called upon to respond in the event of an Operation Plato situation. That requires training and multi-agency exercising.

20.48 In her evidence, Lieutenant Colonel Dr Claire Park, a consultant in pre-hospital care and critical care and anaesthesia who has worked closely with the firearms teams of the Metropolitan Police Service, described her involvement in the
design and delivery of Major Incident training. She explained that this involves the use of simulated casualties, designed to test whether those with particular injury patterns get the required treatment when they need it. It explores whether deaths could have been prevented.\(^{40}\)

It also helps to prepare those who will be required to respond to a mass casualty incident for the significant assault on their senses that the incident will involve.\(^ {41}\)

20.49 Lieutenant Colonel Park described this as “high-fidelity” training.\(^ {42}\) I consider such training to be vital. The Home Office, CTPHQ and the College of Policing should consider introducing the use of regular high-fidelity training to give emergency responders better experience of the stress, pressure and pace of a no-notice attack.

20.50 Training is not enough. Areas for improvement need to be identified and change implemented. The local resilience forums have an important role to play in this, as do each of the individual emergency services and the control rooms. Training is not an end in itself. One of the important purposes of training is to drive change, and that needs to be understood across the emergency services.

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\(^ {40}\) 191/85/21-86/20, 192/61/17-64/16

\(^ {41}\) 191/86/25-87/15

\(^ {42}\) 191/85/21-88/13
Embedding medics with police firearms officers

20.51 I heard evidence about the approach taken by nine other countries to the Care Gap. Each of those countries faces a substantial terrorist threat. I am grateful for the level of co-operation I received. It was necessary for me to hear most of this evidence in a restricted session because to have heard it in an open session may have assisted terrorists to mount further or more deadly attacks in the countries concerned. I have taken that evidence into account in the conclusions I have reached. I set that evidence out in my Report to the extent that it is responsible to do so.

20.52 On the face of it, an effective way of narrowing the Care Gap would be to embed doctors with the police firearms officers who can enter an Operation Plato hot zone. That would involve the doctors deploying into an area where the most seriously injured casualties were likely to be. This would get around all of the delays and difficulties created by the designation of zones. Such doctors would need to be highly skilled and trained so as to enable them to carry out triage, emergency treatment and evacuation in circumstances of extreme danger and stress.
20.53 This is what happens in France, where doctors are embedded with police firearms teams with the job of entering the highest-risk areas, akin to our Operation Plato hot zones. I am able to say this without breaching operational sensitivity because the work of the counter-terrorism unit of the French National Police is public knowledge. That team is known as RAID. This stands for Recherche, Assistance, Intervention, Deterrence, which translates into English as Search, Assistance, Intervention, Deterrence.\footnote{191/4/21-5/4}

20.54 France has experienced much violent Islamist extremist terrorism. In the course of the evidence relating to security for the Arena, I heard about the events of the night of 13\textsuperscript{th} November 2015, when ten ISIS terrorists launched co-ordinated attacks in Paris. Three men went to the Stade de France, where France and Germany were playing football. Each man was wearing an explosive device.

20.55 Each of the attackers detonated their device and died. A passer-by was killed and others injured. Within minutes, further terrorists armed with automatic weapons launched an attack at sites in the city centre, murdering nearly 40 people. Shortly afterwards, a further group of terrorists arrived at the Bataclan theatre, armed with
military-grade firearms and wearing explosives vests. They shot dead three people outside and then entered the theatre, opening fire on the crowd.

20.56 It was during this phase of the Paris attacks that RAID was engaged. Members of the RAID team entered the Bataclan along with commandos of a second police team, the Brigade de Recherche et d’Intervention. This translates into English as the Brigade for Research and Intervention. They did so in order to neutralise the threat, just as police firearms officers would do in a comparable situation in the UK. The difference in France is that embedded within each RAID team is a highly trained physician.

20.57 In 2015, Dr Matthieu Langlois was the Chief Physician of RAID. On 13\textsuperscript{th} November, he formed part of the RAID team that entered the Bataclan. He entered the theatre along with his RAID colleagues and a fellow medic from the Brigade de Recherche et d’Intervention, Dr Denis Safran. As other members of the teams sought out and engaged the terrorists, the two doctors performed triage in the combat zone.\footnote{44}{INQ042566/1}

20.58 They carried out what is described in an article in the journal \textit{Critical Care} as “salvage therapies”.\footnote{45}{191/34/22-37/7}
Tourniquets were applied to 15 patients and a further 15 underwent wound compression with haemostatic dressings; two patients received subcutaneous morphine and two received tranexamic acid (TXA); two thoracic exsufflations were performed. All this occurred in the combat zone.46

Having completed the salvage therapies, the doctors set about managing the evacuation of the injured to hospital, stopping in an area in the entrance to the theatre where additional treatments could be undertaken if absolutely necessary to prevent death before arrival at hospital. All of the casualties were evacuated even before the threat had been neutralised.47 What was achieved was remarkable.

I heard evidence from Dr Langlois. I am grateful to him for being prepared to assist me. He qualified as an intensive care anaesthetist in 2000 and thereafter worked in the accident and emergency department of a major hospital in Paris. In 2008, he joined RAID, initially alongside his existing responsibilities as a hospital consultant. In 2012, he became the Chief Physician of RAID. In that post, he was responsible for the selection and training of RAID’s members and for its operational
management. He developed the tactical response plan of RAID and led the tactical emergency care during all counter-terrorism interventions in France between 2012 and 2021, of which, sadly, there were many.\textsuperscript{48} He was able to speak from a position of considerable authority.

**20.61** Dr Langlois explained that RAID doctors are carefully selected to ensure that they have the physical and psychological qualities necessary to enable them to act effectively in situations of extreme stress.\textsuperscript{49} Following selection, the doctors are highly trained and thereafter undergo regular further training and take part in exercising.\textsuperscript{50}

**20.62** In the event of a terrorist attack such as that which occurred at the Bataclan, the RAID doctors deploy into the area that broadly equates with an Operation Plato hot zone, along with and at the same time as those whose role it is to neutralise the threat. The doctor will triage the casualties and carry out any life-saving interventions that are needed. The casualties will then be extracted to a ‘forward casualty nest’ at the edge of the hot zone, where the risk is acceptable and the casualties can be reassessed. Further treatment can be provided here if necessary to save life.

\textsuperscript{48} INQ042478/1
\textsuperscript{49} 191/6/9-20
\textsuperscript{50} 191/7/17-8/3
before the casualty is extracted to the ‘casualty collection point’ in the green, safe zone and then on to hospital.\footnote{191/13/4-21/2} The casualty will stop at these points prior to hospital only if absolutely necessary to ensure that they are able to survive the extraction.\footnote{191/20/24-25/2}

20.63 The French describe this as the casualty flow. It is designed to get the casualty from the hot zone to treatment at hospital as quickly as possible.\footnote{191/19/7-20/23} I will consider at paragraphs 20.88 to 20.96 what lessons can be learned from the approach in France, which is not unique, to the issue of evacuation to hospital.

20.64 At an early stage, it seemed to me that an obvious way of narrowing the Care Gap was for the UK to adopt a RAID-style model. However, the evidence has persuaded me that the situation is by no means as straightforward as I had thought and hoped. There are a number of cogent reasons why such a model may not transfer across to the UK. It is not possible for me to explain all of those reasons in an open report, but I can say the following.

20.65 In the UK, Armed Response Vehicles provide the primary response to no-notice incidents such as
a terrorist attack. Firearms officers have neutralised the threat during most recent terrorist attacks in the UK. There has been substantial investment in the development of a significant Armed Response Vehicle network. It is not practicable to embed a doctor within each Armed Response Vehicle team. That is a summary of evidence given by CI Thomas in a restricted evidence session on 17th January 2022. There was widespread agreement with his view from other witnesses. Lieutenant Colonel Park has, as I have explained, substantial experience working with the Metropolitan Police Service firearms teams. John Lawrie is a research analyst with expertise in counter-terrorism; he conducted the analysis into the approach taken by different countries to the Care Gap. Both agreed with CI Thomas.

20.66 Counter Terrorist Specialist Firearms Officers (CTSFOs) provide a specialist firearms capability in counter-terrorism and organised crime operations. They will deploy in support of Armed Response Vehicles at incidents if the initial Tactical Firearms Commander decides that their specialist skills and/or equipment would be of value. Because Armed Response Vehicle officers provide the primary response to no-notice
incidents, including Marauding Terrorist Attacks, it is unlikely that a CTSFO team with an embedded clinician would form part of the initial response during the critical stages of the golden hour, the first hour of the emergency response. Indeed, it is almost inevitable that the CTSFO teams would arrive after HART operatives. Although on the night of 22nd May 2017, the CTSFOs did in fact arrive at the Arena before HART, Lieutenant Colonel Park agreed that this is contrary to what could reasonably be expected to occur in general. Normally, they would arrive later.

20.67 CTPHQ maintained that embedding doctors with CTSFOs would therefore bring no material benefit to the response to a terrorist attack and that clinical care is best provided under the control of the NHS and ambulance services. CTSFOs, CTPHQ asserted, would be of no assistance in the early stages of an incident because they would be unlikely to be there. By the time a CTSFO doctor arrived, work should already be under way by HART operatives.

20.68 CTPHQ’s position was that if a greater level of skill and training is required of HART, that is a matter for DHSC, the NHS and ambulance services. The level of HART skill highlights an

56 191/30/8-16 [restricted], INQ042637/5
57 192/27/7-14, 192/29/21-30/4, 192/30/23-31/10
58 191/31/23-32/22 [restricted]
important issue, to which I will turn in paragraphs 20.86 and 20.87.

20.69 A number of further practical issues with embedding doctors within police firearms teams were expressed by other witnesses. Philip Cowburn of NARU, for example, explained that he does not consider there to be, currently, a sufficient number of doctors with expert skills in pre-hospital emergency medicine within the UK to provide a cadre of embedded doctors. He points out that pre-hospital emergency medicine is a relatively new sub-speciality in the UK, compared with France. It is his view that it is vital to find a way of getting experts in pre-hospital emergency medicine forward quickly, but he considers that a RAID-style model is not the way of achieving this.

20.70 The best place for someone with severe injuries to be treated is in hospital. The quicker they get there, the better. Sometimes, it will be necessary for that person to receive treatment at the scene to enable them to survive to hospital. First responder interventions, namely haemorrhage control and airway opening, may suffice and most people can be trained to do those.
turn to that issue in further detail at paragraphs 20.149 to 20.159. However, more sophisticated treatments may be required, such as bridging interventions like chest decompressions or gaining intravenous access to provide analgesia, and these must be done by a healthcare professional.63

20.71 Sometimes, the patient will not survive to hospital unless given enhanced care interventions at the scene.64 Such interventions typically involve addressing internal bleeding. They include the use of advanced techniques such as chest decompressions and thoracotomy. These can be carried out only by those with a high level of skill and training, normally consultants in pre-hospital emergency medicine.65

20.72 Accordingly, it is clear that, if all of those capable of surviving a mass casualty incident are to be given the greatest chance of doing so, clinicians able to provide all three levels of intervention must reach them urgently. On the evidence I heard, the adoption of a RAID-style model is not necessarily the solution. However, I am not satisfied that we have reached the stage in the UK at which such an approach should be discounted altogether.

63 192/2/18-3/18
64 192/22/13-23/21
65 192/24/2-9
20.73 Lieutenant Colonel Park considered that a RAID-style model was worthy of further examination\textsuperscript{66} and John Lawrie agreed.\textsuperscript{67} It was clear to me that CI Thomas was dubious but accepted that further consideration might be of value.\textsuperscript{68}

20.74 Given the very considerable benefits that RAID brought to the response to the Bataclan attack and to other terrorist attacks in France, I consider that this model, or parts of it, should not be rejected until more work has been done. For example, while I accept that it will not be feasible to embed doctors in all Armed Response Vehicle teams, and while it is unlikely to be appropriate to embed doctors in all CTSFO teams, there may be value in doctors being embedded in one or the other type of team in some locations or on some occasions. As is perfectly obvious, some locations and/or occasions may represent more attractive targets for terrorists.

20.75 I recommend that CTPHQ review the evidence heard during the Inquiry, including that heard in restricted sessions, to consider the advantages and disadvantages of embedding doctors with some police firearms teams, and if so, how that could be achieved. CTPHQ should also review

\textsuperscript{66} 192/66/16-70/11
\textsuperscript{67} 188/74/9-75/10 [restricted], 188/83/6-8 [restricted]
\textsuperscript{68} 191/35/2-5 [restricted]
the experience of other jurisdictions that embed medics with police firearms officers, such as RAID in France, to understand how their systems operate and whether they ought to be replicated in the UK or some further learning taken from them.

Alternatives to embedding doctors with police firearms officers

20.76 I recognise that the result of that further consideration may be that a decision is made that doctors should not be embedded with police firearms teams. It is therefore necessary to consider other ways in which a consultant-led response to a terrorist attack can be achieved. Two proposals were explored in the evidence, which merit consideration.

20.77 First, around the country, a number of air ambulance organisations operate. Most within England are charities and the extent to which they have links to the NHS varies between the organisations. In Wales and Scotland, air ambulance services are entirely state-funded. The air ambulance organisations form part of the UK’s frontline emergency response service, providing life-saving treatment to those in urgent need of pre-hospital emergency medicine.
20.78 I understand that most of these organisations provide a consultant-led pre-hospital emergency medicine response rapidly, either by helicopter or, where more appropriate, by rapid-response car.  
Most are therefore able to provide the three levels of intervention to which I have referred, namely first responder interventions, bridging interventions and enhanced care interventions. These interventions are the ones that will save the greatest number of lives in a mass casualty situation.

20.79 Many witnesses considered that air ambulance organisations have a role to play in narrowing the Care Gap in a mass casualty situation resulting from a terrorist attack. Those witnesses included Dr Andrew Curran, Medical Director of the North West Air Ambulance Charity, Dr Thomas Hurst, Medical Director of London’s Air Ambulance Charity, Dr Gareth Davies, who has been responsible for the medical governance of a number of air ambulance organisations, including London’s Air Ambulance Charity, and Lieutenant Colonel Park, who has considerable experience of a number of air ambulance operations. They represented a body of opinion...
with considerable experience and authority on the point.

20.80 Dr Hurst was unequivocal: air ambulance organisations have a valuable role to play in a situation such as that which occurred on 22\textsuperscript{nd} May 2017. That role includes, he considers, both providing life-saving interventions to casualties and providing leadership and advice to the ambulance personnel present at the scene.\textsuperscript{75} Lieutenant Colonel Park further explained the value of air ambulances and those who staff them. She described how they “add a very significant decision-making capability on scene, are less likely to be overwhelmed by the critically injured patient, and are used to dealing with multiple seriously injured patients simultaneously and making rapid decisions during evolving events”.\textsuperscript{76}

20.81 I accept this evidence. I also accept that, for air ambulance operations to make the contribution that they plainly are capable of making in the aftermath of a terrorist attack, and, indeed, to any mass casualty incident, some things need to change.

20.82 Dr Curran explained that air ambulance provision is not available 24 hours each day in every part

\textsuperscript{75} 190/96/4-97/6

\textsuperscript{76} \textit{INQ042598/13} at paragraph 75
of the UK.\textsuperscript{77} He considers that this is inequitable and that there should be 24-hour pre-hospital emergency medicine provision in all parts of the country.\textsuperscript{78} Dr Hurst agreed.\textsuperscript{79}

20.83 Witnesses generally made clear that air ambulance personnel, with some exceptions, are not usually trained in entering or equipped to enter the zones of greatest danger in the event of an Operation Plato incident.\textsuperscript{80} If they are to perform this role, they will require training and equipment. They would have to be trained with the other emergency services that will deploy in response to a terrorist incident.

20.84 I was impressed by the dedication and resourcefulness of those who staff the air ambulances in this country. Most in England are charitable organisations, but they all have a potentially important role to play in the response to a terrorist attack. They are capable of providing the kind of rapid consultant-led response that will be needed. Lieutenant Colonel Park explained that London’s Air Ambulance had deployed in the emergency response to the terrorist attack at Fishmongers’ Hall on 29\textsuperscript{th} November 2019 and had been able to make a significant

\textsuperscript{77} INQ042646/3 at paragraph 10  
\textsuperscript{78} INQ042646/3 at paragraph 14  
\textsuperscript{79} 190/95/4-96/8  
\textsuperscript{80} 192/86/13-87/9, INQ042684/2 at paragraph 7
contribution. That evidence supported me in my view about the potential value of this resource.

20.85 I recommend that DHSC, NHS, NARU, ambulance service trusts, Air Ambulances UK, CTPHQ and JESIP consider how air ambulance organisations might be integrated into the emergency response to a terrorist attack. I further recommend that those organisations consider what training and resources would be required to integrate air ambulance organisations into the emergency response to a terrorist attack. I regard these as potentially important improvements in the emergency response to a terrorist attack and work needs to be done to achieve them urgently.

20.86 Second, it was explained to me that it is possible to train some HART operatives up to the level of providing bridging interventions. However, it is unlikely that they could be trained to provide complex interventions such as the use of a thoracotomy. Such training would not provide a complete solution to the problem. Despite that fact, this is an issue worth considering.

20.87 DHSC and NARU should consider further training of HART personnel so that at least one member...
on every HART deployment has the ability to deliver most enhanced care interventions.

Evacuation to hospital

20.88 In dealing with the approach of RAID in France, I explained that the focus is on the quickest evacuation from the scene to hospital at the expense of treatment, unless that treatment is necessary to enable the casualty to reach hospital alive.

20.89 The current system within the UK ambulance services is based heavily on the idea that triage will take place a number of times and in different places. At its most basic, our current model involves primary triage. This is also known as ‘triage sieve’. Primary triage will take place where the casualty is located or at the Casualty Collection Point. It will be followed by secondary triage, or ‘triage sort’, at some safer location, usually the Casualty Clearing Station.84

20.90 Primary triage involves the casualty being given a designation from P1, the most seriously injured, to P3, walking wounded. Treatment should be given only if vital to save life: for example, the application of a tourniquet to stem catastrophic bleeding or the opening of an airway.85 Those

84 144/134/18-137/25
85 144/136/22-137/4, 68/99/16-100/8
who have died should also be identified during this process. Secondary triage involves the reassessment of the casualty using a more sophisticated method of observation and the application of a wider range of treatments. All of this occurs before the casualty is even in an ambulance. The events of the Attack demonstrate that this process may cause significant delays in casualties arriving at hospital.

20.91 Some countries take a different approach and have a much stronger emphasis on the rapid evacuation of casualties to hospital. France falls into that category. At least one other country has an even stronger focus on evacuation: prioritising the extraction of casualties without delay and with no deference to zoning.

20.92 This is a complicated issue. The evidence I heard does not provide a complete answer. The emphasis in the UK is on ensuring that there are no hold-ups when a casualty arrives at hospital. There was a detailed system in Manchester to ensure that casualties arrived at the most suitable hospital for their treatment and that the hospitals had time to prepare for their arrival.

86 110/38/1-12
87 144/137/5-7
88 191/18/4-20/3
89 188/58/8-60/13 [restricted]
In almost every case, this system as designed worked well on the night of the Attack.

20.93 Arrival at the most suitable hospital is, however, different from arriving at that hospital at an appropriate time. On 22\textsuperscript{nd} May 2017, there were lengthy delays in some casualties arriving at hospital. It may be that other countries deal with the evacuation of casualties to hospital more effectively than the UK does, with their emphasis being on getting casualties to hospital, using whatever vehicles are available, as soon as possible rather than waiting until hospitals are ready.

20.94 One practice that I was told about concerned me. It was explained to me that more ambulances than there were casualties requiring transportation to hospital were needed at a scene before transportation could take place. This is because when the first ambulances arrive at the scene of a Major Incident, all of the paramedics are required to leave their ambulances and go to assist with treating casualties in the Casualty Clearing Station. That leaves no one to drive or look after patients on the journey to hospital: the ambulances remain empty and parked. It is necessary to wait for further ambulances containing paramedics who are not required to assist in the Casualty Clearing Station to arrive before any patient can be moved to hospital. If
none of the ambulances is double-crewed, it will take more ambulances to arrive before transportation begins.

20.95 This does not seem to me to be a satisfactory system, as it builds in additional delay. This delay is made even more severe when ambulance services around the country are already running at, or beyond, their full capacity and it may take a very long time for sufficient additional ambulances to arrive. In evidence I explored whether it were possible for other people, such as police officers, to drive ambulances to reduce the number of paramedics required. I was told that this was not possible, but it seems to me that there must be a workable solution to this problem.

20.96 In the circumstances, I recommend that DHSC, the Faculty of Pre-Hospital Care, the College of Paramedics and NARU review the current model operated in the UK by reference to the different approaches around the world in order to see whether triage at different times and in different places remains best practice, or whether there should be a greater emphasis on rapid evacuation to hospital.

**Early scene triage tool**

20.97 Philip Cowburn has expertise and experience in a number of areas of relevance to the Care Gap.
He is a long-serving consultant in emergency medicine at a busy inner-city emergency department and trauma Team Leader at a major regional trauma centre. He was involved in setting up and developing the Great Western Air Ambulance Charity and has been Acute Care Medical Director of a regional ambulance service for over ten years. He was actively involved in the development, education and governance of HART and now oversees the medical component of those teams from a national perspective. He has worked as medical adviser and clinical governance lead to specialist police teams within the South West for 15 years. He has been Medical Advisor to NARU since 2021.\footnote{192/214/17-219/5}

20.98 At paragraph 20.90, I explained the existing approach to triage. Philip Cowburn told me in evidence that many clinicians in his area of practice had developed a concern that these existing triage tools were "slow and cumbersome".\footnote{192/219/13-25} What was required, they considered, particularly in a mass casualty situation, was something that was very rapidly deployable.\footnote{192/219/25-220/2}

20.99 NHS England oversees the budgeting, planning, delivery and day-to-day operation of the
commissioning side of the NHS in England. Part of NHS England’s role involves ensuring that the NHS is properly prepared for dealing with an emergency. NHS England developed the Emergency Preparedness, Resilience and Response Framework to provide a structure within which all NHS-funded organisations could meet the requirements of the Civil Contingencies Act 2004, among other requirements.  

20.100 As part of that work, NHS England established a group to consider whether a fresh approach to triage was needed. That was a sensible step. Philip Cowburn was appointed to lead this group. Lieutenant Colonel Park is a member of the group and also gave evidence to me about its work. The group has benefited from contributions from experienced military and civilian clinicians in pre-hospital and Major Incident management and from academic experts in the field.

20.101 When Philip Cowburn gave evidence to the Inquiry, he explained that an early scene triage tool had emerged from the work of his group. This was described by him as a simple concept, designed to enable the identification, at speed and by people under stress, of those casualties.

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93 13/2/20-4/3  
94 192/47/5-54/20  
95 INQ042789/6-7
whose lives are truly at risk. Its purpose is to improve upon and replace primary triage.96

20.102 Lieutenant Colonel Park explained in evidence that this tool is based on six main principles: it is simple to use; it prioritises the use of first responder interventions, namely haemorrhage control and airway opening; it removes the requirement to take physiological measurements; it prioritises those with penetrating torso trauma for early evacuation; it does not allow any person other than a healthcare professional to label a casualty as dead; and it involves a straightforward system for the tagging of casualties involving the use of coloured cards to provide visible identification of the priority of patients.97

20.103 The evidence I heard about what happened in the City Room left me in no doubt that effective triage is vital in a mass casualty situation. It will narrow the Care Gap. That is for the obvious reason that in such circumstances there will be patients who will die unless treated promptly, and others, although in need of treatment, whose survival is not at immediate risk. The early identification of the time-critical casualties will enable effective prioritisation. It will make sure that those who need treatment urgently receive it.

96 192/219/19-221/20
97 192/52/15-53/21
20.104 On hearing the evidence, I regarded the development of the early scene triage tool as significant. That was particularly so because it was explained to me that the intention is that this tool be used by all first responders, not just paramedics. 98

20.105 At the time when he gave evidence, Philip Cowburn’s expectation was that major progress would be made in relation to the development of this tool during 2022. In fact, progress was expected both in relation to the early scene triage tool and in relation to the issue of triage more generally. 99

20.106 As a result, in July 2022, I sought an update from Philip Cowburn.

20.107 Philip Cowburn provided me with a comprehensive report in writing on 3rd August 2022. This sets out a proposal for major change in the approach to triage at the scene of a Major Incident. 100

20.108 A concept called the Major Incident Triage Tool has been devised. This tool, which will be known as MITT, was field-tested in August 2021. The testing used both quantitative gauges and qualitative gauges. The former involved

98 192/54/4-55/7, 192/220/22-221/20
99 192/222/20-224/8
100 INQ042789
identifying how long triage had taken. The latter involved asking what those who had used the new tool in the field test thought of it. MITT proved to be superior to the existing system for triage on both gauges. It is proposed that MITT entirely replace the existing approach of primary and secondary triage. That proposal has the support of NHS England. ¹⁰¹

20.109 While Philip Cowburn’s group regarded MITT as a significant improvement on the existing procedures, the group identified an additional need. In the event of a mass casualty situation, there was a risk of responders being overwhelmed by the sheer number of casualties that they needed to triage. What was needed, the group concluded, was an additional tool that was capable of being applied rapidly and by a broader range of responders in a mass casualty situation. ¹⁰² This is the early scene triage tool that Philip Cowburn explained was under development at the time when he gave evidence.

20.110 Work has progressed since then. What the group has now devised is both quick and easy to use. It is designed to provide an element of control and structure to the inevitable confusion that will ensue in the early stages of a Major Incident. Importantly, it can be used by any responder with

¹⁰¹ INQ042789/5-6
¹⁰² INQ042789/6
the ability to provide first responder interventions, not just the staff of an ambulance service.\footnote{INQ042789/7}

20.111 Based on the material currently available, it appears to me that Philip Cowburn’s group has identified a triage tool that allows the rapid assessment of multiple casualties, while prioritising life-saving interventions. Those interventions are ones that must be delivered quickly to maximise the survival of critically injured patients. The working title of this new tool is ‘Ten Second Triage’. If that name endures, it will be known as TST.\footnote{INQ042789/9}

20.112 If all first responders present in the City Room on the night of the Attack had been trained in TST, it would have made a difference. Triage would have been much more efficient.

20.113 The early indications are that TST has the support of the representative bodies of the ambulance service, police, fire and rescue service, and military. By the time Volume 2 of my Report is published, a field test based around a terrorist attack will have been undertaken in relation to TST. As part of that field test, the relationship between MITT and TST will be assessed. I cannot prejudge the outcome of that field test, but it is important that, once the field
test has concluded, NARU and the representative bodies of the other emergency services should analyse what has been learned as quickly as possible and implement change swiftly. 105

20.114 The work of Philip Cowburn’s group has been guided by experts in the field. It has been undertaken to a standard of excellence. Philip Cowburn’s report to me indicates that the emergency services have expressed a commitment to implementing MITT and TST.

20.115 I recommend that the representative bodies of the emergency services review the proposals of Philip Cowburn’s group urgently and, in the event that they agree that they represent an improvement on the existing approach to triage, implement them as soon as possible. The bodies to whom I direct this recommendation are: the College of Policing, the College of Paramedics, the Fire Service College, the National Police Chiefs’ Council, the National Ambulance Resilience Unit and the National Fire Chiefs Council and also, given its oversight role, the Home Office.
Other matters relating to treatment

Introduction

20.116 As I have explained, a number of issues were raised during the evidence that do not strictly fit into either narrowing the gap or filling the gap. Instead, they relate to the treatment of those injured in a mass casualty incident.

20.117 Those issues are: analgesia; blood; freeze-dried plasma; and TXA. It is convenient to deal with them at this point in my Report before turning to the steps that need to be taken to fill the Care Gap: in other words, the steps that need to be taken to empower those who happen to become caught up in the aftermath of a terrorist attack.

Analgesia

20.118 Lea Vaughan was one of two HART operatives who entered the City Room during the critical period of the response. Following the Attack, she prepared a PowerPoint presentation. The purpose of this was to provide training, although no such training was in fact provided.

20.119 In a section of the presentation headed “Problems faced”, she identified an issue that

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INQ035612/258-259
79/15/4-17/22
INQ022850/12
was subsequently explored at various stages in the evidence. Lea Vaughan confirmed that no analgesia was provided to those in the City Room. She considered that it would have been highly desirable to have been able to give analgesia to casualties, but she explained that, once given, it requires the casualty then to be monitored. This prevents the paramedic from moving on to another patient. In other words, the provision of analgesia causes delay.

20.120 Christopher Hargreaves, the HART operative who entered the City Room with Lea Vaughan, echoed her views.

20.121 Both HART operatives considered that steps need to be taken to identify a form of analgesia that can be given to casualties in a situation like the one that existed in the City Room. That analgesia must not delay the work of paramedics in dealing with others.

20.122 Lieutenant Colonel Park had a clear and well-informed view about this issue. She explained that, where a casualty is gravely injured, analgesia has a number of benefits. Relieving pain has its own humanitarian value, but it also assists in evacuating casualties who might otherwise not be able to be moved. There is a
further way in which pain relief can assist. Splinting a limb and applying traction can reduce bleeding. However, these can be very painful processes. Providing adequate pain relief enables these processes to happen when otherwise they might not be possible.\textsuperscript{111}

20.123 Lieutenant Colonel Park recognised the difficulty with administering intravenous analgesia as described by Lea Vaughan but explained that the British Army had found a solution. All soldiers now deploy with fentanyl lozenges, which are sometimes called fentanyl lollipops.\textsuperscript{112} Fentanyl is a strong opioid painkiller, used to treat severe pain, even in children. Lieutenant Colonel Park described lozenges that simply dissolve in the patient’s mouth. Studies in the US military and also within London’s Air Ambulance have found fentanyl lozenges to be practical and safe and to provide effective pain relief even for those with extremely serious injuries.\textsuperscript{113}

20.124 The British Army is able to provide fentanyl lozenges to its soldiers because of a dispensation within the regulatory framework. No such dispensation exists for ambulance services; not even HART operatives are able to deploy with

\begin{itemize}
\item \textsuperscript{111} 192/21/6-16
\item \textsuperscript{112} 192/15/4-17/2
\item \textsuperscript{113} 192/17/3-20
\end{itemize}
fentanyl lozenges. 114 It was clear to me that Lieutenant Colonel Park regarded that situation as anomalous, as did Philip Cowburn.

20.125 Philip Cowburn explained that the inability of those in civilian practice to use fentanyl lozenges was a “massive hindrance” in dealing with a mass casualty incident. 115 In writing following his evidence, he expressed the view that fentanyl lozenges or sufentanil sublingual tablets are ideal for mass casualty situations. They are rapidly absorbed, they can be self-administered or easily given and they do not require supervision of the casualty. 116

20.126 Philip Cowburn regards a situation in which the military can use such analgesia while paramedics and other pre-hospital care professionals cannot as incongruous and unacceptable. He considers that the current situation deprives those injured in a mass casualty incident of the safe and effective analgesia to which they are entitled. 117 I found his views and those of Lieutenant Colonel Park persuasive.

20.127 Some of those awaiting evacuation from the City Room were conscious and in severe pain. If effective pain relief can be provided to such
casualties without harming their chances of survival or the overall rescue effort, it should be. Both Lieutenant Colonel Park and Philip Cowburn consider that this can be achieved and each speaks from a position of authority and experience.

20.128 I recommend that DHSC, the Home Office and the Medicines and Healthcare products Regulatory Agency (MHRA) give urgent consideration to whether the regulatory regime should be altered to enable this to occur. If the decision is that it should, I recommend that NARU consider urgently whether the use of fentanyl lozenges should be rolled out to all HART and other specialist operatives as part of their basic equipment and quite possibly to paramedics more generally.

Blood

20.129 Obviously, where a casualty has suffered an injury that has caused a catastrophic or heavy bleed, the priority must be to stop the bleeding. The evidence made that very clear; it is, in any event, common sense. However, as the circumstances of the Attack make clear, effective action to stop a bleed may not occur. Also, not all catastrophic haemorrhages can be easily controlled. Instinctively, it would therefore seem

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118 192/234/1-16
sensible that ambulances should carry blood or blood products to replace lost volume and help maintain life until the casualty’s arrival at hospital.

20.130 The evidence, however, demonstrated that, in practice, a situation in which all frontline ambulances carry blood or blood products cannot be achieved. That is so for a variety of reasons explained by a number of witnesses, all of whom agreed. Among those witnesses were Dr Timothy Smith, an Associate Medical Director of NWAS and an Enhanced Pre-Hospital Care Consultant with the North West Air Ambulance Charity,\textsuperscript{119} Philip Cowburn of NARU\textsuperscript{120} and Lieutenant Colonel Park.\textsuperscript{121}

20.131 Two principal objections arise, one clinical and the other logistical.

20.132 First, the clinical objection. Pre-hospital blood transfusion is a recognised practice within the UK. However, the decision whether to administer blood is complex and is one that must usually be made by a senior doctor. Lieutenant Colonel Park told me that the decision whether or not to transfuse a patient is sometimes difficult, even for a senior clinician.\textsuperscript{122}

\textsuperscript{119} INQ042524
\textsuperscript{120} 192/234/1-252/20
\textsuperscript{121} 192/56/4-60/18
\textsuperscript{122} 192/58/4-59/11
20.133 It is right that some specialist paramedics are able to deal with this procedure, having received advanced training. However, it is not feasible to train all paramedics in the administration of blood replacement. Philip Cowburn explained that frontline paramedics would be likely to encounter a situation in which a patient required pre-hospital blood less than once a year.  

20.134 While I acknowledge that he was indicating a view that was not based on research, Philip Cowburn’s considerable experience entitles him to express the opinion that training all such personnel would be disproportionate, particularly since there are other ways of dealing with the issue. I have already dealt in paragraphs 20.76 to 20.87 with one of the other potential ways of dealing with the issue, namely having a consultant-led clinical response to a terrorist incident. Below, in paragraphs 20.139 and 20.140, I will deal with another potential way of dealing with the issue, namely the use of freeze-dried plasma. Other witnesses agreed that it was not feasible to train all ambulance personnel or even all specialist staff in the administration of blood. I accept their common view.

20.135 Second, the logistical objection. The challenges involved in the movement of blood in the pre-
hospital environment are significant. It is not necessary for me to go into the detail of this, but, in simple terms, blood must be stored in particular circumstances and then heated prior to use. This requires bespoke equipment, which is expensive. More importantly, it takes time to prepare. Procedures are established for air ambulances to carry and transfuse blood but there simply are not the resources available to scale this up so that all or most ambulances have the same capacity.

20.136 Significant issues arise in relation to the traceability of blood products and also, importantly, the scale of supply. Philip Cowburn explained that blood is a precious resource and that having blood in frontline ambulances would give rise to a significant risk of wastage that might result in lives being lost in a hospital environment. Dr Hurst of London’s Air Ambulance Charity agreed.

20.137 On the evidence, I accept that equipping all frontline ambulances, or even just all HART vehicles, with blood is not feasible.
20.138 Philip Cowburn’s view was that the solution is not to equip all ambulances with blood or blood products, but instead to ensure that there exist mobile resources, such as air ambulances, that possess suitably qualified and equipped staff to transfuse blood into those patients who need it.\(^{131}\) This provides a yet further reason for ensuring that a consultant-led response occurs as soon as possible. I have already recommended that ways of achieving this must be considered.

**Freeze-dried plasma**

20.139 While he does not consider that HART should carry blood or blood products, Philip Cowburn believes that consideration should be given to all HART operatives carrying freeze-dried plasma.\(^{132}\) Freeze-dried plasma is a solution to which water is added in order to reconstitute it. It is then warmed. While it does not carry oxygen, this plasma replaces volume and has an impact on clotting, although not to the same extent as whole blood.\(^{133}\) Overall, it has the potential to benefit those who have experienced catastrophic blood loss in a mass casualty incident.

20.140 I recommend that DHSC, the Faculty of Pre-Hospital Care, the College of Paramedics and
NARU consider whether all HART operatives should be deployed with freeze-dried plasma and trained on its use. This recommendation is dependent on the benefits of the use of plasma being confirmed by research. In considering this recommendation, regard should be had to the following article published online in *The Lancet Haematology* on 7th March 2022: ‘Resuscitation with blood products in patients with trauma-related haemorrhagic shock receiving prehospital care (RePHILL): a multi-centre, open-label, randomised, controlled, phase 3 trial’. This article addresses the benefits of the use of pre-hospital blood products generally.

**Tranexamic acid**

20.141 TXA is a medication that helps blood to clot. It is useful in a number of situations, including in treating blood loss caused by major trauma. TXA was administered to some of those injured in the Attack. It was also used in the response to the Bataclan attack.

20.142 Intravenous administration of TXA may be difficult in patients lacking sufficient volume of blood. It takes approximately ten minutes to administer, during which period the paramedic must remain
with the patient. That will cause delay in the
treatment of other patients in a mass casualty
situation. Both problems could be solved by
the use of intramuscular as opposed to
intravenous TXA. 138

20.143 Philip Cowburn considered that a review should
be carried out into whether frontline ambulances
should carry intramuscular TXA. 139 I agree.
I recommend that the review be undertaken by
DHSC, the Faculty of Pre-Hospital Care, the
College of Paramedics and NARU.

Filling the gap

Introduction

20.144 It is inevitable that members of the public will be
cought up in the aftermath of a terrorist attack.
The government advice for those embroiled in
such a situation is “Run, Hide, Tell”. 140 Run: run
to a place of safety. Hide: it is better to hide than
confront. Tell: tell the police by calling 999.

20.145 Nothing I say in this Part of my Report is intended
to undermine that advice. However, experience
from the UK and around the world demonstrates
that some members of the public choose not to
run and hide, but instead to remain at the scene

138 192/252/21-253/18, 192/259/4-260/4
139 192/252/21-253/6
140 INQ042678 at paragraph 7
and help. Others will run towards danger to provide their assistance. These people are sometimes known as zero responders or immediate responders.\textsuperscript{141}

20.146 The Attack showed that people other than members of the public, such as event medical staff or unarmed police officers, will also run to the scene of a terrorist attack and that police firearms officers are likely to attend quickly.

20.147 The evidence reveals that it is vital that all of those who choose to be present in the aftermath of a terrorist attack in any of these ways are able to provide what I have referred to already as first responder interventions.

20.148 Lieutenant Colonel Park explained the concept of first responder interventions and their significance.\textsuperscript{142} An obstructed airway or a catastrophic bleed may kill within minutes, long before professional clinical care is likely to arrive.\textsuperscript{143} These conditions may be capable of management by the application of simple techniques, which any member of the public can be taught. In my view, there needs to be widespread education about what those techniques are. That will save lives.
Educating the public

20.149 We need to ensure that as many members of the public as possible have the skills needed to provide first responder interventions so that if they wish to provide life-saving assistance they can. I am satisfied that much work is already being done to achieve this, but more can and should be done.

20.150 The charitable sector has done extraordinary work to bring the need for better public education to the forefront. I heard from Brigadier Timothy Hodgetts. Since he gave evidence, Brigadier Hodgetts has been appointed as the Surgeon-General of the UK Armed Forces, the most senior medical officer within the armed forces, and he now holds the rank of Major General. He is also Chair of Trustees of citizenAID, a position he has held since that charity’s inception.

20.151 Brigadier Hodgetts explained that the aim of citizenAID is to provide the public with the knowledge to enable people both to keep safe in deliberate attack situations and to prioritise and treat the seriously injured. citizenAID is designed to empower the public to save lives in the critical minutes before the emergency services are able
to attend: in other words, during the Care Gap. Its work and that of other charities is invaluable. The website of citizenAID can be found at https://www.citizenaid.org/.

20.152 While I welcome the work of citizenAID and other charities in this regard, it is the state that has the primary responsibility for ensuring that members of the public have the knowledge necessary to save lives in a mass casualty incident.

20.153 I acknowledge that counter-terrorism policing has introduced its own initiative. The National Counter Terrorism Security Office has commenced work to encourage employers to train their employees to understand the basics of first aid. That is to their credit, but much more needs to be done. I recommend the following.

20.154 First, the young must have the skills needed to provide life-saving interventions in a mass casualty situation. As of September 2020, all primary and secondary school pupils were required to be taught health education, including first aid, as part of the National Curriculum. This involves children aged over 12 being taught CPR. I agree that this is necessary. The
Department for Education should ensure that it continues.

20.155 I understand that children and young people are not currently taught to deal with catastrophic bleeds or airway impairment.\textsuperscript{149} I consider it vital that training in such matters is provided to young people. This training should be received before they leave secondary school; the earlier it can responsibly be provided, the better. The Department for Education should consider extending the National Curriculum requirement on first aid to incorporate this.

20.156 I recommend that the Department for Education give consideration to including training in all first responder interventions in the National Curriculum.

20.157 Second, until children and young people have all been educated in first responder interventions, there will be a gap. Those who have already left school may lack the necessary skills. That situation needs to be addressed. The public at large cannot be forced to undertake training in first aid interventions. However, something needs to be done to encourage greater awareness within the general population of what can be done to save lives in situations such as the Attack and indeed more generally.

\textsuperscript{149} 192/100/2-101/19
20.158 I recommend that the Home Office consider a public education programme and the introduction of a requirement into law, perhaps through regulations issued under the Health and Safety at Work etc. Act 1974, that employers have a duty to train all employees, or certain categories of employees, in first responder interventions.

20.159 I emphasise that everything that can reasonably be done to educate the general population in first responder interventions should be done.

Control rooms

20.160 The operators within control rooms are able to provide guidance to members of the public who telephone seeking assistance. For example, North West Fire Control had guidance documents providing advice relating to certain risks. These documents enabled operators to provide assistance to callers confronted by building fires, incidents involving collapsed or collapsing structures, wildfires, flooding and acid attacks. Operators were encouraged to deploy this guidance by way of a series of prompts provided by their systems. That is all sensible.

20.161 As the circumstances of the Attack reveal, in the aftermath of a terrorist attack, the control rooms of all the emergency services will receive multiple

150  INQ042676/1 at paragraph 4
calls. Control Room Operators may have a valuable contribution to make in providing guidance on first responder interventions. Such advice is capable of empowering those uninjured members of the public who choose to remain in the aftermath of a terrorist attack by providing them with the assistance they require in order to help the casualties.

20.162 I recognise that Control Room Operators working for the ambulance services already have skills and/or training in this regard, but I consider that there is value in those who work in the control rooms of all three emergency services having the ability to provide advice on basic trauma care. I recommend that the College of Policing, the Fire Service College and National Fire Chiefs Council consider devising training packages for operators within police and fire and rescue service control rooms that achieve this aim, and that DHSC and NARU take steps to ensure that the existing training for ambulance service operators is fit for this purpose.

20.163 Those who work in control rooms should not seek to subvert the government’s “Run, Hide, Tell” message, but experience shows that many members of the public will in fact choose to stay and help. Control Room Operators are well placed to provide them with guidance.
Training of unarmed police officers

20.164 I will next turn to the position of unarmed police officers. I will address the position of firearms officers at paragraphs 20.175 to 20.183.

20.165 Often, unarmed police officers will arrive at the scene of a terrorist attack before the professional clinical response. The response to the Attack is an example of that. Officers of British Transport Police (BTP) were within the Victoria Exchange Complex when the bomb was detonated.\textsuperscript{151} Within minutes of the explosion they had rushed to the City Room, entering within about two minutes.\textsuperscript{152} GMP officers arrived at the scene within a short time of their armed colleagues. By 22:48, GMP unarmed officers had entered the City Room.\textsuperscript{153}

20.166 Police officers such as these should be able to provide first responder interventions, including applying a tourniquet and opening an airway. However, the evidence I heard reveals that the unarmed officers generally lacked the skills to deliver the help they desperately wanted to provide. The footage I watched from body-worn video cameras of the unarmed officers and the evidence more generally demonstrates that the

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officers were frustrated by their inability to do more to help.

20.167 All unarmed police officers should be trained to provide first responder interventions. I heard evidence from a series of police officers of Chief Officer rank. In light of that evidence, I believe that there has now developed an understanding that this is so.

20.168 It is not necessary for me to rehearse all the evidence I heard on this issue. I will, however, refer to the evidence of Assistant Chief Constable Iain Raphael, the Director for Operational Standards in the College of Policing. The College of Policing is the body that sets the standards for policing and develops guidance and policy for policing. That involves the College setting standards for the training of police officers, including in first aid.

20.169 ACC Raphael explained that the College of Policing was undertaking a review of its First Aid Learning Programme (FALP) and that there is an expectation that, from January 2023, the first aid training of all police officers will include training in first responder interventions. This will include the application of tourniquets and the opening of
airways. Some police services, including GMP, have improved their training in this regard ahead of the conclusion of the review.

20.170 To assist the review and with a view to ensuring that expectation becomes reality, I recommend that the Home Office and the College of Policing ensure that all newly recruited and existing police officers and all frontline police staff, such as Police Community Support Officers (PCSOs), are trained in first responder interventions. That training should be provided urgently.

20.171 The evidence I heard left me unconvinced that the amount of time allocated to first aid training under the current system is sufficient to allow for proper instruction in these new skills. Each police service must ensure that adequate time is allocated to training in this crucial topic. The Home Office and the College of Policing should regularly assess and appraise the training on first responder interventions given by each police service to ensure that it is of an appropriate quality and that adequate time is allocated to it.

20.172 I have already referred to TST, the ‘Ten Second Triage’ tool. Philip Cowburn and Lieutenant Colonel Park consider that this tool should be capable of use by unarmed police officers and

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156 192/183/13-187/24
firearms officers. The aftermath of the Attack demonstrated that police officers would have benefited from training in the use of this tool. It would have enabled them to identify those in greatest need of help and to prioritise them for treatment or to direct paramedics to them, if paramedics had been there in sufficient numbers.

20.173 I recommend that the College of Policing ensure that it includes training in TST in its first aid training programme when, and if, it is adopted. This is even more important while paramedics and unarmed police officers have different views as to the degree of risk that it is acceptable to take.

20.174 I recommend that the College of Policing keep the national first aid training for all officers, including firearms officers, under continual review with a view to continuous improvement.

Firearms officers: Care Under Fire

20.175 In her evidence, Lieutenant Colonel Park explained the concept of Care Under Fire. Every soldier in the British Army is taught that, when a fellow soldier is shot on the battlefield, the uninjured soldiers should return fire in order
to neutralise or manage the threat, but then as soon as possible provide first responder interventions for their injured colleague.  

20.176 While the concept is known as Care Under Fire, it obviously applies to other situations in which a soldier is dealing with a threat. For example, it follows from the evidence I heard that where a soldier has been injured by an Improvised Explosive Device (IED), their colleagues would be expected to provide them with life-saving interventions alongside dealing with any secondary device.

20.177 I heard evidence that police firearms officers within the UK have been trained in first responder interventions. Members of Armed Response Vehicle teams will commonly respond at an early stage to a terrorist attack. On the night of the Attack, the first firearms officers had entered the Arena itself by 22:43, just over ten minutes after the explosion.

20.178 The view of senior police officers is that such firearms officers should provide Care Under Fire, giving that term its broad meaning. Matthew Twist is Deputy Assistant Commissioner (DAC) within Specialist Operations, which is part of National

159 191/101/6-102/10
160 191/22/9-25/3 [restricted]
161 INQ035612/75
Counter Terrorism Policing. He explained that he would expect Armed Response Vehicle officers, as they sought to neutralise a threat, to be considering whether they were able to start providing care to the injured. CI Thomas expressed similar views.

20.179 I do not doubt that DAC Twist and CI Thomas, each of whom was experienced and expert, expressed their genuinely held views. However, on the evidence I heard, I do not believe that the firearms officers who formed Armed Response Vehicle teams on the night of the Attack had a sufficient understanding that part of their role was to provide Care Under Fire.

20.180 The firearms officers who initially attended the Arena provided no treatment to any casualty. Indeed, the only firearms officers who provided any treatment did not arrive at the scene until 23:09, 38 minutes after the explosion. They helped to treat a casualty on the raised walkway at 23:12 and a casualty in the City Room at 23:25. I do not criticise the firearms officers, who behaved bravely that night. Rather, I am identifying an apparent disconnect between
the expectations of senior officers and the understanding on the ground.

20.181 Lieutenant Colonel Park, who is heavily involved in the training of the armed assets of the Metropolitan Police Service, confirmed that, although firearms officers are trained in basic life-saving interventions, the need to provide those interventions in the response to a terrorist incident is not well enough understood by those officers. The events of the night of the Attack suggest that Lieutenant Colonel Park is right.

20.182 The capacity of firearms officers to provide first responder interventions will help to fill or shorten the Care Gap because they will generally be on the scene at a very early stage. It is important that they should understand that, having neutralised the threat or having established that there is no threat, they should where possible provide basic life-saving interventions to casualties. I do not believe that this is currently adequately understood by the firearms officers on the ground. I recommend that the College of Policing and CTPHQ ensure that this important issue is urgently addressed in the training of all firearms officers.

20.183 Lieutenant Colonel Park raised the prospect that firearms officers might be deployed with
analgesia. 168 She pointed out that a number of police services had been trialling methoxyflurane, a non-opioid painkiller used for the emergency relief of moderate to severe pain. 169 She stated that consideration ought to be given to rolling this out nationally. 170 Given the early stage at which firearms officers are likely to reach those most seriously injured in a terrorist incident, and given the likelihood that many they encounter will be in pain, this proposal has obvious value. The College of Policing and CTPHQ should review whether firearms officers should be deployed with and trained to use analgesia as part of providing Care Under Fire.

Training of firefighters

20.184 There was widespread agreement that firefighters have a vital role to play in the event of a terrorist attack. They have particular skills in the evacuation of casualties and those skills need to be maintained. They also have first aid skills. I consider that they should be trained to provide first responder interventions. This particularly applies to the specialist resources of the fire and rescue services who may be deployed forward in an Operation Plato situation. But, as with the police, this should also be the position with all
firefighters. The National Fire Chiefs Council expressed the view that this was necessary.\footnote{171} I agree.

20.185 I recommend that the National Fire Chiefs Council and the Fire Service College take steps to devise a training scheme that educates all firefighters in first responder interventions. The National Fire Chiefs Council and the Fire Service College should ensure that the training scheme is implemented first to specialist responders, then to all other firefighters. This should be applied nationally. Finally, the National Fire Chiefs Council and the Fire Service College may find it helpful to consult with the College of Policing when considering the scheme since it is apparent that the College of Policing has already undertaken a good deal of work in relation to this issue as part of its review.

20.186 Philip Cowburn and Lieutenant Colonel Park considered that TST should also be capable of being used by firefighters.\footnote{172} There is no doubt that there will, in the future, be situations in which casualties would benefit from firefighters having the knowledge that this tool would give them. Accordingly, I recommend that the National Fire Chiefs Council and the Fire Service College

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171 & 189/149/16-152/17 \\
172 & 192/54/4-55/2, 192/219/13-221/20
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consider including training in this tool in its first aid training programme.

**Training of event staff licensed by the Security Industry Authority**

20.187 Many events will require the presence of stewards and other security staff and some of those personnel will require a licence issued by the Security Industry Authority (SIA). That body is the subject of examination and recommendations in Parts 3 and 8, respectively, of Volume 1 of my Report.

20.188 Not every member of security personnel is required to be registered by the SIA, so no recommendation I make to the SIA can ensure that every such member of staff is trained in first responder interventions. However, every single additional person who has the necessary skills is capable of making a difference. I consider that all SIA staff should have those skills.

20.189 I recommend that the SIA take steps urgently to devise a training scheme in first responder interventions that educates all of those licensed with it, both existing licensees and applicants for a licence. The SIA may find it helpful to consult with the College of Policing in this, since it is apparent that the College has already undertaken a good deal of work in this regard. I also recommend that
the SIA take steps to encourage the security industry generally to ensure that even those members of staff who do not require an SIA licence develop skills in basic trauma care.

20.190 The Home Office has a working group with the SIA.\textsuperscript{173} I recommend that the Home Office take the action available to it to ensure that all of those licensed or to be licensed by the SIA have appropriate first aid training as I have described it.

Event healthcare services

20.191 This section can be dealt with briefly because, although important, there was widespread agreement across all Core Participants about what was required.

20.192 In Part 16 in Volume 2-I, I set out why the provision of event healthcare services at the Arena on 22\textsuperscript{nd} May 2017 was inadequate. I have little doubt that such serious shortcomings occurred elsewhere at other venues. I fear that they continue to happen. At least in part, they were and are the result of inadequate regulation by the state. That needs to be remedied.

20.193 There should be regulation that addresses the following.

\textsuperscript{173} 188/100/13-101/21
First, a standard should be set for the level of event healthcare services that are required for any particular event. The evidence does not enable me to state what that standard should be, but the standard will inevitably have regard to the size of the crowd likely to attend an event and the profile of the event.

I recommend that DHSC consider what that standard should be. I do not consider that it is a standard that should be contained only within guidance. Serious consideration should be given to putting it on a statutory footing. The consequences of failing to meet the standard could be fatal.

Second, the standard should be capable of enforcement by a regulator. The Care Quality Commission (CQC) is the principal regulator of the health and social care sector. Clear and compelling evidence was given by Dr Edward Baker, the Chief Inspector of Hospitals at the CQC. He stated that the CQC considers that it is the appropriate body to regulate this area of activity. The CQC has made this point to DHSC in plain terms, but there have been delays in implementing the necessary changes. In my view, these changes should happen urgently.

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174 190/125/3-11
175 190/127/6-15, 190/131/23-132/5
176 190/133/11-135/18
20.197 I recommend that DHSC give urgent consideration to making the necessary changes in the law so as to enable the CQC to carry out the work it wishes to undertake in this important area.

20.198 Third, regulation of this area should have teeth. Those who provide event healthcare services may be responsible for the lives of very many people. If they breach the standard of services that the state decides to impose, there is a strong argument that there should be both civil and criminal consequences.

20.199 I recommend that DHSC consider, together with the CQC, whether the consequence of breaching the standard of provision for event healthcare services should be penal, including the possible imposition of custodial sentences.

20.200 All of these matters should be considered as a matter of urgency.

20.201 I recognise that some time is going to pass before the change I recommend is implemented. In the meantime, the licensing regime has a role to play. I acknowledge that this is not a complete answer because not all venues will be subject to licensing requirements. Even where they are, changing existing licences is not straightforward.
20.202 I recommend that the Department for Levelling Up, Housing and Communities review the guidance given to all licensing authorities on the decisions they make in relation to venues that hold events, and on what level of event healthcare services may be required at the events likely to be held at those venues. The guidance should indicate appropriate licence conditions to be used. The licensing authorities should then impose conditions accordingly or make those standards a requirement to meet existing conditions.

Ambulance Liaison Officer

20.203 Jeremy Cowen is an Emergency Planning Officer with the Northern Ireland Ambulance Service. He has a special interest in event and venue safety, and experience and expertise in that area. He provided a witness statement to the Inquiry. 177 It contains his informed views about how the Care Gap should be addressed. I am grateful to him for the valuable contribution he has made to the Inquiry’s work.

20.204 Among Jeremy Cowen’s suggestions was that, where a particular risk threshold for an event is reached, an Ambulance Liaison Officer should be physically present. That person will be a member of the ambulance service. In the event of a Major
Incident, the Ambulance Liaison Officer should be able to gain good situational awareness quickly and therefore pass an early METHANE message. The Ambulance Liaison Officer will also be able to initiate the ambulance service’s Major Incident Plan.\textsuperscript{178}

20.205 It seems to me that the Ambulance Liaison Officer may be able to perform the role of NWAS Operational Commander until someone dedicated to that role arrives. I have no doubt that, on the night of 22\textsuperscript{nd} May 2017, an Ambulance Liaison Officer would have made a valuable contribution to the emergency response.

20.206 There was considerable support for the view of Jeremy Cowen. Keith Prior made clear that NARU agreed that Ambulance Liaison Officers are capable of providing real benefit.\textsuperscript{179} The Ambulance Service Experts agreed in principle that Ambulance Liaison Officers are a good idea.\textsuperscript{180} I also agree.

20.207 The Ambulance Service Experts explained that work remains to be done to make sure that Ambulance Liaison Officers work in practice. In my view, two broad issues need to be addressed. First, there needs to be a mechanism by which

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\item \textsuperscript{179} 190/40/1-41/1
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the threshold at which an Ambulance Liaison Officer must be present at an event is identified. The most important factor will be the number of attendees, but there are likely to be other factors of relevance such as audience profile. Second, there needs to be a mechanism by which a requirement to appoint an Ambulance Liaison Officer in appropriate circumstances can be imposed on venue operators.

20.208 I recommend the following. In the first instance, DHSC and NARU should consider the scope of the role of an Ambulance Liaison Officer and issue guidance to ambulance services. The Home Office and DHSC should consider how the threshold for a requirement that an Ambulance Liaison Officer be present is to be identified.

20.209 If this scheme is going to work, ambulance services will need to be prepared to make members of their staff available to fill the role of Ambulance Liaison Officer. The resources of ambulance services are already stretched. The Home Office, DHSC and NARU should consider how this situation is to be resolved. It is likely, it seems to me, that venue operators will need to fund the presence of an Ambulance Liaison Officer where one is required. The Home Office should also consider how the presence of an Ambulance Liaison Officer in appropriate circumstances can be made mandatory. It may
be that this should form part of the Protect Duty, which I deal with extensively in Volume 1 of my Report, or part of the regulation of event healthcare services.

Equipment

20.210 Another aspect of ensuring preparedness in the event of a terrorist attack is making sure that those who will provide assistance have the equipment they need. That applies to zero responders, to paramedics including members of HART, to police officers whether armed or unarmed, to event medical service providers and to others who may fill the Care Gap. The evidence revealed that, at the moment, there is a risk that some or all of these groups may lack the equipment they require in the event that a mass casualty incident occurs.

Public Access Trauma kits

20.211 The concept of Public Access Trauma (PAcT) first aid kits was explained by DAC Twist in his evidence. The idea is that they are available in publicly accessible locations and contain the equipment that would be required to provide first responder interventions. The kits also provide basic instructions. They are designed for ready
use, even by untrained members of the public. These are plainly an excellent idea.

20.212 CTPHQ has been working with others, including charities, to promote these kits. I commend both CTPHQ and the charities for that work, but so important is this equipment that more needs to be done.

20.213 I recommend that DHSC consider the equipment that ought to be included within a PAcT kit. It is not clear to me that the CTPHQ kit necessarily contains all the equipment that might be used by a zero responder to carry out first responder interventions. In particular, while it does contain tourniquets and instructions, it is not clear to me that it contains instructions and equipment to enable an airway to be opened.

20.214 Brigadier Hodgetts described a “grab bag” that citizenAID makes available. While he was envisaging something that might be used by the organiser of an event as opposed to a member of the public, he described things such as a stretcher that might usefully be included. The contents of PAcT kits need to be given further consideration.

182 189/86/4-87/6
183 68/71/22-72/21
184 68/72/3-5
20.215 I recommend that the Home Office and DHSC consider how a situation is to be achieved in which PAcT kits are available in all locations in which they are most likely to be needed. It may be that this is something that can be addressed as part of the Protect Duty, or alternatively as part of the work that I have recommended DHSC undertake to ensure that there is an appropriate standard imposed on those who provide event healthcare services.

20.216 Ultimately, how this is to be achieved is a matter for government. But it is clearly a matter of importance. I do recognise the difficulties in balancing the need for public accessibility against the risks of theft or vandalism which sadly exist. Such risks will need to be accommodated in the government’s plans, but my expectation is that such issues will have arisen in many other contexts, such as publicly available defibrillators and emergency throwlines, and solutions may be available.

20.217 Connected with PAcT kits, which allow equipment to be available permanently within publicly accessible locations, DAC Twist raised the concept of “drop bags”. These are, as I understood it, essentially the same as PAcT kits, but they are designed to be carried by members.
of Armed Response Vehicle teams and dropped as they enter the scene of a terrorist attack. The aim is that they will then be used by members of the public in the same way as PAcT kits. NARU supports their introduction\textsuperscript{186} and I agree that they are a good idea. DAC Twist explained that they are already in use in a number of police service areas, with full implementation expected by 1\textsuperscript{st} October 2022.\textsuperscript{187} I hope very much that implementation by that date will be achieved.

Hazardous Area Response Team equipment

20.218 As I have explained, Lieutenant Colonel Park described treatments called “bridging interventions”.\textsuperscript{188} These are interventions that a member of the public would not be able to perform.\textsuperscript{189} They require specialist skills and equipment. They involve the splinting and carrying out of traction on broken limbs.\textsuperscript{190} This is an important procedure because it reduces the casualty’s pain, enabling them to be moved, and also because it reduces bleeding, which can cause death.\textsuperscript{191}

20.219 Lieutenant Colonel Park explained that members of HART would not commonly take into
hazardous areas equipment that enables them to carry out bridging interventions.\(^{192}\) It was her view that consideration should be given to the specialist resources of ambulance services carrying such equipment into those zones.\(^{193}\) I agree. I recommend that DHSC, the Faculty of Pre-Hospital Care, the College of Paramedics and NARU consider issuing guidance on how to ensure that specialist paramedics take with them into a warm zone equipment that enables them to carry out bridging interventions.

**Stretchers**

20.220 Once triage and any treatment needed for immediate life-saving purposes, such as the application of a tourniquet or airway release, has been undertaken, casualties need to be evacuated. The means by which this is done is relevant both to the speed at which it will occur and to the safety and comfort of the casualty. What happened on the night of the Attack was unacceptable, with casualties carried away from the City Room on unstable advertising hoardings. The Home Office, DHSC, the Department for Transport and the Department for Levelling Up, Housing and Communities should conduct a review to ensure that stretchers that are appropriate in design and adequate in number

\(^{192}\) 192/11/16-24
\(^{193}\) 192/11/25-13/21
are always available for use by the emergency services and in appropriate locations in the event of a mass casualty incident.

20.221 In 2019, Dr Langlois and colleagues in France carried out an assessment of the types of stretcher that best enable rapid extraction of casualties in mass casualty incidents. The results of that analysis are informative. They are publicly available and should be read by all of those who may have responsibility for the response to any mass casualty incident, including a terrorist attack.

20.222 The technology may have moved on since the work of Dr Langlois and his colleagues, and, in any event, different types of stretcher may be appropriate to different kinds of environments. I consider that work ought to be undertaken in the UK in order to identify the type of stretcher that is of greatest utility in the event of a mass casualty incident. That work should be undertaken by DHSC, with input from other bodies as DHSC considers appropriate. The product of that research should be rolled out to all those with responsibility for the response to a mass casualty incident, including a terrorist attack, whether in the public or private sector.
Part 21
Volume 2 conclusions and recommendations

21.1 There are three sections to Part 21. The first section will set out my overall conclusions. These are drawn from across Volume 2. The second section will list my Recommendations. The third will identify my approach to monitoring the progress of particular Recommendations I make in Volume 2 (Monitored Recommendations).

21.2 The Monitored Recommendations are all in areas where substantial progress can be made during the period I have set for monitoring them.

21.3 The fact that I have not listed a Recommendation as a Monitored Recommendation does not mean that it should not be the subject of prompt attention. There is a great deal of work that needs to be done to address the issues I have identified, which include systemic issues. All those with a responsibility to keep the public safe need to address areas for improvement as a matter of urgency.
Conclusions

21.4 As I said in the Preface to this Volume of my Report, in the immediate aftermath of the Attack on 22nd May 2017 there were heroic acts by numerous people. These were members of the public who were in or around the Arena; people who worked at the Arena or in the Victoria Exchange Complex; and members of the emergency services who went into the City Room in the early stages. These people ignored the risks to their own safety to try to do what they could to help the dying and the injured. They had no protective clothing but they went into the City Room, even though they must have realised that they were putting themselves at risk in doing so. Those acts were acknowledged by me during the Inquiry and I do so again now in this conclusion. Everyone who heard the evidence has great respect and admiration for the people who acted so bravely.

21.5 While not overlooking those acts, I have inevitably been concerned with determining what went wrong and why things went wrong, and making recommendations to try to ensure that they do not go wrong again.

21.6 The evidence I have heard revealed that a great deal went wrong in the emergency response to the Attack on 22nd May 2017.
21.7 Previous tragedies had not resulted in necessary change being implemented. Each of the emergency services had drawn up plans. Those plans had been created with the intention of ensuring that people affected by a terrorist attack would receive the greatest possible assistance. However, on 22\textsuperscript{nd} May 2017, those plans were not known by everyone who should have known about them. Many of those who did respond to the explosion, the non-specialists, had little or no knowledge of the plans that had been devised. But when the plans were known about, they were not always as clear as they might have been. And when they were clear, they were not always properly understood. And when they were known and understood, they were not always put into practice.

21.8 Some of the failures that occurred in the emergency response were down to mistakes made by individuals. It is understandable that individuals under the immense pressure and stress that a terrible incident such as a bombing creates will make mistakes. It is all the more important in those circumstances that there are checks and balances in place. These will ensure that all the things that need to be done have been done, and that the right decisions have been made.
21.9 The almost universal response from senior commanders during the Inquiry’s oral evidence hearings was that it was not their job to ensure that their subordinates had done what they ought to have done. Again that is understandable: checking up on others takes time and may show a lack of belief in the abilities of subordinates. Nevertheless, it is necessary. In at least two of the emergency services, there were single points of failure. Had checks been made by more senior officers as they took up their position in the command structure, serious omissions could have been quickly rectified.

21.10 The response to the explosion started well. Greater Manchester Police (GMP) directed firearms officers in numbers to the site of the explosion. They were quickly able to establish that there were no armed terrorists in the City Room and, by placing armed guards on the entrances to that location, were able to ensure that none could enter. Unarmed and unprotected British Transport Police (BTP) and GMP officers were quickly on the scene doing what they could.

21.11 From that start, it ought to have been possible to get medical assistance to the injured in the City Room speedily. This would have allowed victims to be removed safely on stretchers to the station entrance; from there they could have been put
into ambulances and taken to hospital, where they would have received the best treatment.

21.12 That is not what happened.

21.13 One of the most emotional and upsetting parts of the Inquiry was listening to the evidence of people in the City Room, both rescuers and the injured, who heard the sirens of the ambulances outside and expected to see paramedics arriving imminently, and then hearing of their despair when so many fewer than they reasonably expected actually arrived in the City Room. The failure of the paramedics to arrive in numbers was a terrible disappointment to the injured and the rescuers in the City Room, who did not have the skills to triage the injured and give them the life-saving medical help they might need prior to being moved. Paramedics had these skills. The injured were desperate for help, not realising that decisions that had been made meant they would not see paramedics in the City Room in the numbers hoped for and expected. I set out in Part 17 of my Report the experiences of the injured and those with the deceased in the City Room as they waited in vain for help to arrive.

21.14 Three paramedics went into the City Room to carry out triage and any life-saving interventions that had to take place before the injured were moved. No stretchers were taken from the
ambulances to assist with the removal of the injured. Instead, police officers and members of Arena staff and the public carried the injured along the raised walkway and down a series of stairs to the entrance hall of the station on anything they could find. Advertising hoardings, crowd barriers and tables were used. It was a painful and unsafe way of moving the injured. On the station concourse, a treatment centre was set up where the other paramedics re-triaged and gave much-needed treatment to the injured, including stabilising them sufficiently for the trip to hospital.

21.15 The situation was undoubtedly difficult, but the evacuation of the City Room would have worked much better for everyone if there had been a more co-ordinated response. No one wanted the injured and dying to suffer more than they needed. Everyone involved in the emergency no doubt thought that they were doing their best. In some cases, and for reasons I set out in my Report, their best was not good enough.

21.16 Members of the fire and rescue services are trained to give assistance in circumstances such as those in the City Room. They would have been of great help. They have stretchers that are suitable for use in such situations. Their absence was significant, as they could have provided very substantial assistance in the safe removal of the
injured from the City Room. The fact that most of the members of the other emergency services did not notice that Greater Manchester Fire and Rescue Service (GMFRS) officers were not there helping in the rescue suggests a lack of appreciation of the part that fire and rescue services can and do play. If the Joint Emergency Services Interoperability Principles (JESIP) had been fully embedded in the muscle memory of responders, that would not have happened.

21.17 The suggestion was made during the Inquiry’s oral evidence hearings that the reason GMFRS did not turn up and North West Ambulance Service (NWAS) did not go into the City Room in numbers was because they were risk averse.

21.18 None of the firefighters I heard from were risk averse. Rather, I heard from a number of very angry firefighters who were ashamed of the fact that they did not get to join in the rescue. They desperately wanted to get involved. I am also satisfied that paramedics would have gone into the City Room, if asked to do so, in order to carry out their work of saving lives.

21.19 It is one thing to take risks on your own behalf, but it is quite another for a commander to send people under his or her command into a situation where they may be at risk of death or serious injury. There needs to be an assessment of that
risk before others are potentially placed in danger. None of the commanders I heard from was risk averse for his or her own safety, but some were for the people who might be put at risk by carrying out their orders. All members of the emergency services take risks in the course of their work, and do so willingly, but the extent of that risk needs to be properly assessed by commanders before committing rescuers forward. Evaluating the degree of risk that is acceptable is very difficult. Detailed guidance and assistance needs to be available.

21.20 The best risk assessment is a joint risk assessment between all the emergency services that are on scene. They need to pool their knowledge. While no service is bound to accept the risk assessment of another, it is important that they listen to the views of others. Where one rescue service has more situational awareness than others, there would need to be a good reason for that assessment not to be accepted by everyone. BTP and GMP had the best situational awareness of the risk of working in the City Room as unarmed police were in there in numbers without any special protection. The GMP Operational/Bronze Commander’s view was that it was safe enough for rescuers without special protection to work there. He was right, but nobody from GMP or the other emergency
services asked for his opinion. Firearms officers who were present also thought it was safe enough for such rescuers to be present. Their views were not sought. The only paramedic present in the first 44 minutes thought the same.

21.21 Other inquiries, inquests and investigations have emphasised the importance of the emergency services working together to provide the best result for the injured. Detailed policies, such as JESIP, have been devised, and people trained to put them into practice.

21.22 JESIP emphasises the need for co-ordination, either by locating commanders at the same place and, if that is not possible or is still to happen, by having effective communication between all the emergency services. Manuals have been written on what is needed to make JESIP work; everyone is meant to be trained on the principles. JESIP still failed on 22nd May 2017. Commanders did not co-locate. There was no effective communication. This is not the first incident in which JESIP has failed.

21.23 At one stage during the hearing of evidence, the failures on the night and the failures in JESIP in the past led me to suggest that it should be abandoned.

21.24 However, it was the evidence from all of the witnesses at the Inquiry hearings that the
application of the principles of JESIP was the best way to assist the injured and get them treated quickly. I accept that it is, in light of that evidence, but it is necessary to ensure that JESIP works in practice and not just in theory. I have made recommendations in my Report about how to achieve this. More training, more practice, and the right sort of practice, are needed. Lessons need to be learned when things go wrong in exercises or in a real emergency, and change implemented as a result. Most importantly, individual emergency services must not operate alone. They must respect and understand the contribution that can be made by other emergency services and they must respect the views of others, particularly when it comes to assessing risk.

21.25 The failure of JESIP on 22\textsuperscript{nd} May 2017 meant that those who were having to make decisions assessing risk did not receive information from those who were in the best position to provide the necessary situational awareness to assess that risk. That should not have happened.

21.26 Had there been good communication and co-location on 22\textsuperscript{nd} May 2017, many of the problems that did arise would not have.

21.27 The evidence heard at the Inquiry has led me to the view that necessary changes were not always
identified and implemented as the result of past mistakes, partly because the debrief processes were not as effective as they might have been, and even when shortcomings were identified they were not always put right. In the Inquiry, I heard evidence of exercises where things had gone wrong that were similar to the things that went wrong on 22\textsuperscript{nd} May 2017. This needs to be improved, and I have made a number of recommendations, which I hope will, if accepted, result in improvements.

21.28 There were problems with the debriefing process after 22\textsuperscript{nd} May 2017. It was alarming to hear evidence that the Chief Constable of GMP had informed Lord Kerslake, during his review of the preparedness for and emergency response to the Attack, that GMP could demonstrate that Inspector Dale Sexton had notified the other emergency services of the declaration of Operation Plato. That was incorrect. Inspector Dale Sexton had not done so. The Chief Constable was not deliberately trying to deceive Lord Kerslake; it was what he had been told. It is difficult to understand how that had happened on such a crucial issue.

21.29 What I hope was a constructive part of this Inquiry dealt with what I described as ‘the Care Gap’. There will always be a time lag between the emergency having happened and the arrival
of the emergency services that are able to assist the casualties. That is a critical time when lives can be lost if no action is taken to save casualties. This makes it essential that as much help as possible can be provided on site by people who are in the vicinity and prepared to help. This means that it is vital that establishments of a similar size to the Arena have a reasonable number of adequately trained and equipped medical staff on hand to give emergency care, to bridge the gap before the ambulance service and the fire and rescue service can arrive. Standards need to be laid down and enforced to ensure that this happens. There needs to be liaison between site operators and event healthcare staff and the ambulance service to co-ordinate their responses to an emergency. The in-house healthcare provision at the Arena on 22nd May 2017 was inadequate.

21.30 Police officers, who are often first on the scene, should have trauma training so that they can provide life-saving treatment and do not find themselves in the position that the unarmed officers did on 22nd May 2017. They wanted to provide assistance to casualties but they did not have the necessary training to do so. The same applies to members of the public, who found themselves wishing they had greater first aid skills. Encouragement should be given to the
public generally to acquire the skills needed to help casualties who are in a life-threatening condition. The National Curriculum should include education in first responder interventions and there ought to be incentives to those who have left school to develop those skills.

21.31 I have considered in my Report whether different procedures can be adopted by the emergency services themselves to reduce the effect of the Care Gap. The emphasis in the present system is on ensuring that hospitals are ready for the patients before sending them there. I heard about other countries, such as France, where they operate a different system, aiming to get the injured to hospital as soon as possible by whatever means they can.

21.32 It is important that we do not close our eyes to new ideas. There is still much work to be done on reducing, as far as possible, the Care Gap and its consequences. The witnesses I heard giving evidence about the Care Gap were very impressive. There is a great deal of innovative thinking going into the reduction of the problems caused by the Care Gap. It is very important that the ideas coming out of the new research are considered with an open mind.

21.33 The most important issue in the Inquiry has been whether a more effective rescue effort could have
saved the lives of any of those who died. I deal with that question in Part 18 of my Report and I invite readers to read that to get the full detail. As can be seen, I have concluded that one of those who died, John Atkinson, would probably have survived had the emergency response been better. In the case of Saffie-Rose Roussos, I have concluded that there was a remote possibility that she could have been saved if the rescue operation had been conducted differently. The evidence was conclusive that there was no possibility that any of the others could have survived the murderous actions of SA.

21.34 While we do need to consider whether we should move to different systems to get the injured to hospital more quickly, I accept that the draft hospital dispersal plan activated by NWAS worked well. It meant that casualties were sent to the specific hospital best equipped to deal with their particular injuries, and staff were there waiting to receive them. Despite this, I was concerned about the time it took to get patients to hospital. The evidence of the injured, who seemed to wait for a very long time in the City Room and then in the station entrance before going to hospital, was very moving and telling.

21.35 A constant criticism of some of the emergency services during this Inquiry has been that they were defensive and, rather than join in a genuine
search for what went wrong, they tried to insist that everything they did was correct and, where something went wrong, to blame it on others. If criticism is unjustified, then it does not help a search for the truth simply to accept it. Conversely, it is a natural human reaction to try to avoid blame for some terrible disaster and find some explanation that excuses it, even if it puts the blame on someone else. The real test will be whether action is taken to put right what went wrong, and not just in the short term but until the terrible threat of terrorism has been eradicated.

21.36 I believe that I have got to the truth of what happened on that dreadful night. I have certainly had assistance from many clever, hardworking and motivated people to do so. I am very grateful to them all. I also hope fervently that what comes out of this Inquiry will make a difference, and I ask all those concerned with what happens next to ensure that it does.

Recommendations

21.37 I set out below the recommendations I make arising out of my investigation into the emergency response on 22nd May 2017 (the Recommendations).
21.38 Against each Recommendation I have added a cross-reference. These are mostly to paragraphs within specific Parts of Volume 2, and sometimes to statements from the Emergency Response Experts. These cross-references are intended to assist the reader, and any organisation to which the Recommendation is directed, to understand the issue the Recommendation is seeking to address. The cross-referencing is not exhaustive and each one of the Recommendations should be understood in the context of Volume 2 as a whole. All organisations should, in any event, review the whole of Volume 2 in order to identify what I consider is required of them.
### Greater Manchester Resilience Forum

| R1 | The Greater Manchester Resilience Forum should oversee, at least every six months, a regular tri-service review of the Major Incident plans used by Greater Manchester Police, Greater Manchester Fire and Rescue Service and North West Ambulance Service. The purpose of that review should be to ensure that there is a common understanding by each emergency service of the plans of the other emergency services. It should also ensure that the importance of joint working is embedded within each emergency service. | 12.4 to 12.81 |

### British Transport Police

| R2 | British Transport Police should ensure that all its Inspectors are trained to undertake the Bronze Commander role in the event of a Major Incident. | 12.98 to 12.106 |
| R3 | British Transport Police should review its procedures to ensure the prompt appointment of a Bronze Commander during a Major Incident. | 12.98 to 12.106 |
| R4 | British Transport Police should ensure that all its Sergeants are trained in what is required of a Bronze Commander in the event of a Major Incident. This will help to make sure that the first Sergeant on scene can undertake the initial steps in the emergency response, prior to the arrival of an Inspector. | 12.98 to 12.106 |
| R5 | British Transport Police should work with the Home Office police services with which it shares policing responsibilities at or for a particular location:  
  a. to agree which police service has primacy in the event of a Major Incident;  
  b. to put in place appropriate plans to make clear the responsibilities of each police service in the event of a Major Incident;  
  c. to conduct regular exercises, including joint exercises, to test those plans; and  
  d. to ensure that all police officers and police staff are adequately trained in what will be required of them. | 12.107 to 12.113 |
<p>| R6 | The role of the Senior Duty Officer in a Major Incident should be clearly defined and explained in the British Transport Police Major Incident Manual. This role should have a corresponding action card. | 12.112 to 12.113 |</p>
<table>
<thead>
<tr>
<th>R7</th>
<th>British Transport Police should reflect on its approach to record-making during and immediately following a Major Incident, with a view to improving the current practice.</th>
<th>19.13 to 19.42</th>
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<tbody>
<tr>
<td><strong>Greater Manchester Police</strong></td>
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<tr>
<td>R8</td>
<td>Greater Manchester Police should ensure that its role cards are always immediately accessible to the officers who are to perform those roles.</td>
<td>12.173</td>
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<tr>
<td>R9</td>
<td>Greater Manchester Police’s Major Incident Plan should be reviewed to ensure that it includes clear guidance on the capabilities of Greater Manchester Fire and Rescue Service, including its Specialist Response Team, as well as on the importance of joint working.</td>
<td>12.200 to 12.202</td>
</tr>
<tr>
<td>R10</td>
<td>Greater Manchester Police’s Major Incident Plan should be reviewed to ensure that it includes clear guidance on the capabilities of North West Ambulance Service, including its Hazardous Area Response Team, Ambulance Intervention Team and Special Operations Response Team, as well as on the importance of joint working.</td>
<td>12.200 to 12.202</td>
</tr>
<tr>
<td>R11</td>
<td>Greater Manchester Police should ensure that its plans for responding to a Major Incident, including a terrorist incident, are reviewed regularly by those with the appropriate skills and experience to make meaningful improvements to each plan. This must include a regular review of the Operation Plato plan, which must include obtaining the views of those with experience of firearms policing and of performing the role of Force Duty Officer.</td>
<td>12.235</td>
</tr>
<tr>
<td>R12</td>
<td>Greater Manchester Police should review its Operation Plato plans to ensure that there is only a single plan to which all can work and that this plan gives clear and consistent guidance on how to respond to an Operation Plato incident.</td>
<td>12.303 to 12.310</td>
</tr>
<tr>
<td>R13</td>
<td>Greater Manchester Police should reflect on its approach to record-making during and immediately following a Major Incident, with a view to improving the current practice.</td>
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<tr>
<td>North West Ambulance Service</td>
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<tr>
<td>R14</td>
<td>North West Ambulance Service should review its Major Incident Response Plan to consider whether it should be updated to include a pre-determined attendance for Major Incidents.</td>
<td>12.448</td>
</tr>
<tr>
<td>R15</td>
<td>North West Ambulance Service should review its Major Incident Response Plan to consider whether, in order to speed up mobilisation, it should provide pre-determined attendances for the Hazardous Area Response Team, Ambulance Intervention Team and Special Operations Response Team crews for Major Incidents.</td>
<td>12.449</td>
</tr>
<tr>
<td>R16</td>
<td>North West Ambulance Service should ensure that it has up-to-date site-specific plans for all large, complex or high-risk locations within its area.</td>
<td>12.455 to 12.459</td>
</tr>
<tr>
<td>R17</td>
<td>North West Ambulance Service should ensure that all its site-specific plans are multi-agency and that all Category 1 responders operating in the areas it serves have contributed to them.</td>
<td>12.455 to 12.459</td>
</tr>
<tr>
<td>R18</td>
<td>North West Ambulance Service should ensure that it has a policy that sets out the circumstances in which an Operational Commander may be relieved and how that should occur and be communicated to the outgoing Operational Commander and beyond.</td>
<td>12.480</td>
</tr>
<tr>
<td>R19</td>
<td>North West Ambulance Service should train its Operational Commanders on the appropriate practice for relieving another of command and being relieved of command.</td>
<td>12.480</td>
</tr>
<tr>
<td>R20</td>
<td>North West Ambulance Service should ensure that non-specialist ambulance personnel are involved in multi-agency exercising.</td>
<td>12.500</td>
</tr>
<tr>
<td>R21</td>
<td>North West Ambulance Service should review its Major Incident Response Plan to make clear that the first resource on scene should assume the role of Operational Commander only once they have achieved situational awareness.</td>
<td>14.121</td>
</tr>
<tr>
<td>R22</td>
<td>North West Ambulance Service should ensure that its commanders are adequately trained in the use of operational discretion.</td>
<td>14.214</td>
</tr>
<tr>
<td>R23</td>
<td>North West Ambulance Service should review its policies for mobilising the Hazardous Area Response Team resource, to ensure that this team is available as soon as possible for an emergency where its specialist skills are required.</td>
<td>14.25</td>
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<tr>
<td>Recommendation</td>
<td>Action</td>
<td>Details</td>
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<tr>
<td>R24</td>
<td>North West Ambulance Service should review how it rosters Tactical Advisors and National Interagency Liaison Officers so as to ensure that there is adequate geographical coverage enabling those on duty to arrive promptly at the scene of any Major Incident.</td>
<td>14.542</td>
</tr>
<tr>
<td>R25</td>
<td>North West Ambulance Service should review the number of Tactical Advisors and National Interagency Liaison Officers it has, and whether the number of such specialists, both generally and on call, should be increased.</td>
<td>14.574</td>
</tr>
<tr>
<td>R26</td>
<td>North West Ambulance Service should review its procedures with local NHS trusts to ensure that it has effective policies in place for quickly dispatching patients injured in a Major Incident to an appropriate hospital.</td>
<td>12.370 to 12.373 14.503</td>
</tr>
<tr>
<td>R27</td>
<td>North West Ambulance Service should reflect on its approach to record-making during and immediately following a Major Incident, with a view to improving the current practice.</td>
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<tr>
<td><strong>North West Fire Control</strong></td>
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<tr>
<td>R28</td>
<td>North West Fire Control should take steps to ensure that it is involved in multi-agency exercises, particularly those that test mobilisation and the response to a Major Incident in line with the Joint Emergency Services Interoperability Principles (JESIP).</td>
<td>12.554 12.749</td>
</tr>
<tr>
<td>R29</td>
<td>North West Fire Control should ensure that it regularly tests how it operates, by ensuring that its staff participate in regular exercises and practical tests. These should include multi-agency exercises.</td>
<td>12.602 12.749</td>
</tr>
<tr>
<td>R30</td>
<td>All North West Fire Control staff should be trained on the best practices for responding to a Major Incident, as identified through its participation in exercises. North West Fire Control should ensure that learning is kept under review.</td>
<td>12.602 12.749</td>
</tr>
<tr>
<td>R31</td>
<td>North West Fire Control should review the way it captures and records key information on its incident logs in order to ensure that the information is stored in one place and is readily accessible at all times by those who need it.</td>
<td>15.407</td>
</tr>
<tr>
<td>R32</td>
<td>Greater Manchester Fire and Rescue Service and North West Fire Control should conduct a joint review of the circumstances in which it is appropriate for Greater Manchester Fire and Rescue Service personnel to check the North West Fire Control incident log. Policies should be written by both organisations to reflect the outcome of this review. Training should be delivered to embed it into practice.</td>
<td>15.309 to 15.315</td>
</tr>
<tr>
<td>R33</td>
<td>North West Fire Control should review its guidance and policies on how it receives and passes on information during a Major Incident. It is important that, for any update given, it is established when the last time the person receiving the update was provided with information, to ensure that they are completely up to date. See also R38.</td>
<td>15.172</td>
</tr>
<tr>
<td>R34</td>
<td>North West Fire Control should review how it allocates the best-trained and most suitable Control Room Operators to roles during a Major Incident. It should consider whether it is beneficial to allocate a Control Room Operator to monitor communications on a multi-agency control room talk group and another Control Room Operator as the specific point of contact for the fire and rescue service. Both roles could be supervised by a Team Leader.</td>
<td>15.210 to 15.211</td>
</tr>
<tr>
<td>R35</td>
<td>North West Fire Control should reflect on its approach to record-making during and immediately following a Major Incident, with a view to improving the current practice.</td>
<td>19.13 to 19.42</td>
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**Greater Manchester Fire and Rescue Service**

<p>| R36 | Greater Manchester Fire and Rescue Service should ensure that its commanders are adequately trained in the use of operational discretion. | 12.654 to 12.655 |
| R37 | Greater Manchester Fire and Rescue Service should review the policy by which the Incident Commander takes up the role, in light of the shortcomings I have identified in the policy in operation on 22nd May 2017. | 15.215 to 15.568 |
| R38 | Greater Manchester Fire and Rescue Service should review its guidance and policies on how it receives and passes on information during a Major Incident. It is important that, for any update given, it is established when the last time the person receiving the update was provided with information, to ensure that they are completely up to date. See also R33. | 15.172 |</p>
<table>
<thead>
<tr>
<th>R39</th>
<th>Greater Manchester Fire and Rescue Service should reflect on its approach to record-making during and immediately following a Major Incident, with a view to improving the current practice.</th>
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**Counter Terrorism Policing Headquarters**

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<tr>
<th>R40</th>
<th>Counter Terrorism Policing Headquarters should review the procedures by which it is notified of a terrorist attack to ensure that all police services know that this is an early priority.</th>
<th>13.643</th>
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**SMG**

<table>
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<tr>
<th>R41</th>
<th>SMG should review its processes to ensure that it shares with Greater Manchester Police, Greater Manchester Fire and Rescue Service, British Transport Police and North West Ambulance Service its most current emergency response plans and policies for dealing with an incident at the Arena. It should apply this approach more generally to its operations.</th>
<th>16.30</th>
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<tr>
<th>R42</th>
<th>SMG should ensure that the healthcare service provider at the Arena has a strong working relationship with North West Ambulance Service.</th>
<th>16.74 to 16.75</th>
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<tr>
<th>R43</th>
<th>SMG should ensure that the healthcare service provider at the Arena has adequate staffing and skill levels for every event at that location.</th>
<th>16.19 to 16.22</th>
</tr>
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</table>

| R44 | SMG should review its approach to the provision of healthcare service equipment at the Arena to ensure that adequate equipment is always available. | 16.54 to 16.63 |
## Issues arising at a national level

### Joint Doctrine and Joint Operating Principles

| R45 | The Home Office, His Majesty’s Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College, the National Ambulance Resilience Unit and JESIP should review and, as necessary, update the *Joint Doctrine: The Interoperability Framework* (the Joint Doctrine) and *Responding to a Marauding Terrorist Firearms Attack and Terrorist Siege: Joint Operating Principles for the Emergency Services* (the Joint Operating Principles). The following matters should be considered in that review:
<p>| | |</p>
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<tbody>
<tr>
<td>a.</td>
<td>achieving a situation in which commanders understand that the critical decisions of the commander most directly concerned in the issue under consideration are followed, unless there is a good reason for not doing so;</td>
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<tr>
<td>b.</td>
<td>achieving a situation in which risk appetite is common across the three emergency services – this will require collaborative work;</td>
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<td>c.</td>
<td>achieving a situation in which forward deployment of specialist resources is the presumption, to be displaced only in the presence of a properly evidenced basis for not deploying resources forward; and</td>
</tr>
<tr>
<td>d.</td>
<td>achieving a situation in which the possibility of a secondary device does not delay forward deployment of resources, unless there is a proper basis for believing that such a device exists.</td>
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| R46 | The Home Office, His Majesty’s Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College, the National Ambulance Resilience Unit, individual police services and JESIP should review what changes need to be made to the Major Incident plans and Counter Terrorism Policing Headquarters Operation Plato guidance in order to achieve the aims set out in R45. | 20.46 |
| R47 | The Home Office, His Majesty’s Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College, the National Ambulance Resilience Unity, individual police services and JESIP should develop a nationally agreed format for all plans, placing JESIP at their centre. | INQ042283/3 |

**Multi-agency preparedness**

| R48 | The Home Office and the Department for Levelling Up, Housing and Communities should ensure that there exist robust national and local systems to identify and record the lessons learned from all multi-agency exercises and ensure that change is implemented as a result, where change is indicated. | 12.758 |

| R49 | The Home Office and the Department for Levelling Up, Housing and Communities should ensure that there exist robust national and local systems and sufficient resources to make sure that the debrief process following multi-agency exercises is effective to capture the lessons that need to be learned. | 12.749 to 12.758 |

| R50 | The Home Office, Counter Terrorism Policing Headquarters, the College of Policing, the Fire Service College and the National Ambulance Resilience Unit should consider introducing the use of regular ‘high-fidelity training’ to give emergency responders better experience of the stress, pressure and pace of a no-notice attack. | 20.49 |

<p>| R51 | The Home Office, His Majesty’s Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College, the National Ambulance Resilience Unit and all local resilience forums should take steps to ensure, whether through multi-agency training and exercising or otherwise, that the members of each emergency service are aware of the specialist capabilities of every other emergency service. | 13.432 |</p>
<table>
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<tr>
<th>R52</th>
<th>The Home Office, the National Ambulance Resilience Unit, the College of Policing and the Fire Service College should develop guidance as to where commanders should locate during a spontaneous Major Incident. Steps should be taken to ensure that a consistent approach is taken so that equivalent commanders locate in the same place. During the response to a terrorist attack, the need for commanders on scene who are not engaged in directing individual actions should be recognised and accommodated.</th>
<th>10.134 to 10.136, 12.99, 12.190 to 12.197, 12.625 to 12.626, 13.76, 13.495 to 13.497, 14.453 to 14.457</th>
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<tr>
<td><strong>Multi-agency communication</strong></td>
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<tr>
<td>R53</td>
<td>The emergency services should prepare, train and exercise for how they will maintain effective radio communications between emergency responders on the ground, commanders and control rooms, during the response to a Major Incident.</td>
<td>Parts 12 and 13</td>
</tr>
<tr>
<td>R54</td>
<td>All police services should ensure that they have made adequate provision for Airwave Tactical Advisors, in particular that an identified Airwave Tactical Advisor is either on duty or on call at all times.</td>
<td>12.679 to 12.683, INQ042283/6</td>
</tr>
<tr>
<td>R55</td>
<td>The Home Office, the College of Policing, the Fire Service College and the National Ambulance Resilience Unit should consider together whether an app giving ready access to the contact details for all on-duty and on-call commanders is feasible and, if so, likely to be of benefit in the response to a Major Incident.</td>
<td>13.133 to 13.134</td>
</tr>
<tr>
<td>R56</td>
<td>The College of Policing and Counter Terrorism Policing Headquarters should take steps to ensure that each police service establishes a hotline that enables those within the command structure of the three emergency services to make contact with the Force Duty Officer in the event of a declaration of Operation Plato.</td>
<td>13.501</td>
</tr>
<tr>
<td>R57</td>
<td>The College of Policing, the Fire Service College and National Fire Chiefs Council should consider devising training packages for operators within control rooms, to enable them to give guidance on basic trauma care to 999 callers.</td>
<td>20.160 to 20.163</td>
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</table>
## Planning by police services

| R58 | His Majesty’s Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing and the Home Office should work together to put in place robust systems, policies and guidance to ensure that all police services have sufficient resources dedicated to the development of operational and contingency plans, particularly for responding to Major Incidents, including terrorist attacks. | 12.309 to 12.310 |

| R59 | His Majesty’s Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing and the Home Office should issue guidance for all police services on how often operational plans for responding to a Major Incident, including a terrorist incident, should be reviewed, how that review should be conducted, and what rank and experience the officers involved should have. | 12.309 to 12.310 |

| R60 | All police services should ensure that they have robust version control arrangements in place for all plans. | INQ042283/2 12.303 to 12.310 |

## The funding of police services

| R61 | The Inquiry heard evidence that the impact of public funding cuts fell disproportionately hard on metropolitan police services, such as Greater Manchester Police, compared with non-metropolitan services. In the event that public funding cuts are in the future considered necessary by the government, the Home Office should consider whether some funding arrangement for police services different from that applied in the post-2010 period is necessary. | 12.143 to 12.148 |
## Operation Plato

| R62 | The Home Office, the College of Policing and Counter Terrorism Policing Headquarters should ensure that all police officers to be appointed to the role of Force Duty Officer or Force Incident Manager attend a comprehensive training course dedicated to Operation Plato before they take up their role. Such courses must ensure that those attending understand the exceptional demands that will be placed upon them in the event of an Operation Plato declaration. Any course should include training in the following:
<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>a. the need, following a declaration of Operation Plato, to carry out regular reviews of that declaration;</td>
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<tr>
<td>b. the need to identify with clarity the Operation Plato zones at the scene or scenes covered by the declaration;</td>
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<tr>
<td>c. the need to communicate those zones to all emergency services promptly;</td>
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<tr>
<td>d. the need to keep zoning decisions under review; and</td>
<td></td>
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<tr>
<td>e. the need to work jointly with emergency service partners in the response to an Operation Plato situation.</td>
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<tr>
<td>12.315 to 12.316</td>
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</table>

| R63 | Given the broad command responsibilities that the Force Duty Officer or Force Incident Manager will have in the early stages of the response to a Major Incident, the Home Office and the College of Policing should develop nationally accredited training to prepare those officers for that role. |
| INQ042283/5 |

| R64 | Counter Terrorism Policing Headquarters and the College of Policing should ensure that all firearms officers, including firearms commanders, receive adequate training in Operation Plato, including in what such a declaration means and the demands it will place upon them. This should include instruction in the importance of zoning, communicating zoning decisions to other emergency services and joint working with those other services in the course of the response to an Operation Plato situation. |
| 12.362 13.585 |
| R65 | Counter Terrorism Policing Headquarters and the College of Policing should ensure that all unarmed frontline police officers receive training in what Operation Plato is and what will be expected of them following such a declaration. The training should include the importance of zoning, the identification of who can ordinarily work in different zones and the importance of joint working. | 12.336 to 12.347 | 13.486 |
| R66 | The College of Policing should issue guidance to all police services to ensure the following, in the event of a Major Incident:  
   a. The Force Duty Officer is not expected to deal with media enquiries.  
   b. The important task of ensuring that the media is kept informed is done in a way that does not interfere with the work of the police control room. | 13.250 |
| **Common terminology** | | |
| R67 | The Home Office, His Majesty’s Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College, the National Ambulance Resilience Unit and JESIP should ensure that all emergency services use common terminology to describe the Operation Plato hot, warm and cold zones and all have a common understanding of those terms. | 20.45 |
| R68 | Those organisations should consider what changes need to be made to the Counter Terrorism Policing Headquarters Operation Plato guidance in order to achieve those aims. | 20.46 |
| R69 | The Home Office, His Majesty’s Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College, the National Ambulance Resilience Unit and JESIP should ensure that all emergency services use common terminology to describe the zoning of hazardous areas in non-Operation Plato Major Incident situations and that all services have a common understanding of those terms. The terms should be different from those used when Operation Plato is declared. | 20.45 |
| R70 | Those organisations should consider what changes need to be made to Major Incident plans in order to achieve those aims. | 20.46 |

**Action cards**
| R71 | The Home Office, His Majesty’s Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College and the National Ambulance Resilience Unit should oversee the development and implementation of action cards for the police, fire and rescue service, and ambulance service for use in a Major Incident. This should include the following:

a. ensuring that all control room staff and commanders are trained in the use of the action cards;

b. ensuring that action cards act as a checklist, setting out the key functions of each command role, the role of control room staff and the need for joint working;

c. ensuring that action cards are available immediately to commanders and control room staff during the course of the response to a Major Incident, whether in hard copy or electronically;

d. ensuring that the use of action cards is tested regularly through exercising; and

e. ensuring that the action cards within the control rooms include a prompt to the first commander on scene to co-locate with other emergency service commanders. | 12.165 to 12.166 13.253 |

<p>| Gold and Silver Control Rooms and Strategic Co-ordinating Group meetings |
|---|---|
| R72 | Counter Terrorism Policing Headquarters and the College of Policing should review the advantages and disadvantages of a combined Silver and Gold Control Room as opposed to separate rooms, and issue guidance for all police services on best practice. | 13.505 |
| R73 | The Home Office should consider the introduction of a national standard requiring a meeting of the Strategic Co-ordinating Group to take place no more than two hours after the declaration of a Major Incident where more than one emergency service is engaged in the response to that incident. | INQ042283/4 |</p>
<table>
<thead>
<tr>
<th><strong>Embedding medics with police firearms officers</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R74</strong> Counter Terrorism Policing Headquarters should review the evidence heard during the Inquiry, including that heard in restricted sessions, to consider the advantages and disadvantages of embedding doctors with some police firearms teams, and how, if that is advantageous, it could be achieved.</td>
</tr>
<tr>
<td><strong>R75</strong> Counter Terrorism Policing Headquarters should review the experience of other jurisdictions that embed medics with police firearms officers, such as Recherche, Assistance, Intervention, Dissuasion (RAID) in France, to understand how their systems operate and whether they ought to be replicated in the UK or some further learning taken from them.</td>
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<table>
<thead>
<tr>
<th><strong>Role of air ambulance services</strong></th>
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<tbody>
<tr>
<td><strong>R76</strong> The Department of Health and Social Care, the NHS, the National Ambulance Resilience Unit, ambulance service trusts, Air Ambulances UK, Counter Terrorism Policing Headquarters and JESIP should consider whether air ambulances should be integrated into the emergency response to Major Incidents, including terrorist attacks, and, if so, how that is to be achieved.</td>
</tr>
<tr>
<td><strong>R77</strong> The Department of Health and Social Care, the NHS, the National Ambulance Resilience Unit, ambulance service trusts, Air Ambulances UK, Counter Terrorism Policing Headquarters and JESIP should consider what staff training and resources would be required to integrate air ambulance organisations into the emergency response to Major Incidents, including terrorist attacks.</td>
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<table>
<thead>
<tr>
<th><strong>Police command structure</strong></th>
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</table>
| **R78** Counter Terrorism Policing Headquarters and the College of Policing should issue guidance on the circumstances in which a police officer or officers with responsibility for the tactical/silver command of the unarmed officers at the scene or scenes of a Major Incident should deploy to that scene or scenes. | 13.461  
13.497  
13.540 |
| R79 | The College of Policing and His Majesty’s Inspectorate of Constabulary and Fire and Rescue Services should ensure that each police service has in place a system that means appropriately qualified and experienced personnel are rostered 24 hours each day so that, in the event of a terrorist attack or any Major Incident, a prepared and effective command structure can be geared up swiftly. | 13.548 |
| Use of explosives detection dogs |
| R80 | The Home Office, His Majesty’s Inspectorate of Constabulary and Fire and Rescue Services, Counter Terrorism Policing Headquarters and the College of Policing should take steps to ensure that all police services have in place effective systems for the prompt deployment of explosives detection dogs in circumstances in which such animals are needed. | 13.359 to 13.364 |
| Notification of pre-planned events |
| R81 | The Home Office, the College of Policing and His Majesty’s Inspectorate of Constabulary and Fire and Rescue Services should develop a system for ensuring that the duty command structure in each police service has notice of any significant pre-planned event, such as a major concert or sports match, taking place within the police service area. | 13.491 |
| R82 | The Department of Health and Social Care and the National Ambulance Resilience Unit should develop a system for ensuring that the duty command structure in each ambulance service has notice of any significant pre-planned event, such as a major concert or sports match, taking place within the ambulance service area. | 14.100 |
| R83 | The Home Office, His Majesty’s Inspectorate of Constabulary and Fire and Rescue Services, and the Fire Service College should develop a system for ensuring that the duty command structure in each fire and rescue service has notice of any significant pre-planned event, such as a major concert or sports match, taking place within the fire and rescue service area. | 14.100 |
## Record-keeping

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Description</th>
<th>Paragraphs</th>
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<tbody>
<tr>
<td>R84</td>
<td>The Home Office, the College of Policing, the National Ambulance Resilience Unit and the Fire Service College should ensure that all those who may be required to take up a command position in the event of a Major Incident are issued with a means to record what they say, hear and see unless there are good reasons why they should not be so equipped.</td>
<td>19.22 to 19.29</td>
</tr>
<tr>
<td>R85</td>
<td>Consideration should also be given by those organisations to the provision of such equipment to key personnel within control rooms.</td>
<td>19.22 to 19.29</td>
</tr>
<tr>
<td>R86</td>
<td>The Home Office, the College of Policing, the National Ambulance Resilience Unit and the Fire Service College should ensure that training is given to all who are issued with such equipment, on the circumstances in which it should be used and the importance of its use.</td>
<td>19.22 to 19.29</td>
</tr>
<tr>
<td>R87</td>
<td>The Home Office, the College of Policing, the National Ambulance Resilience Unit and the Fire Service College should ensure that, in the course of exercises, such equipment is used by those who would use it in the circumstances of a real-life incident.</td>
<td>19.22 to 19.29</td>
</tr>
<tr>
<td>R88</td>
<td>The Home Office, the College of Policing, the National Ambulance Resilience Unit and the Fire Service College should take steps to ensure that all emergency services understand the importance of promptly obtaining comprehensive accounts from commanders as part of the debrief process following a Major Incident.</td>
<td>19.43 to 19.46</td>
</tr>
<tr>
<td>R89</td>
<td>The College of Policing should assess whether delays in the provision of written accounts by some firearms officers involved in the response to the Attack were due to Post-Incident Procedures. If so, those procedures should be reviewed.</td>
<td>19.14</td>
</tr>
<tr>
<td>R90</td>
<td>The Home Office, Counter Terrorism Policing Headquarters and the College of Policing should consider whether firearms officers should be equipped routinely with body-worn video cameras.</td>
<td>13.316</td>
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## Police training and training records

<table>
<thead>
<tr>
<th>Recommendation</th>
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<tr>
<td>R91</td>
<td>The Home Office and College of Policing should ensure that any police officer whose position carries with it the expectation that they will assume a Tactical/Silver Commander role in the event of a spontaneous Major Incident (e.g. Night Silver in Greater Manchester Police) has undertaken an accredited course preparing them for that role.</td>
<td>INQ042283/4-5</td>
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<tr>
<td>Reference</td>
<td>Recommendation</td>
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| R92 | The College of Policing should consider whether the current process for maintaining and storing training records for all police officers can be improved. That should include assessing the following:  
  a. the introduction of electronic training records in a standard form across all police services;  
  b. the introduction of centrally held electronic training records for all police officers; and  
  c. the introduction of a system whereby each police officer is required to view their record each year and identify any errors or omissions within it. |
| INQ042283/4 | 13.488 to 13.490 |
| **First aid** | |
| R93 | The Home Office and College of Policing should ensure that all newly recruited and existing police officers and all frontline police staff, such as Police Community Support Officers, are trained in first responder interventions. |
|  | 20.170 to 20.174 |
| R94 | Each police service must ensure that adequate time is allocated to the training of all police officers and frontline police staff in first responder interventions. |
|  | 20.170 to 20.174 |
| R95 | The Home Office and the College of Policing should regularly assess and appraise the training on first responder interventions provided by each police service to ensure that it is of an appropriate quality and that adequate time is allocated to it. |
|  | 20.170 to 20.174 |
| R96 | The College of Policing and Counter Terrorism Policing Headquarters should ensure that all firearms officers are trained to understand that, while their primary role in an Operation Plato situation is to neutralise any armed terrorist, their role also involves providing Care Under Fire. |
|  | 20.175 to 20.182 |
| R97 | The College of Policing and Counter Terrorism Policing Headquarters should review whether firearms officers should be deployed with analgesia and trained in its use, as part of providing Care Under Fire. |
|  | 20.183 |
| **Local resilience forums at a national level** | |
| R98 | Local resilience forums have a vital role in the preparation for the response to any Major Incident. The Cabinet Office and the Home Office should consider implementing an independent inspection regime for local resilience forums. |
|  | INQ042283/1 |
|  | 12.78 to 12.81 |
| R99 | Each emergency service should ensure that it is represented at a senior level at every meeting of a local resilience forum. | 12.21 12.44 to 12.61 |
| R100 | Local resilience forums should monitor attendance and participation at their meetings, and flag promptly any concerns about attendance by members to the leadership of the organisation concerned. The Home Office should ensure that this is being done by local resilience forums. | 12.21 12.44 to 12.61 |
| R101 | The Home Office should consider empowering the leadership of local resilience forums to compel the attendance of a senior representative of its Category 1 and Category 2 responders at all local resilience forum meetings. Inspections by His Majesty’s Inspectorate of Constabulary and Fire and Rescue Services should include an analysis of a service’s engagement with its local resilience forum or forums. Consideration should be given to putting this on a statutory footing. | 12.21 12.44 to 12.61 |
| R102 | The Home Office should consider how local resilience forums are to be funded consistently and sufficiently to enable them to do their important work. | 12.39 |
| R103 | The Home Office should consider, together with local resilience forums, how they are to have sufficient staff and resources to enable them to function effectively. | 12.40 |
| R104 | Local resilience forums should establish procedures to ensure that they oversee the process of identifying the lessons to be learned from major exercises, or serious incidents, in their areas, and that they are responsible for overseeing the debriefing of those events. | 12.74 to 12.77 |

**Ambulance services at a national level**

**Resources**

<p>| R105 | Ambulance service trusts should review their capacity to respond to a mass casualty incident. That should include an assessment of whether they have an adequate number of trained specialist personnel to respond effectively to a mass casualty incident. | 20.11 to 20.23 |
| R106 | Having carried out that review, the trusts should make recommendations to their NHS commissioners about the additional and/or different resources they require in order to ensure that they are able to respond effectively to a mass casualty incident in the numbers required. | 20.11 to 20.23 |</p>
<table>
<thead>
<tr>
<th>R107</th>
<th>The Department of Health and Social Care should give urgent and close consideration to any recommendations made by the trusts and the NHS commissioners.</th>
<th>20.11 to 20.23</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hazardous Area Response Team (HART)</strong></td>
<td><strong>R108</strong> The Department of Health and Social Care and the National Ambulance Resilience Unit should develop procedures to ensure that, so far as possible, each ambulance service trust is able to deploy or call upon HART resources immediately in the event of a Major Incident. As part of that, the Department of Health and Social Care and the National Ambulance Resilience Unit should develop procedures to ensure that, so far as possible, each ambulance service trust can call upon cross-border support in respect of HART resources immediately in the event of a Major Incident. There may be some incidents that are so significant that an individual ambulance service will need to mobilise its own HART resources and also draw upon cross-border support. Procedures need to accommodate this.</td>
<td>20.24 to 20.25 INQ042167/9</td>
</tr>
<tr>
<td>R109</td>
<td>All ambulance service trusts should undertake training and exercising with neighbouring ambulance service trusts to ensure that cross-border support is efficient and effective.</td>
<td>INQ042167/10</td>
</tr>
<tr>
<td>R110</td>
<td>The Department of Health and Social Care and the National Ambulance Resilience Unit should ensure that all ambulance commanders receive regular Major Incident training. The training should include training on HART capabilities, on all the command roles and where they will be located, on how to gain situational awareness through the deployment of sector commanders and other roles, on the importance of getting ambulance personnel to casualties without delay and on the circumstances in which they may use operational discretion.</td>
<td>20.26 to 20.27 14.214</td>
</tr>
<tr>
<td>R111</td>
<td>The Department of Health and Social Care and the National Ambulance Resilience Unit should consider ensuring that there is further training of HART personnel so that at least one member on every HART deployment has the ability to deliver the most enhanced care interventions.</td>
<td>20.86 to 20.87</td>
</tr>
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</table>
### New triage tools

<table>
<thead>
<tr>
<th>R112</th>
<th>The team led by Philip Cowburn has devised a tool that is designed to replace the existing systems of primary and secondary triage. It is known as the Major Incident Triage Tool. It already has the support of NHS England. The National Ambulance Resilience Unit and all ambulance services should consider introducing the Major Incident Triage Tool as a matter of urgency.</th>
<th>20.108</th>
</tr>
</thead>
<tbody>
<tr>
<td>R113</td>
<td>The team led by Philip Cowburn has devised a tool that is designed for use by a wide range of emergency responders in a mass casualty situation. It is known as Ten Second Triage. The National Ambulance Resilience Unit, the College of Policing and the Fire Service College should consider as a matter of urgency whether all of their frontline staff should be trained in the use of Ten Second Triage.</td>
<td>20.109 to 20.115</td>
</tr>
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</table>

### Other matters relating to ambulance services

| R114 | The Department of Health and Social Care and the National Ambulance Resilience Unit should consider whether the Advanced Medical Priority Dispatch System is fit for purpose and, if it is, whether it can be improved. Particular consideration should be given to how the system prioritises emergency calls. | 14.101 to 14.104 |
| R115 | The Department of Health and Social Care, the Faculty of Pre-Hospital Care, the College of Paramedics and the National Ambulance Resilience Unit should review the current model for evacuation to hospital operated in the UK by reference to the different approaches around the world in order to see whether triage at different times and in different places remains best practice, or whether there should be a greater emphasis on rapid evacuation to hospital. | 20.88 to 20.96 |
| R116 | A significant issue in a mass casualty situation is that all of those paramedics who have arrived in ambulances may be required for the treatment of casualties, so that no paramedic is available to drive patients to hospital. The Department of Health and Social Care and the National Ambulance Resilience Unit should consider how to resolve that problem. Consideration should be given to the training of other emergency service personnel in driving ambulances. | 20.94 to 20.95 INQ042167/6-8 |
| R117 | The Department of Health and Social Care and the National Ambulance Resilience Unit should consider whether the Basic Life Support and Advanced Life Support bags used by paramedics should contain SMART Triage Tags or an equivalent. | 14.112 |
| R118 | The Department of Health and Social Care and the Medicines and Healthcare products Regulatory Agency (MHRA) should consider urgently whether the regulatory regime should be altered to enable analgesia, such as fentanyl lozenges or sufentanil sublingual tablets, to be given by paramedics to injured persons. | 20.118 to 20.128 |
| R119 | If the decision is that the regulatory regime should be altered in this way, the National Ambulance Resilience Unit should consider urgently whether the use of such analgesia should be rolled out to all Hazardous Area Response Team and other specialist operatives, as part of their basic equipment, and to paramedics more generally. | 20.118 to 20.128 |
| R120 | The Department of Health and Social Care, the Faculty of Pre-Hospital Care, the College of Paramedics and the National Ambulance Resilience Unit should consider whether all Hazardous Area Response Team operatives should be deployed with freeze-dried plasma and trained in its use. | 20.139 to 20.140 |
| R121 | The Department of Health and Social Care, the Faculty of Pre-Hospital Care, the College of Paramedics and the National Ambulance Resilience Unit should undertake a review into whether frontline ambulances should carry intramuscular tranexamic acid or TXA. | 20.141 to 20.143 |
| R122 | The Department of Health and Social Care and the National Ambulance Resilience Unit should review whether stretchers should be carried on National Capability Mass Casualty Equipment Vehicles. | 14.461 |
| R123 | The Department of Health and Social Care, the Faculty of Pre-Hospital Care, the College of Paramedics and the National Ambulance Resilience Unit should consider issuing guidance on how to ensure that specialist paramedics take with them, into a warm zone, equipment that enables them to carry out bridging interventions. | 20.218 to 20.219 |
| R124 | All ambulance service trusts should consider appointing a person within their control rooms who, in the event of a Major Incident, has the sole role of gathering and collating all available information and intelligence, and sharing it internally and externally to the extent appropriate. | INQ042167/11 |
| R125 | The terms Casualty Collection Point and Casualty Clearing Station are capable of being confused, one for the other, particularly in circumstances of stress. That happened on the night of the Attack. The National Ambulance Resilience Unit should consider whether different and more distinct terms should be used for these two locations. | 14.230 14.335 to 14.349 |

**Ambulance Liaison Officers**

| R126 | The Department of Health and Social Care and the National Ambulance Resilience Unit should consider the scope of the role of an Ambulance Liaison Officer and issue guidance to ambulance services in that regard. | 20.203 to 20.209 |
| R127 | The Home Office and the Department of Health and Social Care should consider how the threshold for a requirement that an Ambulance Liaison Officer be present at an event is to be identified. | 20.203 to 20.209 |
| R128 | The Home Office, the Department of Health and Social Care and the National Ambulance Resilience Unit should consider how to ensure that the role of an Ambulance Liaison Officer is properly resourced and also whether venue operators should fund the presence of an Ambulance Liaison Officer where one is required. | 20.203 to 20.209 |
| R129 | The Home Office should consider how the presence of an Ambulance Liaison Officer in appropriate circumstances may be made mandatory. This may need to be put on a statutory footing. | 20.203 to 20.209 |

**Fire and rescue services at a national level**

<p>| R130 | The National Fire Chiefs Council and the Fire Service College should establish a scheme for ensuring that all fire fighters are trained in first responder interventions. | 20.184 to 20.185 |
| R131 | All fire and rescue services should consider appointing a person within their control rooms who, in the event of a Major Incident, has the sole role of gathering and collating all available information and intelligence, and sharing it internally and externally to the extent appropriate. | INQ042111/6 |</p>
<table>
<thead>
<tr>
<th>Event healthcare services at a national level</th>
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<tbody>
<tr>
<td><strong>R132</strong></td>
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<td><strong>R133</strong></td>
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<td><strong>R134</strong></td>
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<td><strong>R138</strong></td>
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<td>Security Industry Authority</td>
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<td>The public</td>
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<td><strong>Public Access Trauma kits</strong></td>
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<td><strong>Stretchers</strong></td>
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<td>R148</td>
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<td>R149</td>
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Monitored Recommendations

21.39 Of the Recommendations I have made above, I indicate below those I propose to monitor. The numbering is not intended to indicate importance or priority.

21.40 I have grouped the Volume 2 Recommendations together thematically. The effect of this is that there are Monitored Recommendations, which comprise more than one of the Recommendations I made above. This means that some reporting organisations are only expected to report back against specific Recommendations within a Monitored Recommendation. I have identified below which organisations I expect to address each Monitored Recommendation.

21.41 As I did for Volume 1, I shall take a staged approach to monitoring the Recommendations arising out of Volume 2.

21.42 First, I will require an update as to progress from those reporting against the Monitored Recommendations. This will be due approximately three months after the publication of Volume 2. Responses will be added to the Inquiry’s website.

21.43 Second, I will require witness statements from named individuals within each reporting
organisation. Each statement will be required approximately six months after the publication of Volume 2. The witness statements will be added to the Inquiry’s website.

21.44 Third, the Solicitor to the Inquiry will inform those who made the witness statements, as well as all Core Participants, which of those witnesses I intend to hear live evidence from. I will permit a brief window for submissions to be made on this.

21.45 Fourth, I will receive live evidence from those witnesses from whom I consider I should hear. I anticipate hearing that evidence during the summer of 2023.

21.46 The Solicitor to the Inquiry will contact those organisations who are the subject of the Monitored Recommendations and provide exact dates for each stage and to assist in the identification of the individual who can provide witness evidence.

21.47 As I said in Volume 1, it should be understood that I intend to scrutinise what has been done in response to the Monitored Recommendations and use all of the powers available to me, if required, to achieve transparency and accountability.
<table>
<thead>
<tr>
<th>Monitored Recommendations</th>
<th>Reporter</th>
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<td>MR10 British Transport Police</td>
<td>• BTP</td>
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<td>Recommendations R2, R3, R4, R5, R6, R7</td>
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<td>MR11 Greater Manchester Police</td>
<td>• GMP</td>
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<tr>
<td>MR13 North West Fire Control</td>
<td>• NWFC</td>
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<td>Recommendations R28, R29, R30, R31, R32, R33, R34, R35</td>
<td>• GMFRS</td>
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<td>MR14 Greater Manchester Fire and Rescue Service</td>
<td>• GMFRS</td>
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<td>Recommendations R36, R37, R38, R39</td>
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<td>MR15 SMG</td>
<td>• SMG</td>
</tr>
<tr>
<td>Recommendations R41, R42, R43, R44</td>
<td></td>
</tr>
<tr>
<td>MR16 Operation Plato</td>
<td>• Home Office</td>
</tr>
<tr>
<td>Recommendations R62, R63, R64, R65, R66</td>
<td>• College of Policing</td>
</tr>
<tr>
<td>MR17 Use of explosives detection dogs</td>
<td>• Home Office</td>
</tr>
<tr>
<td>Recommendation R80</td>
<td>• HMICFRS</td>
</tr>
<tr>
<td>MR18 First aid</td>
<td>• College of Policing</td>
</tr>
<tr>
<td>Recommendations R93, R94, R95, R96, R97</td>
<td>• Home Office</td>
</tr>
<tr>
<td>MR19 New triage tools</td>
<td>• CTPHQ</td>
</tr>
<tr>
<td>Recommendations R112, R113</td>
<td></td>
</tr>
<tr>
<td>MR20 Other matters relating to ambulance services</td>
<td>• DHSC</td>
</tr>
<tr>
<td>Recommendations R114, R115, R116, R117, R118, R119, R120, R121, R122, R123, R124, R125</td>
<td>• NARU</td>
</tr>
<tr>
<td>MR20 Other matters relating to ambulance services</td>
<td>• Faculty of Pre-Hospital Care</td>
</tr>
<tr>
<td>Recommendations R114, R115, R116, R117, R118, R119, R120, R121, R122, R123, R124, R125</td>
<td>• College of Paramedics</td>
</tr>
<tr>
<td>MR20 Other matters relating to ambulance services</td>
<td>• MHRA</td>
</tr>
<tr>
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</tr>
<tr>
<td>Monitored Recommendations</td>
<td>Reporter</td>
</tr>
<tr>
<td>---------------------------</td>
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</tr>
<tr>
<td>MR21</td>
<td>Event healthcare services at a national level</td>
</tr>
<tr>
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<td>Recommendations R132, R133, R134, R135, R136, R137, R138, R139</td>
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Appendices

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## Appendix 9: List of abbreviations

### Organisations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACPO</td>
<td>Association of Chief Police Officers</td>
</tr>
<tr>
<td>ACPO (TAM)</td>
<td>Association of Chief Police Officers (Terrorism and Allied Matters)</td>
</tr>
<tr>
<td>BTP</td>
<td>British Transport Police</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CPS</td>
<td>Crown Prosecution Service</td>
</tr>
<tr>
<td>CTPHQ</td>
<td>Counter Terrorism Policing Headquarters</td>
</tr>
<tr>
<td>CTPNW</td>
<td>Counter Terrorism Policing North West</td>
</tr>
<tr>
<td>DHSC</td>
<td>Department of Health and Social Care</td>
</tr>
<tr>
<td>DLUHC</td>
<td>Department for Levelling Up, Housing and Communities</td>
</tr>
<tr>
<td>ETUK</td>
<td>Emergency Training UK</td>
</tr>
<tr>
<td>GMFRS</td>
<td>Greater Manchester Fire and Rescue Service</td>
</tr>
<tr>
<td>GMP</td>
<td>Greater Manchester Police</td>
</tr>
<tr>
<td>GMRF</td>
<td>Greater Manchester Resilience Forum</td>
</tr>
<tr>
<td>HMG</td>
<td>Her Majesty’s Government (prior to 8th September 2022)/His Majesty’s Government (from 8th September 2022)</td>
</tr>
<tr>
<td>HMICFRS</td>
<td>Her Majesty’s Inspectorate of Constabulary and Fire and Rescue Services (prior to 8th September 2022)/His Majesty’s Inspectorate of Constabulary and Fire and Rescue Services (from 8th September 2022)</td>
</tr>
</tbody>
</table>
HMPPS Her Majesty’s Prison and Probation Service (prior to 8th September 2022)/His Majesty’s Prison and Probation Service (from 8th September 2022)
LFB London Fire Brigade
LFRS Lancashire Fire and Rescue Service
MHRA Medicines and Healthcare products Regulatory Agency
MPS Metropolitan Police Service
NARU National Ambulance Resilience Unit
Nwas North West Ambulance Service
NWCTU North West Counter Terrorist Unit
NWFC North West Fire Control
SIA Security Industry Authority

Individuals

SA Salman Abedi
HA Hashem Abedi
# Ranks and roles

<table>
<thead>
<tr>
<th>Rank</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC</td>
<td>Assistant Chief Constable</td>
</tr>
<tr>
<td>ACSO</td>
<td>Assistant Commissioner Specialist Operations</td>
</tr>
<tr>
<td>CI</td>
<td>Chief Inspector</td>
</tr>
<tr>
<td>CTSFO</td>
<td>Counter Terrorist Specialist Firearms Officer</td>
</tr>
<tr>
<td>DAC</td>
<td>Deputy Assistant Commissioner</td>
</tr>
<tr>
<td>DC</td>
<td>Detective Constable</td>
</tr>
<tr>
<td>DCC</td>
<td>Deputy Chief Constable</td>
</tr>
<tr>
<td>DCI</td>
<td>Detective Chief Inspector</td>
</tr>
<tr>
<td>DCS</td>
<td>Detective Chief Superintendent</td>
</tr>
<tr>
<td>DI</td>
<td>Detective Inspector</td>
</tr>
<tr>
<td>DS</td>
<td>Detective Sergeant</td>
</tr>
<tr>
<td>EMT</td>
<td>Emergency Medical Technician</td>
</tr>
<tr>
<td>EMT-A</td>
<td>Emergency Medical Technicians Advanced</td>
</tr>
<tr>
<td>EMT-B</td>
<td>Emergency Medical Technicians Basic</td>
</tr>
<tr>
<td>FDO</td>
<td>Force Duty Officer</td>
</tr>
<tr>
<td>NILO</td>
<td>National Interagency Liaison Officer</td>
</tr>
<tr>
<td>PC</td>
<td>Police Constable</td>
</tr>
<tr>
<td>PCSO</td>
<td>Police Community Support Officer</td>
</tr>
</tbody>
</table>
### Other

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMPDS</td>
<td>Advanced Medical Priority Dispatch System</td>
</tr>
<tr>
<td>CSCATTT</td>
<td>Command and Control; Safety; Communication; Assessment; Triage; Treatment; Transport</td>
</tr>
<tr>
<td>CT</td>
<td>computerised tomography</td>
</tr>
<tr>
<td>CT2</td>
<td>Counter-Terrorism Policing Part 2</td>
</tr>
<tr>
<td>FALP</td>
<td>First Aid Learning Programme</td>
</tr>
<tr>
<td>FCP</td>
<td>Forward Command Post</td>
</tr>
<tr>
<td>HART (NWAS)</td>
<td>Hazardous Area Response Team</td>
</tr>
<tr>
<td>HQ</td>
<td>Headquarters</td>
</tr>
<tr>
<td>IED</td>
<td>Improvised Explosive Device</td>
</tr>
<tr>
<td>JESIP</td>
<td>Joint Emergency Services Interoperability Principles</td>
</tr>
<tr>
<td>JOPs</td>
<td>Joint Operating Principles</td>
</tr>
<tr>
<td>MEN</td>
<td>Manchester Evening News</td>
</tr>
<tr>
<td>METHANE</td>
<td>Major Incident; Exact Location; Type of Incident; Hazards; Number of Casualties; Emergency Services (see Figure 23 in Part 11 in Volume 2-I)</td>
</tr>
<tr>
<td>MIMMS</td>
<td>Major Incident Medical Management and Support</td>
</tr>
<tr>
<td>MITT</td>
<td>Major Incident Triage Tool</td>
</tr>
<tr>
<td>PAcT</td>
<td>Public Access Trauma (first-aid kit)</td>
</tr>
<tr>
<td>PDA</td>
<td>pre-determined attendance</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
PPE | personal protective equipment |
PTSD | post-traumatic stress disorder |
RAID | Recherche, Assistance, Intervention, Dissuasion team |
REBOA | resuscitative endovascular balloon occlusion of the aorta |
RVP | Rendezvous Point |
SOP | Standard Operating Procedure |
SORT | Special Operations Response Team |
TATP | triacetone triperoxide |
TST | Ten Second Triage |
TXA | tranexamic acid |
Appendix 10: Key events in the emergency response – chronology

A10.1 In this chronology, I have recorded the key events of the emergency response on 22\textsuperscript{nd} and 23\textsuperscript{rd} May 2017. My intention is that this chronology will give a reader an understanding of how the different emergency services’ responses developed over time and in relation to each other.

A10.2 The considerable assistance given to me by Operation Manteline has meant that many of the timings have been checked and confirmed against the evidence. There are other timings where such a check has not been possible. In relation to these, I have recorded the most likely time based upon the surrounding evidence.

Key

- Blue: British Transport Police (BTP)
- Purple: Greater Manchester Police (GMP)
- Red: Greater Manchester Fire and Rescue Service (GMFRS)
- Orange: North West Fire Control (NWFC)
- Green: North West Ambulance Service (NWAS)
- Light Green: Emergency Training UK (ETUK)
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>22:31</td>
<td><strong>GMP</strong> received its first 999 call from a member of the public.¹</td>
</tr>
<tr>
<td>22:32</td>
<td><strong>NWAS</strong> received its first 999 call from a member of the public.²</td>
</tr>
<tr>
<td></td>
<td>The first emergency responder, <strong>BTP</strong> Police Constable (PC) Jessica Bullough, entered the City Room.³</td>
</tr>
<tr>
<td>22:34</td>
<td>The first <strong>BTP</strong> patrol vehicle arrived at the Victoria Exchange Complex on Station Approach.⁴</td>
</tr>
<tr>
<td></td>
<td>The first <strong>ETUK</strong> medic, Elizabeth Woodcock, entered the City Room.⁵</td>
</tr>
<tr>
<td></td>
<td><strong>GMP</strong> Inspector Dale Sexton became aware of the Attack and simultaneously became <strong>GMP</strong> Tactical/Silver and Strategic/Gold Commander.⁶</td>
</tr>
<tr>
<td></td>
<td><strong>GMP</strong> Inspector Michael Smith was informed of the Attack by <strong>GMP</strong> Control.⁷</td>
</tr>
<tr>
<td></td>
<td><strong>NWFC</strong> received its first notification of the Attack from <strong>GMP</strong>.⁸</td>
</tr>
<tr>
<td>22:36</td>
<td>Director of <strong>ETUK</strong>, Ian Parry, entered the City Room.⁹</td>
</tr>
<tr>
<td>22:37</td>
<td><strong>NWAS</strong> Control notified <strong>NWFC</strong> of the Attack.¹⁰</td>
</tr>
<tr>
<td>22:38</td>
<td>During the call with <strong>GMP</strong>, <strong>NWFC</strong> created an incident log which sent a pre-alert to <strong>GMFRS</strong> Manchester Central Fire Station.¹¹</td>
</tr>
<tr>
<td></td>
<td><strong>NWAS</strong> on-call Tactical Commander Annemarie Rooney was informed of the Attack.¹²</td>
</tr>
</tbody>
</table>

---

1  52/125/14-126/13, INQ023493T/19-22  
2  52/127/22-128/11, INQ015293T  
3  52/131/16-22, INQ035612/14  
4  52/133/21-134/7, INQ035612/21  
5  52/134/10-14, INQ035612/22  
6  INQ007214/8  
7  102/176/21-177/13, INQ018514T/4  
8  122/177/24-178/7, INQ001231/2  
9  52/145/2-6, INQ035612/43  
10  53/4/12-5/9, INQ001218/1  
11  122/177/21-179/9, 69/133/22-134/15, INQ008376/3  
12  115/114/12-20, INQ015353T
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<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>22:39</td>
<td><strong>BTP</strong> Force Incident Manager, Inspector Benjamin Dawson, declared a Major Incident.(^{13}) <strong>GMP</strong> Temporary Superintendent Arif Nawaz (Night Silver) was informed of the Attack by <strong>GMP</strong> Force Duty Supervisor Ian Randall.(^{14})</td>
</tr>
<tr>
<td>22:40</td>
<td><strong>NWFC</strong> informed the <strong>GMFRS</strong> duty National Interagency Liaison Officer (NILO), Station Manager Andrew Berry, of the Attack. Station Manager Berry instructed <strong>NWFC</strong> to mobilise <strong>GMFRS</strong> crews to Philips Park Fire Station as a muster point.(^{15}) <strong>GMP</strong> Inspector Sexton granted Firearms Authority and assumed the role of Initial Tactical Firearms Commander and Strategic Firearms Commander.(^{16}) <strong>NWAS</strong> Tactical Commander Annemarie Rooney telephoned <strong>NWAS</strong> Strategic Commander Neil Barnes to notify him of the Attack and left a voicemail message.(^{17})</td>
</tr>
<tr>
<td>22:41</td>
<td><strong>NWFC</strong> received its only 999 call from a member of the public.(^{18}) First two <strong>GMP</strong> Armed Response Vehicles recorded on Station Approach.(^{19}) <strong>BTP</strong> informed <strong>NWAS</strong> that it had declared a Major Incident.(^{20}) <strong>NWAS</strong> Tactical Commander Annemarie Rooney informed <strong>NWAS</strong> Consultant Paramedic Daniel Smith of the Attack.(^{21})</td>
</tr>
<tr>
<td>22:42</td>
<td><strong>GMP</strong> PC Troy Tyldesley and PC James Dalton entered the Victoria Exchange Complex. They were the first firearms officers to do so.(^{22}) First <strong>NWAS</strong> paramedic, Patrick Ennis, arrived outside the Victoria Exchange Complex in a rapid response vehicle.(^{23})</td>
</tr>
<tr>
<td>Time</td>
<td>Event</td>
</tr>
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<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>22:43</td>
<td><strong>GMP</strong> firearms officers PC Lee Moore and PC James Simpkin conducted a ‘raw check’ of the City Room&lt;sup&gt;23&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td><strong>BTP</strong> nominated the Fishdock car park as a Rendezvous Point.&lt;sup&gt;24&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td><strong>NWas</strong> informed <strong>BTP</strong> that it was sending crews to Manchester Central Fire Station.&lt;sup&gt;25&lt;/sup&gt;</td>
</tr>
<tr>
<td>22:44</td>
<td><strong>BTP</strong> Chief Superintendent Allan Gregory was informed of the Attack by <strong>BTP</strong> Senior Duty Officer, Chief Inspector (CI) Antony Lodge.&lt;sup&gt;26&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td><strong>GMP</strong> Operational/Bronze Commander, Inspector Michael Smith, arrived at the Victoria Exchange Commander Complex.&lt;sup&gt;27&lt;/sup&gt;</td>
</tr>
<tr>
<td>22:45</td>
<td><strong>NWas</strong> declared a Major Incident.&lt;sup&gt;28&lt;/sup&gt;</td>
</tr>
<tr>
<td>22:46</td>
<td><strong>GMP</strong> Operational Firearms Commander, PC Edward Richardson, entered the City Room.&lt;sup&gt;29&lt;/sup&gt;</td>
</tr>
<tr>
<td>22:47</td>
<td><strong>GMP</strong> Inspector Sexton declared Operation Plato.&lt;sup&gt;30&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td><strong>GMP</strong> Operational/Bronze Commander, Inspector Michael Smith, entered the City Room.&lt;sup&gt;31&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

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23  76/62/14-63/8  
24  74/97/1-8, INQ028932/15  
25  INQ015145T  
26  93/106/9-107/10  
27  53/24/12-20, INQ035612/89  
28  53/27/11-28/22  
29  INQ035612/101-103  
30  53/36/2-17, INQ024325/1  
31  102/191/10-192/1, INQ035612/113
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<th>Event</th>
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<tbody>
<tr>
<td>22:50</td>
<td><strong>NWAS</strong> Advanced Paramedic Patrick Ennis entered the Victoria Exchange Complex. Within seconds, he informed <strong>NWAS</strong> Control that all ambulances should come to Hunts Bank. <strong>GMP</strong> PC Grace Barker approached <strong>NWAS</strong> Advanced Paramedic Patrick Ennis and advised all <strong>NWAS</strong> paramedics to go to “the booking office”. <strong>NWAS</strong> Consultant Paramedic Daniel Smith instructed <strong>NWAS</strong> Control to maintain Manchester Central Fire Station as the Rendezvous Point.</td>
</tr>
<tr>
<td>22:51</td>
<td><strong>GMP</strong> Control informed <strong>NWAS</strong> Control that all available ambulances should go to “Hunts Bank”.</td>
</tr>
<tr>
<td>22:52</td>
<td><strong>GMP</strong> CI Mark Dexter assumed the role of Ground Assigned Tactical Firearms Commander and agreed that <strong>GMP</strong> Temporary CI Rachel Buckle would become the Tactical Firearms Commander at <strong>GMP</strong> Headquarters (<strong>GMP</strong> HQ). <strong>GMP</strong> Strategic/Gold Commander, Assistant Chief Constable (ACC) Deborah Ford, was informed of the Attack by <strong>GMP</strong> Tactical/Silver Commander, Temporary Superintendent Nawaz. <strong>GMFRS</strong> duty Group Manager Dean Nankivell was informed of the Attack by <strong>NWFC</strong>.</td>
</tr>
<tr>
<td>22:53</td>
<td><strong>NWAS</strong> Advanced Paramedic Patrick Ennis entered the City Room for the first time.</td>
</tr>
</tbody>
</table>

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32 53/45/15-23, INQ035612/130  
33 INQ035612/132, INQ032872T  
34 76/78/10-79/12  
35 INQ015056T  
36 INQ015139T/1, INQ015139T/2  
37 106/146/9-21  
38 105/39/17-21, 104/38/20-39/8  
39 INQ001224  
40 INQ035612/143
<table>
<thead>
<tr>
<th>Time</th>
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</tr>
</thead>
<tbody>
<tr>
<td>22:54</td>
<td><strong>NWAS</strong> Advanced Paramedic Patrick Ennis sent a METHANE message to <strong>NWAS</strong> Control.</td>
</tr>
<tr>
<td></td>
<td>First <strong>GMFRS</strong> Manchester Central Fire Station appliance arrived at Philips Park Fire Station.</td>
</tr>
<tr>
<td></td>
<td><strong>GMP</strong> Counter Terrorist Specialist Firearms Officers arrived at the Victoria Exchange Complex.</td>
</tr>
<tr>
<td>22:55</td>
<td>First <strong>GMP</strong> Tactical Aid Unit of eight officers, led by Sergeant Kam Hare, entered the City Room.</td>
</tr>
<tr>
<td>22:56</td>
<td><strong>BTP</strong> Gold Commander, ACC Robin Smith, was informed of the Attack by <strong>BTP</strong> CI Lodge.</td>
</tr>
<tr>
<td>22:57</td>
<td>Saffie-Rose Roussos was carried out of the City Room on a makeshift stretcher.</td>
</tr>
<tr>
<td>22:58</td>
<td>First <strong>NWAS</strong> ambulance arrived at the Victoria Exchange Complex.</td>
</tr>
<tr>
<td></td>
<td>Saffie-Rose Roussos was carried out of the Victoria Exchange Complex onto Trinity Way.</td>
</tr>
<tr>
<td></td>
<td><strong>BTP</strong> Force Incident Manager, Inspector Dawson, received a METHANE message from <strong>BTP</strong> Sergeant David Cawley.</td>
</tr>
<tr>
<td>22:59</td>
<td><strong>NWAS</strong> Consultant Paramedic Daniel Smith arrived at the Victoria Exchange Complex.</td>
</tr>
<tr>
<td>23:00</td>
<td><strong>NWAS</strong> Control instructed all vehicles responding to the Attack to go to Hunts Bank.</td>
</tr>
<tr>
<td>23:03</td>
<td><strong>NWAS</strong> Consultant Paramedic Daniel Smith appointed himself <strong>NWAS</strong> Operational Commander.</td>
</tr>
</tbody>
</table>

41 INQ015070T  
42 INQ004284/4  
43 53/61/20-62/6  
44 INQ035612/151, 78/46/18-49/7  
45 94/102/18-103/6, INQ041119/3  
46 174/34/13-15  
47 53/73/1-7, INQ035612/162  
48 174/39/2-8  
49 INQ032071  
50 53/74/19-75/7, INQ035612/169  
51 INQ015093T  
52 INQ035612/194
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>22nd May 2017</td>
<td>Saffie-Rose Roussos was placed into NWAS Ambulance A344, which departed from the Victoria Exchange Complex 11 minutes later. GMFRS Group Manager Ben Levy received a pager message from NWFC notifying him of the Attack. Six NWAS ambulances at Manchester Central Fire Station set off in convoy for Hunts Bank. First NWAS HART operatives from the HART crew based in Greater Manchester arrived on Hunts Bank. NWAS HART crew covering Cheshire and Merseyside agreed with NWAS Control to mobilise to the incident. The first casualty arrived at the Casualty Clearing Station following evacuation from the City Room. GMFRS Chief Fire Officer Peter O’Reilly was informed of the Attack by GMFRS Group Manager Nankivell. NWAS ambulances travelling from Manchester Central Fire Station began to arrive at Hunts Bank. GMP Tactical/Silver Commander, Temporary Superintendent Nawaz, arrived at the Silver Control Room in GMP HQ. NWAS HART operatives Simon Beswick, Christopher Hargreaves and Lea Vaughan convened on Station Approach.</td>
</tr>
</tbody>
</table>

53 174/65/6-16
54 174/89/1-2
55 121/154/20-156/23
56 81/84/15-88/6
57 INQ040616/4
58 81/115/15-118/6
59 INQ041266
60 132/1/22-3/10, INQ004348/66
61 81/84/15-88/6
62 104/52/15-19
63 77/25/4-/26/8
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>22nd May 2017</td>
<td></td>
</tr>
<tr>
<td>23:12</td>
<td><strong>NWAS</strong> Tactical Commander, Annemarie Rooney, arrived at the Silver Control Room in <strong>GMP</strong> HQ.</td>
</tr>
<tr>
<td></td>
<td><strong>BTP</strong> Chief Superintendent Gregory notified <strong>BTP</strong> Superintendent Kyle Gordon of the Attack and appointed him as <strong>BTP</strong> Bronze Commander.</td>
</tr>
<tr>
<td>23:13</td>
<td>Two <strong>NWAS</strong> HART operatives, Christopher Hargreaves and Lea Vaughan, entered the Victoria Exchange Complex.</td>
</tr>
<tr>
<td>23:15</td>
<td><strong>NWAS</strong> HART operatives Christopher Hargreaves and Lea Vaughan entered the City Room.</td>
</tr>
<tr>
<td></td>
<td><strong>GMP</strong> Strategic/Gold Commander, ACC Ford, arrived at <strong>GMP</strong> HQ.</td>
</tr>
<tr>
<td></td>
<td><strong>NWAS</strong> Tactical Commander Annemarie Rooney was briefed by <strong>GMP</strong> Tactical/Silver Commander Temporary Superintendent Nawaz that a suicide bomber was responsible for the Attack, that there were 20 fatalities including the bomber, and that it was not a shooting incident.</td>
</tr>
<tr>
<td>23:17</td>
<td>John Atkinson was carried out of the City Room on a makeshift stretcher.</td>
</tr>
<tr>
<td>23:18</td>
<td><strong>GMP</strong> Tactical Firearms Commander, Temporary CI Buckle, arrived in the Silver Command Room at <strong>GMP</strong> HQ.</td>
</tr>
<tr>
<td>23:20</td>
<td><strong>GMP</strong> Force Duty Supervisor, Ian Randall, left <strong>GMP</strong> Control to set up the Silver Command Room at <strong>GMP</strong> HQ.</td>
</tr>
</tbody>
</table>

64 & 115/122/6-7, INQ014791/5  
65 & 93/168/25-169/12  
66 & 53/98/10-25, INQ035612/252  
67 & INQ035612/258  
68 & 105/86/13-16  
69 & 115/122/6-124/5  
70 & 155/40/11-13  
71 & 100/131/18-20, INQ029004/5  
72 & 99/175/11-12
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
</table>
| 23:23 | **NWas** Operational Commander Daniel Smith provided a METHANE message to **NWas** Control. 73  
**NWas** Ambulance A344 carrying Saffie-Rose Roussos arrived at the Royal Manchester Children’s Hospital. 74  
**Gmp** Ground Assigned Tactical Firearms Commander, CI Dexter, arrived at the Victoria Exchange Complex. 75 |
| 23:24 | John Atkinson arrived at the Casualty Clearing Station. 76 |
| 23:25 | **Gmfrs** Group Manager Carlos Meakin arrived at Philips Park Fire Station. 77  
**Gmp** Ground Assigned Tactical Firearms Commander, CI Dexter, entered the City Room for the first time. 78 |
| 23:26 | Georgina Callander was carried out of the City Room on a makeshift stretcher. 79 |
| 23:28 | Georgina Callander arrived at the Casualty Clearing Station. 80 |
| 23:34 | **Btp** Chief Superintendent Gregory took over as Silver Commander from **Btp** Inspector Dawson. 81 |
| 23:35 | **Gmfrs** Group Manager Levy arrived at Philips Park Fire Station. 82 |
| 23:39 | Georgina Callander was placed into **NWas** Ambulance A347, 83 which departed from the Victoria Exchange Complex one minute later. 84  
The last living casualty was evacuated from the City Room. 85 |

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73 53/106/20-107/11, INQ034313/1  
74 174/92/6-9  
75 53/108/17-24, INQ035612/302  
76 155/54/9-11  
77 121/83/23-84/7, INQ004300/3  
78 INQ035612/310  
79 155/28/16-21  
80 155/29/10-11  
81 92/124/1-9  
82 121/190/10-11  
83 155/34/11-13  
84 155/35/21-22  
85 54/8/11-12
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>22nd May 2017</td>
<td></td>
</tr>
<tr>
<td>23:40</td>
<td><strong>GMFRS</strong> duty Assistant Principal Officer, Area Manager Paul Etches, was the first to arrive at the <strong>GMFRS</strong> Command Support Room.(^{86})</td>
</tr>
<tr>
<td></td>
<td><strong>GMFRS</strong> Station Manager Berry arrived at Philips Park Fire Station.(^{87})</td>
</tr>
<tr>
<td>23:41</td>
<td><strong>GMFRS</strong> Group Manager Nankivell arrived at the Command Support Room.(^{88})</td>
</tr>
<tr>
<td>23:43</td>
<td><strong>NWAS</strong> Cheshire and Merseyside HART leader Ronald Schanck arrived at Manchester Central Fire Station.(^{89})</td>
</tr>
<tr>
<td>23:44</td>
<td>In a call to <strong>NWFC</strong>, <strong>GMP</strong> requested the attendance of a <strong>GMFRS</strong> NILO in the Silver Control Room at <strong>GMP</strong> HQ.(^{90})</td>
</tr>
<tr>
<td>23:45</td>
<td><strong>GMP</strong> Superintendent Craig Thompson arrived at <strong>GMP</strong> HQ.(^{91})</td>
</tr>
<tr>
<td></td>
<td><strong>GMFRS</strong> Group Manager Levy informed <strong>GMFRS</strong> Station Manager Berry that he was now the Incident Commander.(^{92})</td>
</tr>
<tr>
<td>23:47</td>
<td><strong>BTP</strong> PC Philip Healy and Police Dog Mojo entered the City Room.(^{93})</td>
</tr>
<tr>
<td>23:48</td>
<td><strong>NWAS</strong> Ambulance A347 carrying Georgina Callander arrived at Manchester Royal Infirmary.(^{94})</td>
</tr>
<tr>
<td>23:49</td>
<td><strong>GMFRS</strong> Chief Fire Officer O’Reilly and <strong>GMFRS</strong> Group Manager John Fletcher arrived at the Command Support Room.(^{95})</td>
</tr>
<tr>
<td>23:50</td>
<td>John Atkinson was placed into <strong>NWAS</strong> Ambulance A368,(^{96}) which departed from the Victoria Exchange Complex ten minutes later.(^{97})</td>
</tr>
<tr>
<td></td>
<td><strong>NWAS</strong> Deputy Director of Operations, Stephen Hynes, arrived at the Victoria Exchange Complex on Station Approach.(^{98})</td>
</tr>
</tbody>
</table>

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\(^{86}\) 129/189/16-20
\(^{87}\) 119/195/22-196/11, INQ004300/1
\(^{88}\) INQ004300/4
\(^{89}\) 81/119/6-9
\(^{90}\) 54/7/17-24
\(^{91}\) 108/26/19-27/3
\(^{92}\) 122/14/22-15/5
\(^{93}\) 54/10/22-11/8, INQ035612/392
\(^{94}\) 155/38/15-17
\(^{95}\) 128/49/19-50/8
\(^{96}\) 159/18/2-6
\(^{97}\) 159/29/8-10
\(^{98}\) 54/14/5-11, INQ035612/405
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>22(^{nd}) May 2017</td>
<td>23:54 <strong>GMFRS</strong> Station Manager Berry requested a Forward Command Post from <strong>GMP</strong> and was told it was the Boddingtons car park.(^{99})</td>
</tr>
<tr>
<td></td>
<td>23:56 <strong>BTP</strong> CI Andrea Graham was identified on CCTV for the first time at the Victoria Exchange Complex, walking along the raised walkway towards the City Room.(^{100})</td>
</tr>
<tr>
<td></td>
<td>23:57 Stephen Hynes replaced Daniel Smith as <strong>NWas</strong> Operational Commander.(^{101})</td>
</tr>
<tr>
<td></td>
<td>23:58 <strong>GMP</strong> Silver Control Room Operators used the proposed multi-agency control room talk group to see which other agencies were listening. <strong>NWFC</strong> replied to say that it was.(^{102})</td>
</tr>
</tbody>
</table>

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99 54/13/3-19  
100 54/19/21-20/15, INQ035612/419  
101 54/20/16-21/1  
102 54/22/15-23/4
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>23rd May 2017</td>
<td></td>
</tr>
<tr>
<td>00:00</td>
<td><strong>GMP</strong> Temporary Superintendent Nawaz handed over tactical/silver command to <strong>GMP</strong> Temporary Superintendent Christopher Hill.¹⁰³</td>
</tr>
<tr>
<td>00:02</td>
<td>First <strong>GMFRS</strong> appliance arrived at Manchester Central Fire Station.¹⁰⁴</td>
</tr>
<tr>
<td>00:05</td>
<td><strong>GMFRS</strong> NILO, Station Manager Michael Lawlor, arrived at <strong>GMP</strong> HQ.¹⁰⁵</td>
</tr>
<tr>
<td></td>
<td><strong>GMFRS</strong> Station Manager Berry arrived at Manchester Central Fire Station.¹⁰⁶</td>
</tr>
<tr>
<td>00:06</td>
<td><strong>N WAS</strong> Ambulance A368 carrying John Atkinson arrived at Manchester Royal Infirmary.¹⁰⁷</td>
</tr>
<tr>
<td>00:15</td>
<td><strong>GMP</strong> Tactical/Silver Commander, Temporary Superintendent Hill, informed <strong>GMFRS</strong> Station Manager Lawlor that Operation Plato had been declared.¹⁰⁸</td>
</tr>
<tr>
<td></td>
<td><strong>GMFRS</strong> Group Manager Levy instructed <strong>NWFC</strong> to record him as Officer in Charge (Incident Commander) and enquired whether Operation Plato had been declared. <strong>NWFC</strong> said that it had not.¹⁰⁹</td>
</tr>
<tr>
<td>00:18</td>
<td><strong>GMP</strong> Force Duty Officer Inspector Sexton handed over the Tactical Firearms Commander role to <strong>GMP</strong> Superintendent Thompson.¹¹⁰</td>
</tr>
<tr>
<td></td>
<td><strong>GMP</strong> Tactical/Silver Commander, Temporary Superintendent Hill, informed <strong>NWAS</strong> Tactical Commander Annemarie Rooney that Operation Plato had been declared.¹¹¹</td>
</tr>
<tr>
<td></td>
<td><strong>GMFRS</strong> Station Manager Lawlor informed Group Manager Fletcher of the Operation Plato declaration.¹¹²</td>
</tr>
<tr>
<td>00:30</td>
<td><strong>NWAS</strong> Strategic Commander Barnes arrived at the Silver Control Room at <strong>GMP</strong> HQ.¹¹³</td>
</tr>
</tbody>
</table>

¹⁰³ INQ004284/13
¹⁰⁴ 104/208/5-7
¹⁰⁵ INQ026726/1
¹⁰⁶ INQ004284/14
¹⁰⁷ 159/30/7-12
¹⁰⁸ INQ026726/2
¹⁰⁹ INQ001204/1
¹¹⁰ 98/1/24-2/8, INQ024325/50-51
¹¹¹ 115/133/24-134/20, INQ014791/9
¹¹² 128/81/14-19, INQ004348/37
¹¹³ 115/49/7-10
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>23rd May 2017</td>
<td></td>
</tr>
<tr>
<td>00:36</td>
<td>First <strong>GMFRS</strong> fire appliance arrived at the Victoria Exchange Complex on Station Approach.</td>
</tr>
<tr>
<td>00:38</td>
<td><strong>GMFRS</strong> Station Manager Berry arrived outside the Victoria Exchange Complex.</td>
</tr>
<tr>
<td>00:54</td>
<td><strong>GMP</strong> CI Dexter declared the scene was “warm going cold” in conversation with <strong>GMFRS</strong> Station Manager Berry and <strong>NWAS</strong> Operational Commander Stephen Hynes.</td>
</tr>
<tr>
<td></td>
<td><strong>NWAS</strong> Tactical Commander, Annemarie Rooney, informed <strong>NWAS</strong> Operational Commander, Stephen Hynes, of the Operation Plato declaration.</td>
</tr>
<tr>
<td>00:57</td>
<td><strong>GMP</strong> Temporary Superintendent Hill declared a Major Incident on behalf of <strong>GMP</strong>.</td>
</tr>
<tr>
<td>01:16</td>
<td><strong>GMP</strong> Strategic/Gold Commander, ACC Ford, agreed with <strong>BTP</strong> Gold Commander, ACC Robin Smith, that <strong>GMP</strong> was the lead agency in the response.</td>
</tr>
<tr>
<td>01:23</td>
<td><strong>BTP</strong> Bronze Commander, Superintendent Gordon, arrived at the Victoria Exchange Complex.</td>
</tr>
<tr>
<td>01:53</td>
<td><strong>BTP</strong> CI Susan Peters arrived at <strong>GMP</strong> HQ and assumed the role of Silver Control liaison.</td>
</tr>
<tr>
<td>02:10</td>
<td><strong>GMFRS</strong> Chief Fire Officer O’Reilly arrived at <strong>GMP</strong> HQ.</td>
</tr>
<tr>
<td>02:50</td>
<td>The last casualties were transported from the Casualty Clearing Station to hospital by ambulance.</td>
</tr>
<tr>
<td>04:15</td>
<td>A Strategic Co-ordinating Group meeting was held at <strong>GMP</strong> HQ following the arrival of all Strategic/Gold Commanders.</td>
</tr>
</tbody>
</table>

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114 54/40/19-24, INQ035612/469
115 54/41/6-22, INQ035612/470
116 INQ040657/69-70, INQ035612/522
117 115/140/19-23, INQ014791/11
118 INQ022399/11
119 94/133/15-136/4
120 95/66/9-16
121 INQ002000/102
122 INQ026726/2
123 INQ041266
124 105/206/4-14
Appendix 11: Emergency Response

Experts

A11.1 I will set out below a summary of the relevant expertise of those who assisted me in relation to the emergency services response. It reflects the position when they gave evidence in 2021.

Fire and Rescue Expert

Matthew Hall

A11.2 Matthew Hall served in the Royal Navy before joining the London Fire Brigade (LFB) in 1990. While holding the rank of Station Manager between 2002 and 2005, he became an instructor for the Institution of Fire Engineers¹ and qualified as a Tactical/Silver Commander.²

A11.3 He was part of the Special Operations Group at LFB³ before being seconded to the Department for Communities and Local Government in early 2006 to assess the operational service delivery of the UK Fire and Rescue Service. Later that year, he became Staff Officer to the LFB Deputy Commissioner.⁴ In 2008, he was promoted to Group Manager and led on a number of special projects, such as strategic response

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¹ 142/4/24-5/14
² 142/5/20-23
³ 142/6/5-7
⁴ 142/7/4-13
arrangements and Strategic/Gold Commander training.  

A11.4 From 2011 to 2014, he was the National Interagency Liaison Officer (NILO) Co-ordinator. He delivered NILO training courses as an Associate of LFB Enterprises Limited between 2016 and 2019. In his last two years of service with LFB, he was part of the Technical and Service Support Unit, focusing on the development of technology for equipment and more efficient emergency responses.

A11.5 During his service, he conducted the review into the emergency response to the Marchioness disaster on behalf of LFB and was involved with the review following the 7/7 attack. Ahead of the 2012 Olympics, he was the UK Fire and Rescue Service representative in the multi-agency joint operational group for Marauding Terrorist Firearms Attack response. He led on the development and delivery of the role of the Fire and Rescue Service within the National Olympic Co-ordination Centre, contributing to Joint Operating Principles at the time.

5 142/7/4-8/1  
6 142/8/8-13  
7 142/9/13-21  
8 142/5/15-19  
9 142/6/8-11  
10 142/8/14-9/7
A11.6 He retired as Deputy Assistant Commissioner in 2016. Since then, he has provided multi-agency and interoperability training to a variety of bodies, including government departments and the armed forces.\textsuperscript{11}

Ambulance Service Experts

Christian Cooper

A11.7 Christian Cooper served as an ambulance officer and paramedic for the Great Western Ambulance Service between 2000 and 2007. He was Resilience Manager for the South West Strategic Health Authority until 2009. In 2009, he became the Hazardous Area Response Team and Specialist Operations Manager for the Great Western Ambulance Service.\textsuperscript{12}

A11.8 From 2013, he was the Head of Quality and Improvement for the National Ambulance Resilience Unit.\textsuperscript{13} At the time of giving evidence to the Inquiry in September 2021, he was the National Head of Operations for the Unit. In this role he had responsibility for overseeing the development of the national and contractual standards that apply to ambulance trusts, to
enable them to respond effectively to Major Incidents.\textsuperscript{14}

\textbf{Michael Herriot}

\textbf{A11.9} Michael Herriot worked in nursing between 1976 and 1980\textsuperscript{15} before becoming a paramedic for the East Sussex Ambulance Service. By 1995, he was the Assistant Chief Ambulance Officer for the Scottish Ambulance Service.\textsuperscript{16}

\textbf{A11.10} Between 1995 and 1997, he worked at the Home Office Emergency Planning College\textsuperscript{17} as a course director.

\textbf{A11.11} Since April 1997, he has been the Associate Director for Special Operations and Emergency Planning at the Scottish Ambulance Service, where he is responsible for special operations and emergency planning.\textsuperscript{18}

\textbf{Policing Experts}

\textbf{Scott Wilson}

\textbf{A11.12} Scott Wilson was a Detective Superintendent in Counter-Terrorism Command for the Metropolitan Police Service (MPS) between 2008 and 2010.\textsuperscript{19}

On promotion to Detective Chief Superintendent

\begin{itemize}
  \item 14 144/4/9-18
  \item 15 144/5/1-3
  \item 16 144/5/6-8
  \item 17 144/5/9-11
  \item 18 144/5/12-15
  \item 19 146/2/19-21
\end{itemize}
in 2010, he became the Head of Emergency Planning. This role included preparing for the London Olympics in 2012.\textsuperscript{20}

\textbf{A11.13} He was the Head of the MPS Intelligence Bureau between 2013 and 2014.\textsuperscript{21} Between 2014 and 2018, he was the National Co-ordinator for Protect and Prepare, having strategic oversight of the National Counter-Terrorism Security Office and leading the policing response to high-risk threats. During this time, he worked domestically and internationally, setting up an international team in 2015 following the terrorist attacks in Tunisia.\textsuperscript{22}

\textbf{A11.14} In his role as National Co-ordinator, he conducted a full review of police strategies and capabilities, including firearms capacity, command and control, and protective security.\textsuperscript{23} He developed the national police counter-terrorism awareness campaigns from 2014 to 2018 and operated as the strategic lead for Operation Temperer.\textsuperscript{24} He was responsible for the management of counter-terrorism exercising\textsuperscript{25} and co-authored the third

A11.15 He was one of the Senior Investigating Officers for the Glasgow Airport attack in 2007 and the Senior Identification Manager for the London Bridge attack in 2017. He retired from the MPS as a Detective Chief Superintendent in 2018.

Iain Sirrell

A11.16 Iain Sirrell began his career with the MPS in 1988, transferring to North Yorkshire Police in 1992 before retiring from the MPS as a Chief Inspector in 2018. He was the Police Training College Manager between 2006 and 2008.

A11.17 He was a control room Force Incident Manager from 2008 until 2010 and from 2013 to 2016. During this time, he also qualified as a Silver Commander and made major changes to the control room in relation to its counter-terrorism response.

A11.18 He was occupationally trained as a counter-terrorism security co-ordinator and had responsibility for command and control in a
national counter-terrorism programme for police and military exercises.\textsuperscript{31}

**Ian Dickinson**

A11.19 Ian Dickinson had a long career in policing, rising to the rank of Deputy Chief Constable in Lothian and Borders Police before retiring as Assistant Chief Constable.\textsuperscript{32}

A11.20 He has substantial experience in strategic command, having been the Deputy National Co-ordinator for counter-terrorism in Scotland. He was in post as a Strategic Commander at the time of the Glasgow Airport attack in 2007.\textsuperscript{33}

A11.21 He now works at the Emergency Planning College, along with Scott Wilson and Iain Sirrell. As part of the Cabinet Office Civil Contingencies Secretariat, the Emergency Planning College delivers training courses from an operational, tactical and strategic level to local authorities and emergency services in the UK and internationally.\textsuperscript{34}

\textsuperscript{31 146/6/22-25}
\textsuperscript{32 146/7/9-18}
\textsuperscript{33 146/7/21-8/3}
\textsuperscript{34 146/8/11-22}
Supporting research analyst

John Lawrie

A11.22 John Lawrie is a researcher and analyst who supported Matthew Hall in the preparation of his expert reports into the response of the Greater Manchester Fire and Rescue Service to the Attack.35

A11.23 He worked in law enforcement for 25 years and was engaged in specialist roles for the majority of that time. He held the positions of Staff Officer, Contingency Planner and Emergency Planning Officer. He has been a firearms instructor36 and has delivered firearms command and control processes to police services since the 1990s.37

A11.24 He has been a Tactical Advisor in two national forces as well as in the National Crime Agency, the Regional Crime Squad and the London Flying Squad.38 He was engaged in operations throughout one of the busiest periods of counter-terrorist operations in the UK.39

A11.25 For a number of years, he researched and authored cross-government reports as an intelligence analyst in Whitehall. He has acted

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35 142/11/12-19
36 142/11/24-12/7
37 142/12/12-14
38 142/12/7-11
39 142/12/15-18
as a delegate to the United States, the Middle East and Europe. John Lawrie now operates as a consultant, specialising in threat, risk, and political and religious extremism. He is a keynote speaker on UK NILO courses and has given lectures to the European Commission. 40

A11.26 During his time as an intelligence analyst, he specialised in firearms, weapons-effects and ballistics, and terrorist tactics and training. In partnership with the Home Office, he worked with all three emergency services supporting investment in the preparation for terrorist attacks.

40 142/12/19-13/11
Appendix 12: Medical and Survivability Experts

A12.1 I will set out below a summary of the relevant expertise of those who assisted me in relation to the injuries which were sustained by those who died. It reflects the position when they gave evidence in 2021.

Forensic pathology

Philip Lumb

A12.2 Dr Philip Lumb is a Home Office-registered forensic pathologist.\textsuperscript{1} He was Lead Pathologist in response to the Attack, with responsibility for co-ordinating the team of pathologists in the early stages of the investigation.\textsuperscript{2}

A12.3 Before 2017, Dr Lumb was regularly involved in planning and preparation for the pathological response to mass casualty incidents.\textsuperscript{3} He was involved in the response to the Selby rail disaster in 2001 and the inquests into the Hillsborough disaster.\textsuperscript{4}

\textsuperscript{1} 149/105/24-25
\textsuperscript{2} 149/110/4-24
\textsuperscript{3} 149/108/7-109/1
\textsuperscript{4} 149/109/2-10
Jack Crane

A12.4 Professor Jack Crane is a medical doctor and forensic pathologist. He was State Pathologist for Northern Ireland between 1990 and 2014. He is a Professor of Forensic Medicine at Queen’s University Belfast.

Blast Wave Panel of Experts

Mark Ballard

A12.5 Lieutenant Colonel Dr Mark Ballard is a Lieutenant Colonel in the Royal Army Medical Corps and a Fellow of the Royal College of Radiologists. He has deployed to Afghanistan as both a general duties medical officer and a consultant radiologist.

A12.6 Since 2013, he has been a consultant radiologist at the Queen Elizabeth Hospital, Birmingham. He was the Consultant Adviser in Radiology to the British Army between 2015 and 2019 and has consulted for the Ministry of Defence since 2019.
A12.7 Lieutenant Colonel Ballard has published and lectured nationally on the topics of ballistic injuries, blast images and tourniquets.\textsuperscript{13} He is a contributor to the NHS England clinical guidelines on Major Incidents and mass casualty events.\textsuperscript{14}

Anthony Bull

A12.8 Professor Anthony Bull is a bioengineer and Head of the Department of Bioengineering at Imperial College London, where he leads the Centre for Blast Injury Studies. The Centre is cutting-edge in its interdisciplinary approach to conducting research. With embedded military and medical personnel, it is the only centre of its kind.\textsuperscript{15}

A12.9 Professor Bull has extensive experience in trauma research and was awarded a fellowship with the Royal Academy of Engineering in 2014. He is a member of the World Council of Biomechanics.\textsuperscript{16}

Jonathan Clasper

A12.10 Colonel Professor Jonathan Clasper was a serving officer with the British Royal Army Medical Corps until 2019.\textsuperscript{17} He was a consultant
in orthopaedic surgery at Frimley Park Hospital until 2021 and is a Fellow of the Royal College of Surgeons of Edinburgh and London.

A12.11 He is a visiting professor in bioengineering at Imperial College London and Clinical Lead for the Royal British Legion Centre for Blast Injury Studies. He has extensive operational experience of military trauma, having treated and researched injuries from the military conflicts in Iraq and Afghanistan.

Alan Hepper

A12.12 Since 2002, Alan Hepper has been an engineer at the Defence Science and Technology Laboratory, where he undertakes research to understand the effect of injuries from military weapons.

A12.13 He has provided expert witness evidence to the Special Investigation Branch of the Royal Military Police and contributed to the evidence in the inquests into the 7/7 attack and Birmingham bombings in 1974.
Peter Mahoney

A12.14 Colonel Professor Peter Mahoney joined the Territorial Army in 1980 and is a member of the reserve forces. He has deployed to Iraq and Afghanistan, where he was involved in the clinical management of casualties with blast and ballistic injuries.

A12.15 He is a consultant in anaesthesia with fellowships in pre-hospital care and anaesthesia. He has obtained a PhD in defence and security and a postgraduate diploma in forensic investigation.

Cardiology

Paul Rees

A12.16 Surgeon Commander Dr Paul Rees is a consultant in cardiology, general internal medicine and pre-hospital emergency medicine at the Barts Heart Centre in St Bartholomew’s Hospital, London. He performs intervention and cardiology duties as part of a high-volume 24-hour heart attack centre team.

26 150/4/25-5/4
27 150/4/14-16
28 150/5/4-7
29 150/4/21-23
30 150/5/8-9
31 161/19/16-18
32 161/19/21-20/3
A12.17 He is a Surgeon Commander in the Royal Navy, with three years’ experience as a submarine medical officer. He has deployed with a Commando Brigade in Iraq and served in Afghanistan, where he worked in the field hospital and as a consultant leading the Medical Emergency Response Team.

A12.18 He regularly undertakes flying duties with the East Anglian Air Ambulance. He is also Co-lead for the British Cardiovascular Interventional Society focus group on out-of-hospital cardiac arrests.

Radiology

Richard Wellings

A12.19 Dr Richard Wellings graduated as a medical doctor in 1982 and became a consultant in 1993. He is a consultant radiologist at the University Hospital of Coventry and Warwickshire and a Fellow of the Royal College of Radiologists.

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33 161/19/19-20
34 161/20/15-18
35 161/20/19-24
36 161/20/6-12
37 176/120/23-121/1
38 176/120/20-22
39 176/121/4-6
A12.20 He is an honorary clinical lecturer at the University of Warwick. He has peer-reviewed articles in relation to radiology and has published on the subject for the Royal College of Physicians.

Pre-hospital care and orthopaedic trauma surgery

Aswinkumar Vasireddy

A12.21 Mr Aswinkumar Vasireddy is a pre-hospital care consultant involved in the management of critically injured patients, and has led on the complex trauma referral system for five years. He is also an orthopaedic fellow and trauma surgeon at King’s College Hospital, specialising in the management of complex trauma.

A12.22 He works as a research lead and lectures at the Institute of Pre-Hospital Care at London’s Air Ambulance. He is an honorary clinical lecturer in the Medical School at Queen Mary University of London. Mr Vasireddy teaches nationally and internationally in orthopaedics and general and pre-hospital trauma care.
A12.23 He is a non-executive director for an NHS trust and has memberships with the British Orthopaedic Association and the Orthopaedic Trauma Societies of the UK and USA. He has also completed core training in anaesthesia, intensive care and emergency medicine.

Pre-hospital care and emergency medicine

Gareth Davies

A12.24 Dr Gareth Davies is a consultant in emergency medicine and pre-hospital care. He was Medical Director of London’s Air Ambulance from 1996 to 2018, with responsibility for the care and treatment strategies of over 40,000 seriously injured patients. During this time, he attended and provided medical treatment at numerous Major Incidents.

A12.25 He is the Co-developer and Convenor of the Royal College of Surgeons’ pre-hospital and resuscitative thoracotomy course. Dr Davies also led the team which delivered the resuscitative endovascular balloon occlusion of the aorta (REBOA) initiative. He has contributed to national working groups on trauma and major
incidents\textsuperscript{52} and has published over 60 peer-reviewed papers.\textsuperscript{53} He lectures in pre-hospital care at Queen Mary University of London.\textsuperscript{54}

Claire Park

A12.26 Lieutenant Colonel Dr Claire Park is a consultant in pre-hospital care, critical care and anaesthesia in the British Army. She has deployed to Afghanistan three times as a member of the Medical Emergency Response Team and to North Africa with a small forward surgical team.\textsuperscript{55}

A12.27 She was the Clinical Governance Lead for the Medical Emergency Response Team between 2013 and 2016.\textsuperscript{56} She has held consultant roles within the NHS and was the Major Incident Lead with London’s Air Ambulance. She was also the Post-incident Lead for the Fishmongers’ Hall and London Bridge attacks.\textsuperscript{57}

A12.28 She is a consultant in critical care and trauma at King’s College Hospital\textsuperscript{58} and provides clinical governance to the MPS and the National Police Clinical Governance Panel.\textsuperscript{59}

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Appendix 13: Acknowledgements

A13.1 I wish to acknowledge my gratitude to the members of the Greater Manchester NHS Resilience Hub. It was set up in response to the Attack in 2017 to co-ordinate care and support for thousands of children, young people and adults whose mental health or emotional wellbeing was affected. That is a role the Hub continued to perform throughout the Inquiry. It provided tireless assistance to witnesses, families and others to support them through the traumatic evidence that was heard about the Attack and the emergency response. I am greatly indebted to them.

A13.2 The Inquiry was assisted by many contributions from members of the public who followed the evidence and provided helpful insights on aspects of the hearings. I wish in particular to thank those who took the time to contact the Inquiry and share their own experiences with my team. I would especially wish to thank Jeremy Cowen, whose experiences of working as a paramedic provided an important contribution to the evidence I heard on the Care Gap and the recommendations I have made.