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Manchester Arena Inquiry
Volume 2: Emergency Response

Volume 2-1

Report of the Public Inquiry into the
Attack on Manchester Arena
on 22nd May 2017

Chairman: The Hon Sir John Saunders

November 2022

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Presented to Parliament pursuant to section 26 of the Inquiries Act 2005
Ordered by the House of Commons to be printed 3 November 2022

HC 757-1



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ISBN 978-1-5286-3710-7

E02730081 11/22

Printed on paper containing 40% recycled fibre content minimum

Printed in the UK by HH Associates Ltd. on behalf of the Controller of His Majesty's Stationery Office

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 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.² 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.

¹ See Appendix 1 in Volume 1

² [2/71/16-72/6](#), [INQ012286/2](#), [INQ005866/2](#), [INQ004984/2](#), [INQ006661/6](#), [INQ024259/3](#), [INQ006024/3](#), [INQ003647/2](#)

I am satisfied that the way in which the firearms officers acted meant that, had there been a threat from 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 NWS. In this Part, I record the help NWS 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

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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



- 9.6 Alison Howe was the mother of Sasha and Darcie and the stepmother of Lewis, Jack, Jordan and Harris.¹ Her husband was Stephen Howe.² Her parents were Sue and George Cann.³ She was 44 years old at the time of her death on 22nd May 2017.⁴
- 9.7 Stephen described how he first met Alison. He told her almost immediately that he loved her and would marry her one day.⁵ 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.⁶
- 9.8 Alison was adored by her family and loved as a wife, stepmother and mother.⁷ Family was her life.⁸ I heard how close she was to her mother, with whom she spent so much time, constantly laughing and enjoying a "beautiful relationship".⁹ Alison had a positive, engaging personality and gave love generously to those in her life.

¹ [152/9/2-3](#)

² [152/9/4](#)

³ [152/9/4-5](#)

⁴ [152/9/6-7](#)

⁵ [10/23/3-5](#), [152/9/22-24](#)

⁶ [10/19/22-25](#)

⁷ [152/9/8-9](#)

⁸ [10/19/16](#)

⁹ [10/18/8-20](#), [10/20/2-4](#)

9.9 Alison's "*Super Six*"¹⁰ children wrote a poem in which they told their mum how much they loved her. They thanked her for her love and kindness.¹¹ Her husband proudly gave Alison credit for the way she had brought up their children and for the strength they had received from her.¹² She was a force for good.¹³

Events of 22nd May 2017

9.10 Alison attended the Arena that night with her friend, Lisa Lees, and their daughters.¹⁴ Their daughters went to watch the concert. Alison and Lisa returned to collect them afterwards.¹⁵ Together, they entered the City Room at 22:27:01 from the direction of Manchester Victoria Railway Station.¹⁶

¹⁰ [10/22/18](#)

¹¹ [10/21/25-22/18](#)

¹² [10/24/10-13](#)

¹³ [152/14/9](#)

¹⁴ [152/3/23-24](#)

¹⁵ [152/4/1-11](#)

¹⁶ [152/4/8-9](#)

Angelika and Marcin Klis



- 9.11 Angelika and Marcin Klis were born in Poland.¹⁷ Marcin was 42 years old at the time of his death on 22nd May 2017. Angelika was 39 when she died.¹⁸
- 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.¹⁹ By 2007, the family had moved to England.²⁰
- 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.²¹ Angelika loved lying in the sunshine and being with her daughters, shopping and going for massages.²² Marcin loved photography and rock music.²³ They travelled together and took holidays in Rome, Egypt and Poland.²⁴ Spending time as a family is what made them both happiest.²⁵
- 9.14 Aleksandra and Patrycja described Angelika and Marcin as their best friends and spoke of their *"amazing parents"*.²⁶ 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."*²⁷

¹⁷ [6/1/20-21](#), [150/103/8-10](#)

¹⁸ [150/103/11-13](#)

¹⁹ [6/1/25-2/3](#), [150/103/14-17](#)

²⁰ [6/2/8-9](#), [150/103/18-19](#)

²¹ [6/2/20-3/2](#), [150/104/12-19](#)

²² [6/2/14-18](#)

²³ [6/2/19](#)

²⁴ [6/2/19-22](#)

²⁵ [6/2/23-24](#)

²⁶ [6/3/8](#), [6/3/22](#), [150/104/8-9](#), [150/104/19](#)

²⁷ [6/3/3-7](#), [150/104/3-7](#)

Events of 22nd May 2017

- 9.15 Angelika and Marcin and their daughters arrived at the Arena that night as a family.²⁸ Angelika and Marcin left their daughters there, having arranged to meet up after the concert.²⁹ 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.³⁰ They were holding each other at the point of the detonation.³¹

²⁸ [150/104/21-22](#)

²⁹ [150/104/22-24](#)

³⁰ [150/105/14-17](#)

³¹ [150/105/16-23](#)

Chloe Rutherford and Liam Curry



- 9.17 Chloe Rutherford was the daughter of Lisa and Mark Rutherford and the sister of Scott.³² She was 17 years old at the time of her death on 22nd May 2017.³³
- 9.18 Liam Curry was the son of Caroline and Andrew Curry and the brother of Zack.³⁴ He was 19 years old when he died.³⁵
- 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.³⁶ She went to college to study music performance, where she discovered a love of songwriting.³⁷ Chloe expressed herself through writing lyrics and performing her own music, often raising money for charity.³⁸ Liam excelled in sports, particularly cricket, for which he shared a passion with his father.³⁹ He went on to study sports science at college and then university.⁴⁰
- 9.20 Liam and Chloe were two very happy teenagers. They had been dating since 2014, after meeting at a cricket club.⁴¹ Their relationship blossomed on what Liam's mother described as the "QWERTY keyboard of love".⁴²

³² [154/95/7-8](#)

³³ [154/95/10-11](#)

³⁴ [154/95/2-3](#)

³⁵ [154/95/5-6](#)

³⁶ [7/17/4-16](#)

³⁷ [7/22/15-23](#)

³⁸ [7/22/11-24](#)

³⁹ [7/13/18-23](#), [7/14/18-19](#)

⁴⁰ [7/23/8-16](#)

⁴¹ [7/19/11-15](#), [154/95/17-18](#)

⁴² [7/19/15-16](#)

- 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.⁴³ Chloe was described as being Liam's "rock" during this time.⁴⁴
- 9.22 Liam had decided that he wanted to join the police.⁴⁵ Chloe had secured an apprenticeship with a local travel agency.⁴⁶ She was thrilled about this. In the months that were to follow the Ariana Grande concert,⁴⁷ they had trips to Majorca and New York planned.⁴⁸
- 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.⁴⁹ They had so much in their lives to look forward to.⁵⁰ Their families were in no doubt that they would have married and had a family.⁵¹

Events of 22nd 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.⁵² They sent pictures to their families from their seats in the Arena.⁵³
- 9.25 They entered the City Room together at 22:30:49.⁵⁴

⁴³ [7/25/21-23](#), [154/97/16-19](#)

⁴⁴ [7/26/16-17](#), [154/97/19-22](#)

⁴⁵ [7/28/16-20](#), [154/96/10-11](#)

⁴⁶ [7/28/11-15](#)

⁴⁷ [7/29/9-15](#)

⁴⁸ [7/27/13-28/3](#)

⁴⁹ [154/97/6-8](#)

⁵⁰ [7/28/9](#), [7/29/9-10](#)

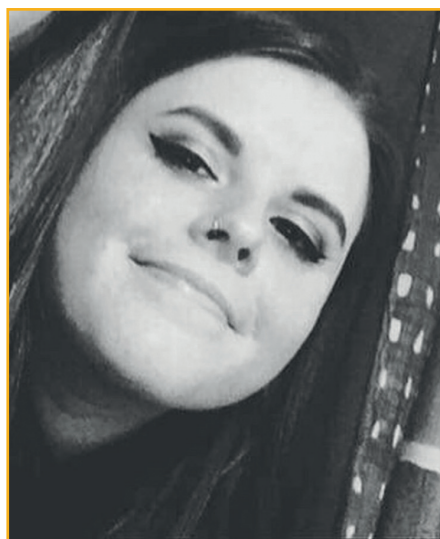
⁵¹ [7/28/21-29/8](#), [154/98/6-10](#)

⁵² [154/98/23-99/2](#)

⁵³ [154/99/2-5](#)

⁵⁴ [154/99/8-9](#)

Courtney Boyle



- 9.26 Courtney Boyle was the daughter of Deborah Hutchinson and Robert Boyle. She was the sister of Nicole.⁵⁵ Courtney was 19 years old at the time of her death on 22nd May 2017.⁵⁶
- 9.27 Many spoke of Courtney's positive, caring nature.⁵⁷ That, together with her witty, funny personality, made her very popular.⁵⁸ She put others first and made sure that Nicole and Deborah kept smiling when times were tough.⁵⁹ Courtney was intelligent. She achieved her dream of going to university to study criminology and psychology.⁶⁰ Deborah recalls that Courtney was the happiest she had ever seen her. She simply loved her life.⁶¹ Courtney achieved first-class honours at the end of her first year. She was awarded a posthumous honorary degree from her university in July 2017.⁶²
- 9.28 Courtney loved music, and it was through music that she met her boyfriend Callum, at Leeds Festival.⁶³ They had the best time of their lives together.⁶⁴ For Callum, Courtney *"made the good times great and the bad times bearable"*.⁶⁵ He described how lucky he felt to have met Courtney.⁶⁶

⁵⁵ [150/114/3-5](#)

⁵⁶ [150/114/7-8](#)

⁵⁷ [5/83/11-15](#)

⁵⁸ [5/85/9-12](#)

⁵⁹ [5/84/18-19](#), [5/85/15-23](#)

⁶⁰ [150/114/23-115/1](#)

⁶¹ [5/83/11-12](#), [150/115/2-6](#)

⁶² [5/84/20-24](#), [150/115/7-10](#)

⁶³ [5/82/8-22](#), [150/114/18-21](#)

⁶⁴ [5/89/3-5](#), [150/116/21](#)

⁶⁵ [5/89/4-5](#), [150/116/22-23](#)

⁶⁶ [150/117/7-8](#)

9.29 Courtney was an enormous part of the lives of all her family.⁶⁷ Her aunt, uncle and cousins described their special close bond⁶⁸ and told of some of their happiest memories together.⁶⁹ Courtney adored her sister. They were best friends and Nicole told of how Courtney was her protector.⁷⁰ Nicole wants to ensure that Courtney is forever remembered as a girl who *“shone so brightly in any place she was and still does today”*.⁷¹

Events of 22nd May 2017

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.⁷² While Nicole attended the concert, Courtney and her family enjoyed a meal together in Manchester.⁷³ Courtney was very excited about her forthcoming trip to Amsterdam with Callum.⁷⁴

9.31 Courtney kept in contact with Nicole throughout the show.⁷⁵ As they returned to the Arena to collect Nicole, Deborah remembers the laughter she shared with Courtney as they sat in the car.⁷⁶ Courtney and Philip left the car and went to collect Nicole, entering the City Room together at 22:22:11.⁷⁷

⁶⁷ [150/116/4-6](#)

⁶⁸ [5/86/11](#), [150/116/11-16](#)

⁶⁹ [5/87/13-88/9](#)

⁷⁰ [5/85/15-19](#)

⁷¹ [5/86/4-6](#), [150/115/22-25](#)

⁷² [150/117/11-13](#)

⁷³ [150/117/23-118/1](#)

⁷⁴ [5/83/21-24](#), [150/117/19-20](#)

⁷⁵ [5/84/6-7](#), [150/117/23-24](#)

⁷⁶ [150/118/1-3](#)

⁷⁷ [150/118/7-10](#)

Eilidh MacLeod



- 9.32 Eilidh MacLeod was the daughter of Marion and Roddy MacLeod and the sister of Shona and Laura.⁷⁸ She was 14 years old at the time of her death on 22nd May 2017.⁷⁹
- 9.33 Eilidh was a happy girl with a great sense of fun and humour.⁸⁰ She was a much-loved middle sister and very family orientated.⁸¹ I heard how close she was to her sisters, with whom she shared so much laughter.⁸² She was a “*shining light*” in her family’s life.⁸³
- 9.34 Eilidh was popular at school.⁸⁴ As her mum Marion said, “*It wasn’t hard to love Eilidh. She loved everything about her life.*”⁸⁵ Her friends remember her beautiful personality and how she made them laugh with her sense of humour and infectious laugh.⁸⁶ Eilidh enriched the lives of many.⁸⁷

⁷⁸ [153/57/3-4](#)

⁷⁹ [153/57/7-8](#)

⁸⁰ [4/20/1-8](#), [153/57/13-19](#)

⁸¹ [4/26/14](#), [153/57/12-13](#)

⁸² [4/20/10-21](#), [153/58/2-7](#)

⁸³ [153/58/1](#)

⁸⁴ [153/58/22](#)

⁸⁵ [4/21/5-6](#), [153/59/17-18](#)

⁸⁶ [4/32/17-20](#), [153/59/1-4](#)

⁸⁷ [153/68/11-12](#)

9.35 Eilidh loved music, which was an enormous part of her life.⁸⁸ She was a talented bagpipe player.⁸⁹ I heard how proud her family were when she enjoyed success at the World Pipe Band Championships in August 2016.⁹⁰ I have no doubt that Eilidh would have achieved anything she set her mind to.⁹¹ As her mother said, *"The world was her oyster."*⁹²

Events of 22nd May 2017

9.36 Eilidh was extremely excited that her countdown to the concert was finally over.⁹³ She and her mother travelled from Scotland to Manchester. They stayed in a hotel the night before the concert.⁹⁴

9.37 Earlier that day, they enjoyed a trip to the Trafford Centre to spend quality time with Eilidh's godmother.⁹⁵ The group had a lovely time together, enjoying lunch and shopping, while Eilidh talked about the concert excitedly.⁹⁶ Marion dropped Eilidh and her friend off at the Arena.⁹⁷ When she was seated, Eilidh made a video call to her mum. Marion recalls how happy Eilidh was.⁹⁸

9.38 Eilidh and her friend entered the City Room at 22:30:49.⁹⁹

⁸⁸ [153/58/8-9](#)

⁸⁹ [153/58/9-11](#)

⁹⁰ [4/22/11-20](#), [153/58/15-17](#)

⁹¹ [153/68/11-12](#)

⁹² [4/21/7-8](#), [153/59/20](#)

⁹³ [153/60/6-7](#)

⁹⁴ [153/60/4-10](#)

⁹⁵ [153/60/10-14](#)

⁹⁶ [153/60/18-22](#)

⁹⁷ [153/62/13-63/16](#)

⁹⁸ [153/63/19-64/1](#)

⁹⁹ [153/65/15-16](#)

Elaine Mclver



- 9.39 Elaine Mclver was the daughter of Patricia and Frank Mclver and sister of Paul and Lynda.¹⁰⁰ Her partner was Paul Price.¹⁰¹ Elaine was 43 years old at the time of her death on 22nd May 2017.¹⁰²
- 9.40 Elaine was the love of Paul's life.¹⁰³ They met in the autumn of 2014.¹⁰⁴ Paul told of their shared love of music and plans for the future together.¹⁰⁵ They had just had an offer accepted on a house, which they were very excited about.¹⁰⁶ They had spoken of travelling, including to Australia, New Zealand and Canada.¹⁰⁷ Paul felt that they had a long future ahead of them and that they "*were finally going to live happily ever after*".¹⁰⁸
- 9.41 Elaine's family spoke about her personality. She was described as having a "*lust for life*",¹⁰⁹ a massive heart and personality, and being a leader with a "*strong sense of fairness and justice*".¹¹⁰ With these qualities, it is perhaps no surprise that she became a police officer, a career she loved.¹¹¹ 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*",¹¹² the family's favourite.¹¹³

¹⁰⁰ [156/38/24-39/1](#)

¹⁰¹ [156/39/1](#)

¹⁰² [156/39/3-4](#)

¹⁰³ [9/50/6](#)

¹⁰⁴ [9/52/19-22](#)

¹⁰⁵ [9/51/6-10](#)

¹⁰⁶ [9/64/5-8](#)

¹⁰⁷ [9/67/13-17](#)

¹⁰⁸ [9/68/12-14](#)

¹⁰⁹ [156/41/5](#)

¹¹⁰ [156/43/1](#)

¹¹¹ [156/41/22-23](#)

¹¹² [156/42/19-20](#)

¹¹³ [156/42/18](#)

9.42 Her family made it clear that Elaine would not want to be remembered as a victim.¹¹⁴ I have no doubt it is the joy and love she brought to her family and friends that will be remembered above all.

Events of 22nd May 2017

9.43 Paul and Elaine travelled to Manchester that evening to take Paul's daughter and her friend to the concert.¹¹⁵ 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.¹¹⁶ Paul's memories are of them speaking about the new house¹¹⁷ and that it was a beautiful evening.¹¹⁸

9.44 Paul and Elaine returned to the Arena at around 22:00¹¹⁹ to collect Paul's daughter. They entered the City Room from the direction of Manchester Victoria Railway Station at 22:06:23.¹²⁰ They waited together in the City Room for the girls to return, listening to the sound of the concert ending.¹²¹

¹¹⁴ [156/41/8](#)

¹¹⁵ [9/65/12-15](#)

¹¹⁶ [156/54/17-23](#)

¹¹⁷ [9/65/25-66/1](#)

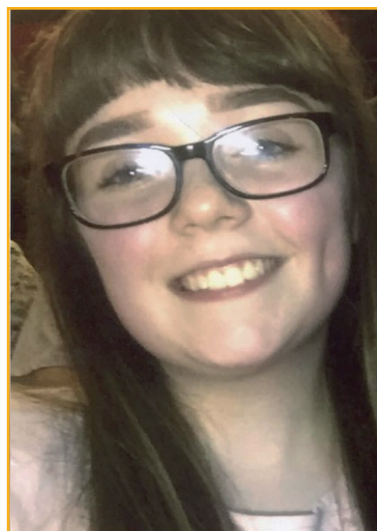
¹¹⁸ [9/65/22](#)

¹¹⁹ [156/45/23-24](#)

¹²⁰ [156/46/1-2](#)

¹²¹ [156/56/10-18](#)

Georgina Bethany Callander



- 9.45 Georgina Callander was the daughter of Lesley and Simon Callander and the younger sister of Daniel and Harry.¹²² She was 18 years old at the time of her death on 23rd May 2017.¹²³
- 9.46 Georgina was an Ariana Grande “superfan”¹²⁴ and had met her once before 22nd May 2017.¹²⁵ 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.¹²⁶ Much of that travelling had been with her mother Lesley, from whom she was “inseparable”.¹²⁷ They had travelled to many places, including both the east and west coasts of America, Italy, France and every theme park in the UK.¹²⁸
- 9.47 Georgina achieved a lot in her 18 years, showing skill in both ballet and taekwondo in her younger years.¹²⁹ She achieved distinctions in all of her exams¹³⁰ and was awarded a place to study paediatrics at university.¹³¹ 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.”¹³² I have no doubt that she would have gone on to help countless people.

¹²² [155/2/23-25](#)

¹²³ [155/2/25-3/1](#)

¹²⁴ [6/52/7](#)

¹²⁵ [6/52/8](#)

¹²⁶ [6/52/8-10](#)

¹²⁷ [6/51/22](#)

¹²⁸ [6/37/20-25](#), [6/38/7-12](#)

¹²⁹ [7/3/10-14](#)

¹³⁰ [7/7/18-20](#)

¹³¹ [6/51/7-10](#)

¹³² [6/50/25](#), [6/51/25-52/2](#)

- 9.48 Georgina's parents both spoke of their memories of her beautiful smile and her unmistakable and infectious laughter.¹³³ Her brother Harry reflected on the happy memories that will always be with the family. He said, *"I know in my heart of hearts what she wanted most for us is to all live, laugh and love as she did."*¹³⁴

Events of 22nd May 2017

- 9.49 Georgina travelled to Manchester on 22nd May 2017 with her mother Lesley, and they booked into a local hotel where they spent time getting ready for the evening together.¹³⁵ 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.¹³⁶
- 9.50 As the concert was ending, Georgina and her friend left their seats and walked through the doors to the City Room at 22:30:51.¹³⁷ Her friend recalls Georgina smiling back at her as she began to run across to a merchandise stall.¹³⁸

¹³³ [6/30/25](#), [6/54/15-16](#), [7/5/11-19](#), [7/8/5-6](#)

¹³⁴ [6/55/6-8](#)

¹³⁵ [155/5/10-12](#)

¹³⁶ [155/5/13-6/2](#)

¹³⁷ [155/6/10-11](#)

¹³⁸ [155/6/17-19](#)

Jane Tweddle



- 9.51 Jane Tweddle was the mother of Harriet, Lily and Isabelle Taylor, the daughter of Margarett and Alan Tweddle and the sister of Paul.¹³⁹ She was 51 years old at the time of her death on 22nd May 2017.¹⁴⁰
- 9.52 Jane was a much-loved mum, daughter, sister, auntie and friend.¹⁴¹ She was her daughters' "warrior mum", teaching them to be kind and to stick together.¹⁴² She filled the home with love and laughter.¹⁴³ 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."¹⁴⁴ Jane's outlook on life continues to inspire them.¹⁴⁵
- 9.53 Jane was extremely close to her family. I heard of Jane's "special and comical"¹⁴⁶ relationship with her mother Margarett, who remembers Jane's smile, laughter and love of life.¹⁴⁷ Jane was a much-loved aunt. She provided a second home for her nieces and nephews, who knew her door was always open.¹⁴⁸ Jane's brother, Paul, knows that her strength, love and laughter will always live on in her close-knit family.¹⁴⁹

¹³⁹ [151/26/23-25](#)

¹⁴⁰ [151/27/1-2](#)

¹⁴¹ [151/27/3-4](#)

¹⁴² [10/12/24-25](#), [151/27/4-5](#)

¹⁴³ [151/27/5-6](#)

¹⁴⁴ [151/27/25-28/2](#)

¹⁴⁵ [10/14/23](#), [151/27/10-11](#)

¹⁴⁶ [10/13/17-19](#)

¹⁴⁷ [151/27/12-13](#)

¹⁴⁸ [10/14/2-4](#)

¹⁴⁹ [151/27/13-15](#)

- 9.54 Jane was cherished and trusted by the young people whose lives she touched while working at a high school.¹⁵⁰ 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.¹⁵¹

Events of 22nd May 2017

- 9.55 Jane travelled to the Arena with her friend Joanne Aaron, whose daughter was attending the concert.¹⁵² Jane and Joanne Aaron were due to pick Joanne’s daughter and her friend up afterwards.¹⁵³
- 9.56 While they waited for the concert to finish, Jane and Joanne Aaron enjoyed a meal and coffee together in Manchester.¹⁵⁴ Joanne Aaron recalls that they had a good night together.¹⁵⁵ They discussed plans for the future and Jane spoke about her daughters and what they were up to.¹⁵⁶
- 9.57 Jane and Joanne Aaron entered the City Room at 22:23:45.¹⁵⁷

¹⁵⁰ [10/15/1-2](#), [151/27/17-19](#)

¹⁵¹ [10/15/7-8](#), [151/27/21-24](#)

¹⁵² [151/28/6-8](#)

¹⁵³ [151/28/8-10](#)

¹⁵⁴ [151/28/16-18](#)

¹⁵⁵ [151/28/18-19](#)

¹⁵⁶ [151/28/19-21](#)

¹⁵⁷ [151/28/25-29/1](#)

John Atkinson



- 9.58 John Atkinson was the son of Daryl and Kevin Price and brother of Laura, Stacey and Amy.¹⁵⁸ John was 28 years old at the time of his death on 23rd May 2017.¹⁵⁹
- 9.59 John was very bright. He had a Mensa IQ score of 137 at eight years old.¹⁶⁰ By the age of 25, he had passed all his NVQs and reached management level.¹⁶¹ He chose a career working with young adults with autism and behavioural difficulties, which he loved.¹⁶² His working life was spent helping those in care.¹⁶³ 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.¹⁶⁴ His mum told of his generosity and kindness.¹⁶⁵
- 9.60 John was a fitness fanatic, who loved music, dancing and life in general.¹⁶⁶ He was the centre of his family’s world,¹⁶⁷ and was described as their *“heart and soul”*.¹⁶⁸ I heard that his smile would light up the room¹⁶⁹ and that he had an *“addictive”* personality.¹⁷⁰ He loved everyone and everyone loved him.¹⁷¹

¹⁵⁸ [4/35/13-15](#), [158/3/24-25](#)

¹⁵⁹ [158/4/10-11](#)

¹⁶⁰ [4/35/23-24](#), [158/4/25](#)

¹⁶¹ [4/35/22-23](#), [158/4/15-5/1](#)

¹⁶² [4/35/19-21](#), [158/4/19-21](#)

¹⁶³ [158/4/18-25](#)

¹⁶⁴ [4/38/20-22](#)

¹⁶⁵ [4/36/17-19](#)

¹⁶⁶ [4/36/1-16](#), [158/5/6-7](#)

¹⁶⁷ [4/37/2](#)

¹⁶⁸ [4/40/3-4](#)

¹⁶⁹ [4/36/23-24](#)

¹⁷⁰ [4/35/15](#)

¹⁷¹ [4/36/24-25](#)

He adored his sisters and nephews, and hoped to one day provide foster care for children.¹⁷² His parents remember *“his laugh, his humour, his personality, his love for his family, his thoughtful ways”*.¹⁷³

9.61 John was kind, generous and made people laugh. There is less laughter in the world without him.¹⁷⁴

Events of 22nd 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.¹⁷⁵ Gemma recalls that the concert was really good and they had a lovely time together.¹⁷⁶

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.¹⁷⁷ John and Gemma entered the City Room at 22:30:48.¹⁷⁸

¹⁷² [4/36/19-22](#)

¹⁷³ [4/37/3-4](#)

¹⁷⁴ [160/218/2-4](#)

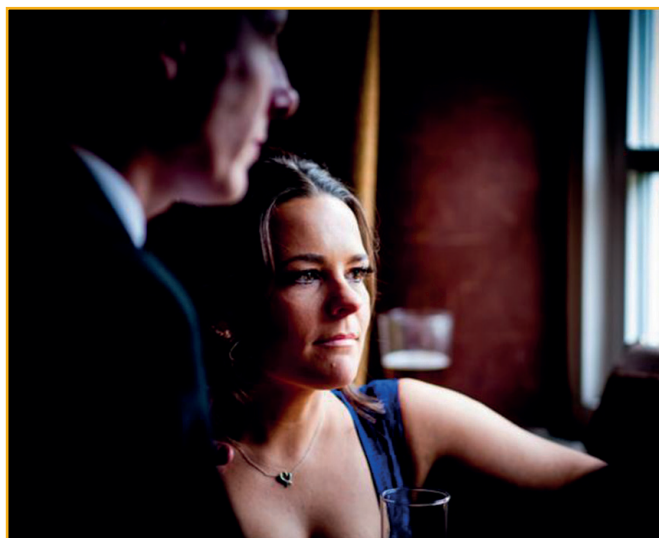
¹⁷⁵ [158/6/9-13](#)

¹⁷⁶ [158/6/19-20](#)

¹⁷⁷ [158/6/21-24](#)

¹⁷⁸ [158/7/1-3](#)

Kelly Brewster



- 9.64 Kelly Brewster was the daughter of Kim and Kevin Brewster and the sister of Claire and Adam.¹⁷⁹ Her partner was Ian Winslow.¹⁸⁰ She was 32 years old at the time of her death on 22nd May 2017.¹⁸¹
- 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"*.¹⁸² She lived life to the full.¹⁸³ Her adventurous spirit saw her travel across the world, including solo trips to Australia and America, where she made many friends and came back with many happy memories.¹⁸⁴ Kelly always had stories to tell about her travels and her hopes for the places she would visit in the future.¹⁸⁵ In her 32 years, she did more than many do in a lifetime.¹⁸⁶
- 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.¹⁸⁷
- 9.67 Kelly met Ian at her 30th birthday party.¹⁸⁸ Her family remember that it was clear from their first meeting that they were made for each other.¹⁸⁹ They would leave little notes around the house to say how much they loved each other,

¹⁷⁹ [154/2/10-11](#)

¹⁸⁰ [154/2/13](#)

¹⁸¹ [154/2/17-18](#)

¹⁸² [5/97/21-24](#), [154/2/21](#)

¹⁸³ [5/111/22-23](#)

¹⁸⁴ [5/97/23-24](#), [5/102/8-25](#), [154/3/17-22](#)

¹⁸⁵ [5/103/16-18](#)

¹⁸⁶ [5/113/15-16](#)

¹⁸⁷ [154/3/6-7](#)

¹⁸⁸ [5/103/19-25](#), [154/3/23](#)

¹⁸⁹ [5/105/5-6](#), [154/3/23-4/1](#)

and both shared a passion for travel.¹⁹⁰ 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.¹⁹¹

- 9.68 On the morning of 22nd May 2017, Kelly and Ian had an offer accepted on their new home. They were excited about their plans for the future, including growing their family.¹⁹² Kelly's family and friends said that Kelly was the happiest she had ever been,¹⁹³ and that she and Ian "*were the true definition of soulmates*" who would have been together forever.¹⁹⁴

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- 9.69 Kelly attended the concert with her niece, and her sister Claire Booth.¹⁹⁵ On the journey, Claire remembers hearing Kelly speak to Ian on the phone and that they were "*so happy and excited*" about the house that it was infectious.¹⁹⁶ It set the mood for the evening.
- 9.70 Kelly, Claire and Claire's daughter all enjoyed the concert.¹⁹⁷ It was still dark in the Arena bowl and Ariana Grande was saying goodnight as they left their seats.¹⁹⁸ Together, they entered the City Room at 22:30:53.¹⁹⁹

¹⁹⁰ [5/104/6-20](#), [154/4/2-3](#)

¹⁹¹ [5/104/24-105/4](#), [154/4/6-9](#)

¹⁹² [5/105/9-11](#), [154/4/10-12](#)

¹⁹³ [5/105/17](#), [5/116/1-8](#), [154/4/12-14](#)

¹⁹⁴ [5/106/1-3](#), [154/4/1-2](#)

¹⁹⁵ [154/4/16-17](#)

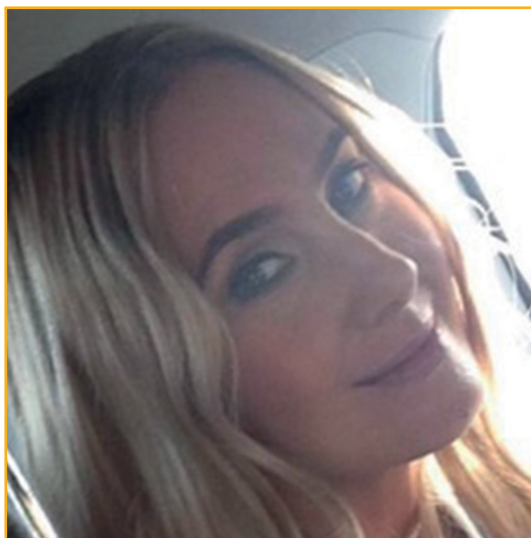
¹⁹⁶ [138/66/3-5](#)

¹⁹⁷ [138/70/8](#)

¹⁹⁸ [138/71/3-5](#)

¹⁹⁹ [154/5/23](#)

Lisa Lees



- 9.71 Lisa Lees was the daughter of Ivan and Elaine Hunter, and sister of Lee.²⁰⁰ She was married to Anthony Lees and was the mother of Lauren and India.²⁰¹ She was also a grandmother.²⁰² She was 43 years old at the time of her death on 22nd May 2017.²⁰³
- 9.72 Lisa was a very positive person. She was always singing and dancing, and made every situation fun.²⁰⁴ Anthony described Lisa as “*funny, exciting, full of laughter, full of life*”.²⁰⁵ She was dedicated to her career and put 110 per cent into her work.²⁰⁶ It gave her family so much pride to see her set up an award-winning business providing holistic therapies to terminally ill children.²⁰⁷ It was one of Lisa’s greatest achievements.²⁰⁸ She later returned to college to teach the next generation of beauticians, to pass on her skills.²⁰⁹
- 9.73 Her daughters spoke of Lisa with great love and warmth. She was their best friend.²¹⁰ She would tell them that they could achieve anything if they put their minds to it, and they should “*always believe*”.²¹¹ Her positive attitude lives on

²⁰⁰ [6/5/10-12](#)

²⁰¹ [6/5/14-25](#)

²⁰² [6/9/9-10](#)

²⁰³ [152/1/25](#)

²⁰⁴ [6/10/22-23](#)

²⁰⁵ [6/9/18-20](#)

²⁰⁶ [6/7/6](#)

²⁰⁷ [6/6/6-22](#)

²⁰⁸ [6/17/19](#)

²⁰⁹ [6/17/11-13](#)

²¹⁰ [6/24/15-16](#)

²¹¹ [6/10/15-17](#)

through her children. India aspires to be just like her mum.²¹² Lauren plans to help her mother's memory live on in her own children and to be there for her sister and family.²¹³

- 9.74 As Lisa's mother said, Lisa touched so many lives with her love and compassion.²¹⁴ Her infectious laugh and her ability to light up a room²¹⁵ will never be forgotten.

Events of 22nd May 2017

- 9.75 Lisa attended the Arena that night with a friend, Alison Howe, and their daughters.²¹⁶ Their daughters went to watch the concert. Lisa and Alison returned to collect them afterwards.²¹⁷ Together, they entered the City Room at 22:27:01 from the direction of Manchester Victoria Railway Station.²¹⁸

²¹² [6/10/20-21](#)

²¹³ [6/24/23-25](#)

²¹⁴ [6/18/15-16](#)

²¹⁵ [152/3/13-15](#)

²¹⁶ [152/3/23-24](#)

²¹⁷ [152/4/8-11](#)

²¹⁸ [152/4/8-9](#)

Martyn Hakan Hett



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.²¹⁹ He was a brother to Daniel, stepbrother to Matt and Emma and half-brother to Louise and Nikita.²²⁰ Martyn was 29 years old at the time of his death on 22nd May 2017.²²¹

9.77 Martyn had an instantly engaging personality. His mother spoke of his *"incredible passion for life"* and *"catching charisma"*.²²² 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,²²³ but equally took the time to make whoever he was with know that they mattered.²²⁴ He had so many friends and displayed such compassion for others.²²⁵ 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"*.²²⁶ He brought people together and allowed them all to shine.²²⁷

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.²²⁸ He also made a number of television appearances. I heard of his impact even on those who had

²¹⁹ [156/3/1-2](#)

²²⁰ [156/3/4-6](#)

²²¹ [156/3/9-10](#)

²²² [5/3/2-11](#)

²²³ [5/3/6](#)

²²⁴ [5/3/19-22](#)

²²⁵ [5/13/12-17](#), [156/3/13-19](#)

²²⁶ [156/4/13-18](#)

²²⁷ [5/14/11](#), [156/4/18-20](#)

²²⁸ [5/9/16-17](#)

never met him, and how he touched people's lives.²²⁹ One of them said, *"Life is full of negatives. Don't be another one. Be more Martyn."*²³⁰ #BEMOREMARTYN became a hashtag in the aftermath of the announcement of Martyn's death.²³¹

- 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"*.²³² I can understand that. Martyn's friends and family are right to be proud of him. His future was very bright.

Events of 22nd May 2017

- 9.80 Martyn attended the concert that night with three of his closest friends: Paul, Chris and Stuart.²³³ They were celebrating Paul's birthday and Martyn's upcoming trip to America.²³⁴ 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.²³⁵ Martyn left his seat near the end of the show and was seen to enter the City Room at 22:28:42.²³⁶

²²⁹ [5/31/4-10](#)

²³⁰ [5/32/21-22](#)

²³¹ [5/31/22-32/8](#)

²³² [5/2/14-16](#)

²³³ [156/7/1-3](#)

²³⁴ [156/7/3-4](#)

²³⁵ [156/7/12-13](#)

²³⁶ [156/8/13-14](#)

Megan Joanne Hurley



- 9.81 Megan Hurley was the daughter of Michael and Joanne Hurley and the sister of Bradley.²³⁷ She was 15 years old at the time of her death on 22nd May 2017.²³⁸
- 9.82 Megan had a real talent for sport. She competed for her school in running and was a strong swimmer.²³⁹ She loved spending time on a jet ski with her dad.²⁴⁰ She loved history, but also had a creative side and chose photography and graphic design as two of her GCSEs.²⁴¹
- 9.83 I heard about Megan's surprising maturity and that she had *"a very gentle, quiet nature that everyone was endeared by"*.²⁴² Family friends commented that Megan *"was the daughter that you hoped your own daughters would turn into"*.²⁴³ She was family orientated and idolised all her cousins.²⁴⁴ Her parents felt that, given her caring nature, she would make an amazing midwife.²⁴⁵ She had also been considering a career in physiotherapy, or perhaps becoming a vet because of her love of animals.²⁴⁶

²³⁷ [153/2/20-21](#)

²³⁸ [153/2/23-24](#)

²³⁹ [5/37/21-22](#), [5/39/23-25](#)

²⁴⁰ [5/39/21-22](#)

²⁴¹ [5/37/19-38/4](#), [5/40/5-6](#)

²⁴² [5/38/17-19](#), [5/44/3-4](#), [5/75/14-17](#)

²⁴³ [5/48/24-25](#)

²⁴⁴ [5/40/17-21](#)

²⁴⁵ [5/41/2](#)

²⁴⁶ [5/41/1-6](#)

- 9.84 Megan's bond with her brother Bradley was commented upon by many. Some spoke of being "*in awe*" of their relationship,²⁴⁷ and that they were like best friends, with a "*sort of secret language*", which saw them laughing hysterically at things no one else understood.²⁴⁸
- 9.85 I heard from many people who loved Megan. They spoke of her beautiful and infectious smile²⁴⁹ and how it was easy for her to make others feel happy.²⁵⁰ It is said that she made and kept friends easily²⁵¹ and I can see why.

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- 9.86 Megan loved Ariana Grande and received a ticket to the concert as a Christmas present.²⁵² Bradley bought a ticket so that he could go with her.²⁵³ 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.²⁵⁴
- 9.87 On the day of the concert, Megan and Bradley spent time getting ready together, joking and taking photographs.²⁵⁵ There was a happy atmosphere in the Hurley home and they were both excited about the night ahead.²⁵⁶ After being dropped off by their parents, Megan and Bradley bought T-shirts before finding their seats.²⁵⁷ Megan and Bradley spent the concert singing, dancing and taking photographs together, having a wonderful night.²⁵⁸ They left their seats after the encore and walked together, holding hands and laughing, to the City Room.²⁵⁹ They entered the City Room at 22:30:49.²⁶⁰

²⁴⁷ [5/52/7-8](#)

²⁴⁸ [5/49/7-11](#), [5/53/19-20](#)

²⁴⁹ [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](#)

²⁵⁰ [5/64/4-7](#), [5/65/12-17](#), [5/66/20-24](#), [5/67/17-21](#)

²⁵¹ [5/36/14-17](#)

²⁵² [153/4/10-13](#)

²⁵³ [138/148/2-3](#)

²⁵⁴ [138/148/6-11](#)

²⁵⁵ [138/149/3-16](#)

²⁵⁶ [138/149/25-150/4](#)

²⁵⁷ [138/152/2-3](#)

²⁵⁸ [138/154/13-18](#), [138/155/7-13](#)

²⁵⁹ [138/155/14-16](#), [138/156/3-8](#)

²⁶⁰ [153/5/5-6](#)

Michelle Kiss



- 9.88 Michelle Kiss was the daughter of Christine and Mick and sister to Nichola.²⁶¹ She was the much-loved wife of Anthony (Tony) Kiss, and mother to their three children.²⁶² Michelle was 45 years old at the time of her death on 22nd May 2017.²⁶³
- 9.89 Michelle and Tony were childhood sweethearts.²⁶⁴ Tony described her as his “*guiding light*” from the first moment they met.²⁶⁵ 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.²⁶⁶ In 1995, they got married on a beach in Barbados, surrounded by close family and friends.²⁶⁷ By 2004, their family was complete.²⁶⁸ They were soulmates and their love story endured for 30 special years.²⁶⁹
- 9.90 Michelle loved and embraced life.²⁷⁰ Tony described her as having “*an aura of love and positivity that glowed with each of her smiles*”.²⁷¹ Michelle’s family described her as the “*hub*” of her family.²⁷² They remember her devotion to her husband and children and how she loved them beyond measure.²⁷³ Family was

²⁶¹ [8/16/8-10](#)

²⁶² [151/19/23-24](#)

²⁶³ [8/16/7-8](#), [151/20/1-2](#)

²⁶⁴ [8/21/8-9](#)

²⁶⁵ [8/16/15-16](#)

²⁶⁶ [8/17/14-18](#)

²⁶⁷ [8/17/23-25](#)

²⁶⁸ [8/26/13-14](#)

²⁶⁹ [8/21/6-9](#)

²⁷⁰ [8/16/11-12](#), [151/20/5](#)

²⁷¹ [8/18/11-12](#)

²⁷² [8/25/18](#)

²⁷³ [151/22/2-3](#)

the most important part of Michelle's life.²⁷⁴ She was loving, selfless and a natural homemaker, with the ability to bring people together.²⁷⁵ Tony and Michelle were the proudest of parents and so very happy.²⁷⁶

- 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.²⁷⁷

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- 9.92 Michelle attended the Arena with her friend Ruth Murrell, to drop off their daughters at the concert.²⁷⁸ Michelle and Ruth went into Manchester City Centre together while the concert was on, before returning to the Arena to collect their daughters.²⁷⁹ Michelle and Ruth entered the City Room at 22:18:43.²⁸⁰

²⁷⁴ [8/33/20-21, 151/21/10](#)

²⁷⁵ [8/18/2-9, 151/20/17](#)

²⁷⁶ [8/19/17-18](#)

²⁷⁷ [8/22/19-25, 151/26/7-9](#)

²⁷⁸ [151/22/13-14](#)

²⁷⁹ [151/22/20-21](#)

²⁸⁰ [151/22/22-23](#)

Nell Jones



- 9.93 Nell Jones was the daughter of Jayne and Ernie Jones and sister of Sam, Joe and William.²⁸¹ She was 14 years old at the time of her death on 22nd May 2017.²⁸²
- 9.94 Nell was gifted in very many ways. She excelled in English and maths and was placed on the *“gifted and talented register”*.²⁸³ She was described as a *“sheer delight”*²⁸⁴ to teach and a *“fabulous role model for others to look up to”*.²⁸⁵
- 9.95 Alongside her academic ability, Nell had a passion for drama. She shone on stage and loved entertaining others.²⁸⁶ She had a *“bright, bubbly, vibrant personality”*²⁸⁷ and she put her heart and soul into every performance she gave.²⁸⁸ She stood out as a star right from the start.²⁸⁹
- 9.96 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.²⁹⁰ Nell was described as the fun one in the friendship group, with a *“wicked sense of humour”*.²⁹¹ 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.”*²⁹² Nell’s parents are right to be very proud of her.

²⁸¹ [152/22/20-21](#)

²⁸² [152/22/23-24](#)

²⁸³ [8/3/9-11](#)

²⁸⁴ [8/3/24-25](#)

²⁸⁵ [8/4/3-4](#)

²⁸⁶ [8/4/12-13](#)

²⁸⁷ [8/4/13-14](#)

²⁸⁸ [8/4/13-15](#)

²⁸⁹ [8/7/2](#)

²⁹⁰ [8/9/1-5](#), [8/9/16-20](#), [8/11/2-21](#)

²⁹¹ [8/8/17](#), [8/9/6](#)

²⁹² [8/10/4-6](#)

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9.97 Nell was not a huge Ariana Grande fan, but was so excited to be going to the concert that night with a friend.²⁹³ Her mother Jayne had given her some money to spend at the merchandise stalls and told her to have a lovely time.²⁹⁴ Nell's friend recalls how much they enjoyed the concert and that they were singing and dancing from the very first song.²⁹⁵ They left after the final song and entered the City Room at 22:30:43.²⁹⁶

²⁹³ [152/25/9-13](#)

²⁹⁴ [152/25/15-19](#)

²⁹⁵ [152/26/4-6](#)

²⁹⁶ [152/26/7-9](#)

Olivia Paige Campbell-Hardy



- 9.98 Olivia Campbell-Hardy was the daughter of Charlotte Hodgson and Andrew Hardy.²⁹⁷ She was a much-loved stepdaughter, sister and granddaughter.²⁹⁸ She was 15 years old at the time of her death on 22nd May 2017.²⁹⁹
- 9.99 Olivia was a happy, determined girl who had packed so much into her 15 years.³⁰⁰ 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,³⁰¹ to the way she would speak in “*dinosaur language*”³⁰² and do Judge Rinder impressions.³⁰³ Anything she did, she made funny.³⁰⁴ She was always making people laugh and made an impact on everyone she met.³⁰⁵ Olivia didn’t just walk into a room; she would make an entrance.³⁰⁶ In addition to her loud and boisterous side, Olivia was gentle and caring and would “*fight for the underdog*”.³⁰⁷ She always put others before herself.³⁰⁸ She made the world a better place.³⁰⁹

²⁹⁷ [9/71/6](#), [10/3/8-9](#)

²⁹⁸ [9/71/8-12](#), [10/7/13-18](#), [10/3/6-14](#)

²⁹⁹ [9/71/7](#)

³⁰⁰ [151/12/20-21](#)

³⁰¹ [9/74/21-75/12](#)

³⁰² [9/80/11-15](#)

³⁰³ [9/80/16-20](#)

³⁰⁴ [9/78/13](#)

³⁰⁵ [9/81/16](#), [151/13/1](#), [151/13/10-11](#)

³⁰⁶ [151/12/24-25](#)

³⁰⁷ [151/15/9-11](#)

³⁰⁸ [9/77/17-18](#)

³⁰⁹ [9/84/11-12](#)

- 9.100** Olivia was a talented singer and had a promising future ahead of her.³¹⁰ She loved performing with her primary school choir, with her great-grandma 'Larlar'³¹¹ and even auditioned for *Britain's Got Talent*.³¹² Her mother recalls her singing at a family wedding aged 11, and reducing grown men to tears.³¹³ Her father recalls how proud he was when she sang at her Grandad Steve's 60th birthday party.³¹⁴ She dreamed of performing in the West End, of finding fame and getting a house in New York.³¹⁵
- 9.101** Olivia was clearly special and loved by all of her family.³¹⁶ 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.³¹⁷

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- 9.102** Olivia was a fan of Ariana Grande and had been offered a ticket by her friend.³¹⁸ They were extremely excited in the lead-up to the concert.³¹⁹ After school, they got the tram into Manchester and had something to eat before going into the Arena.³²⁰ Olivia's friend spoke of the fun they had at the concert, "*singing along*" and "*messing about*" together.³²¹ He said Ariana Grande "*was fantastic. We loved her.*"³²²
- 9.103** Olivia was in contact during the concert with her mum, who told Olivia that she loved her.³²³ Olivia and her friend left their seats after the encore and entered the City Room at 22:30:51.³²⁴

³¹⁰ [151/13/3-4](#)

³¹¹ [10/5/8-11](#), [151/13/5-6](#)

³¹² [10/4/13-14](#), [151/13/6-7](#)

³¹³ [9/81/2-7](#), [151/13/7-9](#)

³¹⁴ [10/5/22-23](#)

³¹⁵ [9/80/2-8](#)

³¹⁶ [151/12/6-8](#)

³¹⁷ [9/84/21-24](#)

³¹⁸ [10/6/17-20](#)

³¹⁹ [10/6/20-21](#)

³²⁰ [151/15/20-23](#)

³²¹ [151/16/11-14](#)

³²² [151/16/16-17](#)

³²³ [151/16/5-7](#)

³²⁴ [151/16/18-25](#)

Philip Tron



- 9.104** Philip Tron was the son of June and Keith Tron and father of Olivia.³²⁵ He was the twin brother of Rachel and the brother of Andrew, Michael and Victoria.³²⁶ Philip was 32 years old at the time of his death on 22nd May 2017.³²⁷
- 9.105** Philip was a larger-than-life character.³²⁸ He was a joker, hugely likeable and had *"the most recognisable big smile"*.³²⁹ He was a *"family-loving guy"*³³⁰ who would get the older generation up on the dancefloor at family functions, even those in wheelchairs, and twirl them around the floor.³³¹ Family was the most important thing to Philip and, above all, he wanted to find the right partner, settle down and have more children.³³²
- 9.106** 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"*³³³ for family and friends needing jobs carried out.³³⁴ His sister Vicky joked that Philip was a *"jack of all trades and master of none"*.³³⁵

³²⁵ [151/1/16-20](#)

³²⁶ [7/36/22-37/1](#)

³²⁷ [151/1/22-23](#)

³²⁸ [151/11/2-3](#)

³²⁹ [7/48/4-5](#)

³³⁰ [7/34/12](#)

³³¹ [7/35/3-6](#)

³³² [7/42/24-43/2](#)

³³³ [7/39/8-9](#)

³³⁴ [7/39/8-13](#)

³³⁵ [7/48/13](#)

- 9.107 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.³³⁶ 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"*.³³⁷
- 9.108 His happy-go-lucky character meant that he had many friends.³³⁸ I heard that Philip had a reputation for practical jokes and also for shying away from buying a round of drinks, much to the amusement of his family.³³⁹ 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!"*³⁴⁰ Philip's spirit of fun has left his loved ones with many happy memories. He will live on through those.³⁴¹

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- 9.109 Philip had attended the Arena with his 'mam' June, girlfriend Deborah Hutchinson and Deborah's daughters Courtney and Nicole Boyle.³⁴² Nicole had a ticket to the Ariana Grande concert and they were dropping her off.³⁴³ They spent time in Manchester shopping and sightseeing, and while Nicole was at the concert, the rest of the group went out for dinner.³⁴⁴
- 9.110 They returned to the car after their meal, where they waited for the concert to finish.³⁴⁵ June recalls she was having a jokey argument with Philip because he had written rude words in her quiz book.³⁴⁶ This kind of prank was typical of Philip, and as he and Courtney left to collect Nicole, June remembers laughing with him.³⁴⁷ Philip and Courtney entered the City Room at 22:22:11 from the direction of Manchester Victoria Railway Station.³⁴⁸

³³⁶ [7/41/1-8](#)

³³⁷ [7/40/10-21](#)

³³⁸ [7/35/18-19](#), [7/34/24-25](#)

³³⁹ [7/45/16-20](#)

³⁴⁰ [7/48/6-9](#)

³⁴¹ [151/11/9-11](#)

³⁴² [151/7/17-19](#)

³⁴³ [151/7/20-21](#)

³⁴⁴ [151/7/21-25](#)

³⁴⁵ [151/8/4-6](#)

³⁴⁶ [151/8/6-8](#)

³⁴⁷ [151/8/5-13](#)

³⁴⁸ [151/8/14-16](#)

Saffie-Rose Roussos



- 9.111 Saffie-Rose Roussos was the daughter of Lisa and Andrew Roussos.³⁴⁹ She was the younger sister of Ashlee Bromwich and Xander Roussos.³⁵⁰ Saffie-Rose was eight years old at the time of her death on 22nd May 2017.³⁵¹
- 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”*.³⁵² Later, at school discos, that quiet little girl *“became confident whilst dancing and singing”*.³⁵³ 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.³⁵⁴ She found joy in everything she did and brought a great deal of happiness to those around her.³⁵⁵
- 9.113 Saffie-Rose had bravery and strength.³⁵⁶ *“Couldn’t do it’ wasn’t Saffie’s style”* and the bangs and injuries that came from the backflips and somersaults never stopped her.³⁵⁷ All she ever wanted was a *“cuddle and kiss”* to make things better.³⁵⁸
- 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”*.³⁵⁹ Her father described her as *“perfection”* and remembers *“her beauty,*

³⁴⁹ [174/6/15-16](#)

³⁵⁰ [174/6/18-20](#)

³⁵¹ [174/6/21-22](#)

³⁵² [9/38/22](#), [9/39/18-23](#), [9/40/6-8](#)

³⁵³ [9/39/20-22](#)

³⁵⁴ [9/46/6-12](#)

³⁵⁵ [9/46/13-15](#)

³⁵⁶ [9/15/6](#)

³⁵⁷ [9/16/9](#), [9/16/19-21](#)

³⁵⁸ [9/16/20-22](#)

³⁵⁹ [174/7/18-20](#)

big brown eyes and smile” and how spending time with her felt like *“magic”*.³⁶⁰ She had a way with people who were drawn to her amazing magnetic personality.³⁶¹ She was so loved by her family and friends.

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- 9.115** Saffie-Rose received tickets to the Ariana Grande concert as a Christmas gift.³⁶² She was ecstatic to receive the tickets, to finally be going to see her *“idol”* along with Lisa and Ashlee.³⁶³ She would talk about it all the time, *“it was just the conversation of every day”* at home.³⁶⁴
- 9.116** On 22nd May 2017, Saffie-Rose returned from school and got ready for the concert.³⁶⁵ She wore an Ariana Grande Dangerous Woman Tour T-shirt and carried her Ariana Grande handbag.³⁶⁶ Andrew recalls waving Saffie-Rose, Lisa and Ashlee off and that he had never seen Saffie-Rose so excited.³⁶⁷ She was *“on cloud nine”*.³⁶⁸
- 9.117** Ashlee recalls having a good time at the concert and dancing with Saffie-Rose.³⁶⁹ 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 and Ashlee dance together and how happy Saffie-Rose was.³⁷⁰
- 9.118** They left their seats at the end of the concert.³⁷¹ Saffie-Rose, holding her mother’s hand, entered the City Room from the concourse area at 22:30:45.³⁷²

³⁶⁰ [174/8/9-11](#)

³⁶¹ [9/45/4-6](#)

³⁶² [174/145/7-13](#)

³⁶³ [174/145/17-146/10](#)

³⁶⁴ [174/146/2-6](#)

³⁶⁵ [174/11/1-2](#)

³⁶⁶ [174/11/2-4](#)

³⁶⁷ [174/11/9-11](#)

³⁶⁸ [174/11/12-13](#)

³⁶⁹ [174/11/23-25](#)

³⁷⁰ [174/148/25-149/3](#)

³⁷¹ [174/149/20-150/5](#)

³⁷² [174/12/8-13](#), [174/150/3-4](#)

Sorrell Leczkowski



- 9.119 Sorrell Leczkowski was the daughter of Samantha Leczkowski and the sister of Sebastian and Sophie.³⁷³ Sorrell was 14 years old at the time of her death on 22nd May 2017.³⁷⁴
- 9.120 Sorrell was a happy, positive and caring girl.³⁷⁵ She would “*light up the room as she entered, singing and dancing*”.³⁷⁶ Her independent spirit emerged from an early age.³⁷⁷ I heard of her powers of persuasion, even from the age of two, her sarcastic wit and her no-nonsense approach to life.³⁷⁸
- 9.121 Sorrell had a large, but close friendship group at school.³⁷⁹ Samantha agreed with the deputy head’s assessment that Sorrell was “*the roots and trunk and her friendships were the branches*”.³⁸⁰ She held everyone together and was a natural leader.³⁸¹

³⁷³ [153/68/22-24](#)

³⁷⁴ [4/41/23-24](#), [153/69/4-5](#)

³⁷⁵ [4/45/6-7](#)

³⁷⁶ [4/45/7-8](#)

³⁷⁷ [153/69/10-13](#)

³⁷⁸ [4/45/10-24](#), [4/55/23-24](#)

³⁷⁹ [4/48/3-4](#)

³⁸⁰ [4/48/15-21](#)

³⁸¹ [4/48/19-21](#)

- 9.122 Sorrell's family all adored her.³⁸² She was family orientated and loved it when everyone came together.³⁸³ Her family recall many happy memories together on holidays and days out.³⁸⁴ 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".³⁸⁵
- 9.123 Sorrell was creative, talented and ambitious.³⁸⁶ She had a clear plan for her future.³⁸⁷ 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.³⁸⁸ 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.³⁸⁹ Sorrell was awarded a posthumous honorary membership of the Barnard and Columbia Architecture Society, in light of her achievements.³⁹⁰
- 9.124 Sorrell's mother was so proud of Sorrell, whom she regarded not only as her daughter but also her best friend.³⁹¹ Sorrell considered her mum to be her "rock".³⁹² Sorrell should have had a "long, fun-filled life ahead of her"³⁹³ and, with her drive and determination, would have achieved so much.

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- 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.³⁹⁴ 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 to an end.³⁹⁵ While in the car, Sorrell helped Pauline and Samantha play a word game.³⁹⁶
- 9.126 They entered the City Room at 22:17:56, where they waited for Sorrell's sister and her friend.³⁹⁷ Pauline and Samantha recall how Sorrell was singing, dancing and making them laugh.³⁹⁸

³⁸² [153/69/14](#)

³⁸³ [153/69/16-17](#)

³⁸⁴ [153/69/14-15](#)

³⁸⁵ [153/69/17-21](#)

³⁸⁶ [153/69/22-25](#)

³⁸⁷ [153/69/25-70/1](#)

³⁸⁸ [153/70/2-5](#)

³⁸⁹ [4/49/4-11](#), [153/70/6-9](#)

³⁹⁰ [4/47/22-25](#)

³⁹¹ [4/46/7-8](#), [4/48/1](#), [4/49/21-23](#)

³⁹² [4/49/12-13](#)

³⁹³ [4/45/9](#)

³⁹⁴ [153/71/3-7](#)

³⁹⁵ [153/71/10-12](#)

³⁹⁶ [153/71/14-15](#)

³⁹⁷ [153/71/17-18](#)

³⁹⁸ [153/71/19-20](#)

Wendy Fawell



- 9.127 Wendy Fawell was the daughter of Julia and Michael Tiplady and the sister of Andrew. She was mother to Adam and Charlotte.³⁹⁹ Wendy was 50 years old at the time of her death on 22nd May 2017.⁴⁰⁰
- 9.128 Wendy was a fun person who had a great deal to live for.⁴⁰¹ Her family told of how Wendy loved socialising and spending time with family and friends.⁴⁰² She was *"the life and soul of a party"*⁴⁰³ and loved having people around her.⁴⁰⁴ She was a brilliant cook.⁴⁰⁵ Her family recall amazing Christmas dinners and that Wendy would host barbecues with enough food to feed an army.⁴⁰⁶ *"This was Wendy at her best: looking after everyone, making sure they were having a good time."*⁴⁰⁷
- 9.129 Wendy loved being a mum to Adam and Charlotte, who *"were always paramount in her thoughts and deeds"*.⁴⁰⁸ She was a wonderful mother.⁴⁰⁹ Her caring nature meant she tried to mother everyone⁴¹⁰ and *"gave so much of herself"*.⁴¹¹ Her mother, Julia, told of Wendy's love of Elvis Presley and the *"wicked sense of humour"* she had inherited from her.⁴¹²

³⁹⁹ [152/15/1-3](#)

⁴⁰⁰ [152/15/4-5](#)

⁴⁰¹ [9/3/6](#), [152/16/7-8](#)

⁴⁰² [152/16/8-9](#)

⁴⁰³ [9/2/17-18](#)

⁴⁰⁴ [9/2/24-25](#)

⁴⁰⁵ [152/16/14-15](#)

⁴⁰⁶ [9/9/14-15](#), [152/16/15-16](#)

⁴⁰⁷ [9/9/15-17](#)

⁴⁰⁸ [9/10/8-9](#), [152/16/10](#)

⁴⁰⁹ [9/10/8](#)

⁴¹⁰ [152/16/10-11](#)

⁴¹¹ [152/16/25-17/1](#)

⁴¹² [9/6/17-7/11](#), [9/7/14-23](#)

9.130 I heard much about Wendy's love of children, not just her own but also those she worked with.⁴¹³ In recent years, she was a dinner lady and worked at a before and after school club.⁴¹⁴ For Wendy, working with children was her dream.⁴¹⁵ Not only that, but she had a great talent for it.⁴¹⁶ She took to it like "a duck to water" and passed her qualifications "with flying colours".⁴¹⁷ She was kind, compassionate and had a fun personality, which meant that children enjoyed spending time with her.⁴¹⁸ 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.⁴¹⁹ 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.⁴²⁰

9.132 Wendy and Caroline returned to the Arena to collect their children, entering the City Room from the raised walkway at 22:30:24.⁴²¹ Wendy and Caroline separated in the City Room in order to ensure that they did not miss their children in the crowds.⁴²²

⁴¹³ [9/2/12-14](#), [152/21/23-24](#)

⁴¹⁴ [152/16/19-21](#)

⁴¹⁵ [9/8/22-23](#)

⁴¹⁶ [152/21/24-25](#)

⁴¹⁷ [9/8/22-24](#), [152/15/18-19](#)

⁴¹⁸ [152/15/18-16/24](#)

⁴¹⁹ [152/17/5-7](#)

⁴²⁰ [152/17/8-16](#)

⁴²¹ [152/17/19-23](#)

⁴²² [152/17/24-18/2](#)

Part 10

What went wrong

Introduction

- 10.1 Significant aspects of the emergency response on 22nd 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'.¹ In my Report, the term will be used to refer to the period from 22:31 to 23:30. In using this term, I recognise that one hour is an arbitrary period of time. The time it takes to respond will be dependent on many

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](#)

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 22nd 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.² The five main principles for achieving this, known as the *“Principles for joint working”*, were: communication, co-location, co-ordination, shared situational awareness and joint understanding of risk.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 *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.
- 10.16** 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”*.⁴ 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”*.⁵
- 10.17** 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.”*⁶ 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.
- 10.18** 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).

² [INQ004542/16](#)

³ [INQ004542/5](#)

⁴ [INQ004542/8](#)

⁵ [INQ004542/8](#)

⁶ [INQ004542/17](#)

- 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"*.⁷
- 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 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 NWS at 22:41. It did

⁷ [INQ001231/2](#)

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”*.⁸ 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.

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.”*⁹
- 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.¹⁰ GMP Control informed NWAS Control that there were *“probably at least 20”* police officers on the scene.¹¹
- 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.

⁸ [INQ002000/29](#)

⁹ [INQ015140T/2](#)

¹⁰ [INQ015140T/3](#)

¹¹ [INQ015140T/2](#)

- 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 NWS. This would have given NWS 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"*.¹³ It was passed on to NWS 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 NWS 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

¹² [INQ018514T/4](#)

¹³ [INQ007214/10](#)

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** NWS had decided that Manchester Central Fire Station would be used by its ambulances as an RVP. NWS 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 NWS. 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.

NWS Tactical Commander and the Hazardous Area Response Team

- 10.58** At the same time, NWS Control contacted Annemarie Rooney, the NWS on-call Tactical Commander. She was told that there were reports of a bomb explosion at the Arena. At 22:39, Annemarie Rooney told NWS Control,

*"[W]e need to get HART."*¹⁴ HART stands for Hazardous Area Response Team. HART is an NWS specialist resource with training and equipment that enable it to work in hazardous areas.

- 10.59** NWS 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. NWS 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 NWS 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 NWS 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.

¹⁴ [INQ015353T/1](#)

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*”.¹⁵
- 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.

¹⁵ [97/174/24-175/21](#)

¹⁶ [INQ018839T/8](#)

¹⁷ [102/100/2-11](#)

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 NWS 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”.¹⁸ He entered the Victoria Exchange Complex at 22:50 and updated NWS 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 NWS. They want every NWS there ... At the booking office which is just ... upstairs.”¹⁹ 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.

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.

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

¹⁹ [76/77/25-79/22](#)

- 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 NWS Consultant Paramedic Daniel Smith

- 10.83 At the same time, Consultant Paramedic Daniel Smith radioed NWS Control. At that time, he was travelling to the Victoria Exchange Complex. He told NWS 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 NWS 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

²⁰ [INQ018514T/14](#)

²¹ [INQ018644T/9](#)

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*”²² 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

²² [101/76/11-19](#)

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 NWS 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. NWS 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 NWS.
- 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 NWS Control

10.116 At 22:51, GMP Control told NWS 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 NWS 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 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.

NWS 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 NWS 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 NWS Control replied to confirm that *“everyone is now making their way to Hunts Bank”*.²⁶ 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.

²³ [INQ015139T/1](#)

²⁴ [INQ015139T/1](#)

²⁵ [INQ015139T/1](#)

²⁶ [INQ015070T](#)

10.123 The METHANE message did not identify that GMFRS personnel were not present or that they were needed. NWS did not share the METHANE message with BTP, GMP or NWFC. This compounded the earlier failure by NWS 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*".²⁷ 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 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 NWS "Bronze Commander"

10.128 At 22:55, NWFC was informed by GMP Control that NWS had a "*Bronze Commander*" on the scene. This was a reference to Patrick Ennis, who Inspector Smith had mistaken for the NWS 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.

²⁷ [103/24/11-25/3](#)

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."*²⁸
- 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.

²⁸ [INQ028932/52](#)

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.
- 10.168** 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

10.169 The area in which casualties receive treatment before being moved to hospital in a mass casualty situation is called a Casualty Clearing Station. In the course of his conversation with Patrick Ennis, Daniel Smith decided to locate the Casualty Clearing Station by the War Memorial entrance.

10.170 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"*.²⁹ 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

²⁹ [119/128/1-5](#)

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."*³⁰ 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.

³⁰ [109/199/21-200/9](#)

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 NWS 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 NWS could co-ordinate 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** NWS 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.³¹ 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.
- 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.

³¹ [107/90/10-20](#)

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 NWS 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 NWS. 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 NWS 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 NWS 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."*³² 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"*.³³ Dissatisfied 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 NWS 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.

³² [INQ018835T/13](#)

³³ [INQ018835T/15](#)

- 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 22nd 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 NWS 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.
- 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.

¹ [INQ004542](#)

² [INQ008372/1](#)

³ [INQ041126](#)

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).⁴ Underpinning and complementing it were the Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005 (the 2005 Regulations).⁵
- 11.6** Section 2(1) and Schedule 1 of the 2004 Act described a number of organisations as “*Category 1 responders*”.⁶ 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.⁷

⁴ [Civil Contingencies Act 2004](#)

⁵ [Civil Contingencies Act 2004 \(Contingency Planning\) Regulations 2005](#)

⁶ [Civil Contingencies Act 2004, Schedule 1, Part 1](#)

⁷ [INQ004370/12](#) at paragraph 6.1

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.⁸ 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 operations; and difficulties resulting from the lack of a common Rendezvous Point.

⁹ Rt Hon. Lady Justice Hallett DBE, *Coroner's Inquests into the London Bombings of 7 July 2005, Report under Rule 43 of The Coroner's Rules 1984*, 6 May 2011

- 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 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.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).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.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.
- 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.¹⁶

¹⁰ [INQ024271/47](#)

¹¹ [INQ024271/47](#) at paragraph 4.1.2

¹² [INQ018900](#)

¹³ [INQ016167/1-8](#)

¹⁴ [INQ024271/48](#)

¹⁵ [INQ004542](#)

¹⁶ [INQ024271/50](#)

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."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".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.

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."¹⁹

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.

¹⁷ [INQ004542/2](#)

¹⁸ [INQ004542/2](#)

¹⁹ [INQ004542/5](#)

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 Doctrine²⁰

- 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."*²¹ 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.

²⁰ INQ004542/5

²¹ INQ004542/5

²² INQ004542/10

²³ INQ004542/12

- 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.

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."²⁴

- 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."²⁵

- 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."²⁶* 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.²⁷ 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.²⁸

- 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.²⁹ During the first ten minutes, the only emergency service with personnel in the

²⁴ [INQ004542/6](#)

²⁵ [INQ004542/13](#)

²⁶ [INQ004542/6](#)

²⁷ [142/26/1-18](#), [142/196/3-17](#), [143/130/23-131/7](#)

²⁸ [INQ004542/8](#)

²⁹ [92/43/18-44/18](#)

City Room was BTP.³⁰ 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 2017.³¹ In Parts 12 and 13, I shall provide more detail in relation to this.

Principle 2: Communication

11.37 The Joint Doctrine stated:

“Meaningful and effective communication between responders and responder agencies underpins effective joint working.”³²

11.38 It also stated:

“Using terminology that either means different things to different people, or is simply not understood across different services is a potential barrier to interoperability.”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 23:39.³⁴ 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 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.³⁵ Some NWS 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.³⁶ 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.

³⁰ [INQ035612/5](#)

³¹ [122/155/21-158/10](#), [INQ017957/1-4](#)

³² [INQ004542/6](#)

³³ [INQ004542/7](#)

³⁴ [98/119/13-120/4](#)

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](#)

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.”³⁷

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.³⁸ 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.³⁹ 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.⁴⁰

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

³⁷ [INQ004542/7](#)

³⁸ [101/2/24-3/6](#), [102/162/1-17](#)

³⁹ [95/34/13-35/9](#)

⁴⁰ [110/94/15-19](#), [110/107/6-108/3](#)

⁴¹ [INQ004542/7](#)

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.

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 NWS 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, NWS 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 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.”⁴⁵

⁴² [INQ004542/17](#)

⁴³ [103/1/6-19](#)

⁴⁴ [185/61/7-65/15](#)

⁴⁵ [INQ004542/8](#)

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."⁴⁶

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.

⁴⁶ [INQ004542/5](#)

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.⁴⁷

- 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

⁴⁷ [INQ004542/8](#)

⁴⁸ [INQ004542/9](#)

M	MAJOR INCIDENT	Has a major incident or standby been declared? (Yes / No - if no, then complete ETHANE message)	Include the date and time of any declaration.
E	EXACT LOCATION	What is the exact location or geographical area of the incident?	Be as precise as possible, using a system that will be understood by all responders.
T	TYPE OF INCIDENT	What kind of incident is it?	For example, flooding, fire, utility failure or disease outbreak.
H	HAZARDS	What hazards or potential hazards can be identified?	Consider the likelihood of a hazard and the potential severity of any impact.
A	ACCESS	What are the best routes for access and egress?	Include information on inaccessible routes and rendezvous points (RVPs). Remember that services need to be able to leave the scene as well as access it.
N	NUMBER OF CASUALTIES	How many casualties are there, and what condition are they in?	Use an agreed classification system such as 'P1', 'P2', 'P3' and 'dead'.
E	EMERGENCY SERVICES	Which, and how many, emergency responder assets and personnel are required or are already on scene?	Consider whether the assets of wider emergency responders, such as local authorities or the voluntary sector, may be required.

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 the M/ETHANE model. Declaring a major incident begins the process of activating relevant plans.”⁵⁰

⁴⁹ INQ004542/9

⁵⁰ INQ004542/26

- 11.59** BTP and NWS personnel provided METHANE messages to their respective control rooms.⁵¹ 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 NWS 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 NWS. Separately, NWS declared a Major Incident. Neither BTP nor NWS 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

⁵¹ [73/68/1-11](#), [110/46/21-47/9](#), [110/177/10-180/11](#)

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?"⁵³*

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."⁵⁴

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.

...

⁵³ [INQ004542/11-12](#)

⁵⁴ [INQ004542/12](#)

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

- 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

⁵⁵ [INQ004542/27-28](#)

⁵⁶ [INQ004542/23](#)

⁵⁷ [INQ004542/15](#)

11.71 Figure 24 shows the Joint Decision Model process:

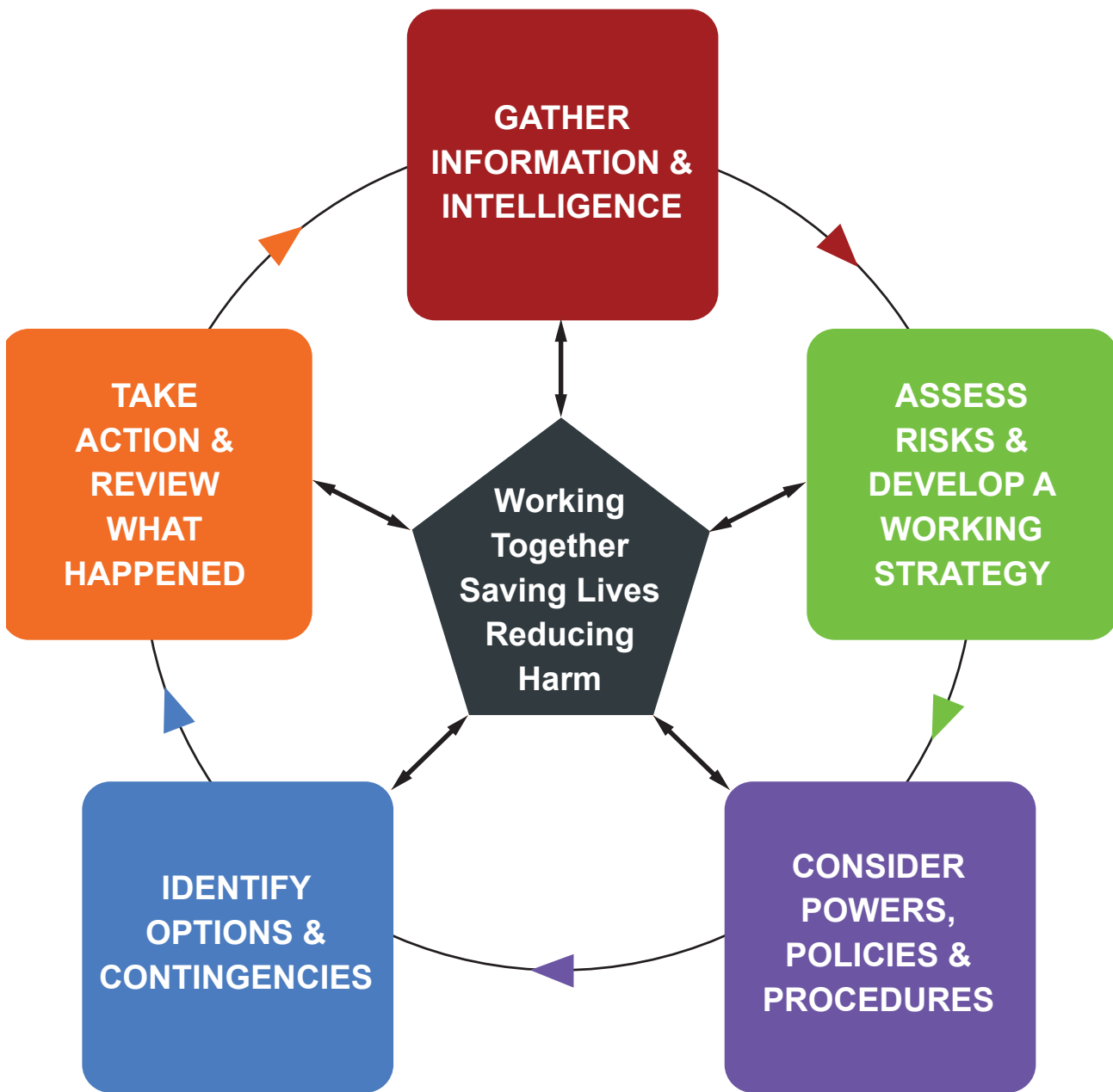


Figure 24: Joint Decision Model⁵⁸

11.72 The most important consideration, throughout the decision-making process, is “to save lives and reduce harm”.⁵⁹ Every stage of the decision-making process should have this as its focus.

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

⁵⁸ INQ004542/15

⁵⁹ INQ004542/16

*continuous effort as the situation, and responders' understanding, will change over time. Understanding the risks is vital in establishing shared situational awareness.*⁶⁰

- 11.74** When making his initial command decisions, the NWAS Operational Commander should have worked with GMP to gather and assess information and intelligence.⁶¹ 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.⁶² 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 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 ...

⁶⁰ [INQ004542/15-16](#)

⁶¹ [110/110/15-111/10](#)

⁶² See Appendix 11 in Volume 2-II

...

*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.*⁶³

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.

⁶³ [INQ004542/30-31](#)

The Joint Operating Principles

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.

⁶⁴ [INQ008372/1](#)

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.”⁶⁵

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

⁶⁵ [INQ008372/2](#)

Glossary

11.85 The Glossary contained the following definitions:

Cold Zone	Area where it has been assessed that there is no immediate threat to life.
Warm Zone	Where the attackers are believed to have passed through but could enter/re-enter imminently. These areas cannot be guaranteed as safe.
Hot Zone	Where the attackers are present and/or there is an immediate threat to life.
On-scene commander	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.
Tactical Firearms Commander (TFC)	Develops, commands and coordinates the overall tactical response in accordance with strategic objectives.
Strategic Firearms Commander (SFC)	Determines the strategic objectives and sets any tactical parameters. Retains strategic oversight and overall command responsibility.

Table 1: Selected definitions from Glossary in JOPs 3⁶⁶

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]."*⁶⁷

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.

⁶⁶ INQ008372/4-5

⁶⁷ INQ008372/5

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

⁶⁸ [INQ008372/6](#)

⁶⁹ [INQ008372/8](#)

⁷⁰ [INQ008372/8](#)

⁷¹ [60/40/17-41/18](#)

⁷² [110/142/10-18](#)

Identification, mobilisation and scene assessment

Paragraph 4.1

11.92 Paragraph 4.1 of JOPs 3 stated:

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

Operation PLATO is the multi-agency response to the incident, whilst MTFAs describes the type of incident. Early identification of an MTFAs 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.”⁷³

11.93 On 22nd May 2017, Operation Plato was mentioned by firearms officers at 22:38⁷⁴ and 22:43.⁷⁵ Operation Plato was formally declared by the FDO, Inspector Sexton, at 22:47.⁷⁶ 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 MTFAs has been declared to enable FRS and Ambulance services to put their contingency plans into effect.*”**

As soon as the police have declared an MTFAs, the ambulance and FRS control rooms should be notified immediately. It is imperative that this action is undertaken straight away so that MTFAs 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.”⁷⁷

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.

⁷³ [INQ008372/9](#)

⁷⁴ [INQ018367T/2](#)

⁷⁵ [INQ024445T/1](#)

⁷⁶ [97/162/22-164/3](#)

⁷⁷ [INQ008372/9](#)

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

⁷⁸ [INQ008372/10](#)

⁷⁹ [97/93/10-94/6](#)

⁸⁰ [97/54/4-15](#)

*and assumes the role of 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.*⁸¹

- 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.⁸² 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 Firearms 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.⁸³ He did not 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."⁸⁴

- 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.⁸⁵ Four minutes after the declaration of Operation Plato, GMP Control informed NWS Control that they should send ambulances to Hunts Bank.⁸⁶ This was not adopted immediately by NWS for all of its personnel. I shall return to this in Part 14.

⁸¹ [INQ008372/10-11](#)

⁸² [53/108/17-24](#)

⁸³ [102/28/21-29/1](#), [102/35/20-38/7](#)

⁸⁴ [INQ008372/11](#)

⁸⁵ [147/5/1-6/2](#)

⁸⁶ [INQ015139T/1](#)

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.”⁸⁷

11.105 No Forward Command Post (FCP) was established by the police or any other agency during the critical period of the response.⁸⁸

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.”⁸⁹

11.107 An FCP could and should have been established by GMP approximately 30 minutes after the explosion.⁹⁰

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

⁸⁷ [INQ008372/13](#)

⁸⁸ [147/6/7-14](#)

⁸⁹ [INQ008372/13](#)

⁹⁰ [147/7/3-13](#)

⁹¹ [INQ008372/14](#)

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 were the GMP firearms officers.⁹² 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.”⁹³

11.111 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

11.112 Paragraph 4.12 of JOPs 3 stated:

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

⁹² [97/113/5-114/23](#)

⁹³ [INQ008372/14-15](#)

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.”⁹⁴

- 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 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 circumstances, it is assessed that it is reasonable to deploy officers with standard personal protective equipment should deployment take place.”⁹⁶

⁹⁴ [INQ008372/15](#)

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](#)

⁹⁶ [INQ008372/17](#)

- 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.⁹⁷ 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 NWS Operational Commander and the National Interagency Liaison Officer from GMFRS understood JOPs 3.⁹⁸ It was not the intended meaning.⁹⁹
- 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.¹⁰⁰

⁹⁷ [110/142/10-22](#), [106/86/25-88/10](#), [141/33/13-34/20](#), [120/246/20-247/12](#)

⁹⁸ [106/86/25-88/10](#), [110/142/10-22](#), [120/246/20-247/12](#)

⁹⁹ [141/33/13-34/20](#)

¹⁰⁰ [141/33/13-34/20](#)

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.
- 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.

¹⁰¹ [145/44/22-45/20](#)

¹⁰² [INQ042758](#)

¹⁰³ [145/45/6-20](#)

¹⁰⁴ [145/48/10-17](#)

¹⁰⁵ [133/89/18-22](#), [INQ042758](#), [INQ041126](#)

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

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.”¹⁰⁷

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”.¹⁰⁸

11.125 A list of hazards or threats that might result in an emergency were listed. This included “bomb threat”.¹⁰⁹

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.¹¹⁰ 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.

¹⁰⁶ [INQ042758/1](#)

¹⁰⁷ [INQ042758/1](#)

¹⁰⁸ [INQ042762/1](#)

¹⁰⁹ [INQ042762/5](#)

¹¹⁰ [INQ042763/1](#)

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.”¹¹¹

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”*.¹¹² 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.¹¹³

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.”*¹¹⁴ The Ambulance Service Experts, Christian Cooper and Michael Herriot, stated that the guidance expected a comprehensive risk assessment.¹¹⁵ They explained that this should identify the *“right skills”* required to anticipate the type of conditions that may be encountered.¹¹⁶

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.¹¹⁷

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.¹¹⁸

11.132 There was an expectation that all details of cover being provided should be made in writing.¹¹⁹

¹¹¹ [INQ042763/1](#)

¹¹² [INQ042763/3](#)

¹¹³ [INQ042763/2](#)

¹¹⁴ [INQ042763/2](#)

¹¹⁵ See Appendix 11 in Volume 2-II

¹¹⁶ [145/49/5-14](#)

¹¹⁷ [INQ042763/5](#)

¹¹⁸ [INQ042763/5](#)

¹¹⁹ [INQ042763/6](#)

11.133 RVPs should be shared with staff within an event to “assist a smooth flow to any incident, whether major or not”.¹²⁰ 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”.¹²¹

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.¹²²

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.¹²³

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.”¹²⁴ 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.”¹²⁵ 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.¹²⁶

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 safe can only be determined after a comprehensive risk assessment.¹²⁷

¹²⁰ [INQ042763/7](#)

¹²¹ [INQ042763/7](#)

¹²² [INQ042763/9](#)

¹²³ [INQ042763/10](#)

¹²⁴ [INQ041126/10](#) at paragraph 5.47

¹²⁵ [INQ041126/11](#) at paragraph 5.48

¹²⁶ [145/48/1-7](#)

¹²⁷ [INQ042764/1](#)

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

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

Table 2: Outline guidance table for healthcare provision at medium-sized events¹²⁸

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

¹²⁸ [INQ042764/2](#)

¹²⁹ [INQ042763/7](#)

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.

Greater Manchester Resilience Forum preparedness

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

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
- 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 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.¹⁴

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](#)

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](#)

¹⁴ [58/36/12-20](#)

- 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.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.¹⁶ The preparation of plans and the exercising of those plans were of critical importance.¹⁷
- 12.13** Local resilience forums were required to produce a Community Risk Register.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.¹⁹ The Community Risk Register reflected a strategic approach to preparing for emergencies.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.²¹ The publicly available copy of the Community Risk Register in place at the time listed "*Terrorist attacks on crowded places*" as a recognised risk.²²

Resilience and Emergencies Division

- 12.14** In 2017, the Resilience and Emergencies Division was responsible for liaison and co-ordination of the national network of local resilience forums. It was part of the Department for Communities and Local Government.²³ It had offices in Leeds, Birmingham, Bristol and London.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.²⁵
- 12.15** In 2017, Margaret Gillespie was the Department for Communities and Local Government's Head of Resilience for the North of England.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

¹⁵ [58/16/15-17/8](#)

¹⁶ [58/37/2-20](#)

¹⁷ [58/37/21-38/1](#)

¹⁸ [INQ019376/10](#)

¹⁹ [58/31/19-32/10](#), [INQ018888/1-3](#)

²⁰ [58/36/17-23](#)

²¹ [58/32/13-33/5](#)

²² [INQ019168/42](#)

²³ [68/123/6-18](#)

²⁴ [68/123/4-18](#)

²⁵ [68/117/3-12](#), [68/115/9-17](#)

²⁶ [68/115/4-8](#)

²⁷ [68/118/7-18](#)

- 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.³³ She believed that its work at “persuasion” and “influencing” was very effective.³⁴ 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.³⁵ A local resilience forum, however, did not have powers to penalise members who did not attend.³⁶ 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.³⁷
- 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.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.

²⁸ [68/118/20-119/19](#)

²⁹ [68/119/6-9](#), [68/137/2-25](#)

³⁰ [68/119/24-120/7](#)

³¹ [68/141/18-22](#)

³² [68/142/23-143/4](#)

³³ [68/147/14-148/13](#), [68/151/2-152/16](#), [68/155/12-156/13](#)

³⁴ [68/155/15-156/10](#)

³⁵ [INQ019376/11](#)

³⁶ [58/25/18-26/12](#), [68/152/17-153/16](#)

³⁷ [117/3/13-17](#)

³⁸ [58/26/13-27/19](#)

- 12.22 The Resilience and Emergencies Division captured lessons learned from the local response to an incident and fed that into central government.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.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.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.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.⁴³ A representative from the Resilience and Emergencies Division fulfilled this role in the Strategic Co-ordinating Group in response to the Attack.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.⁴⁵

GMRF

- 12.25 GMRF was set up in 2005.⁴⁶ Its terms of reference set out its core objectives.⁴⁷ These focused on ensuring that responders co-ordinate 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

³⁹ [INQ018892/107](#), [68/125/15-126/21](#)

⁴⁰ [68/125/9-126/21](#)

⁴¹ [68/149/25-150/5](#)

⁴² [68/141/18-21](#)

⁴³ [68/149/10-150/10](#)

⁴⁴ [68/123/19-124/20](#)

⁴⁵ [68/151/12-152/16](#)

⁴⁶ [58/45/7-10](#), [Greater Manchester Resilience Strategy 2020-2030](#) at page 26

⁴⁷ [58/45/11-46/13](#), [INQ012418/1](#)

⁴⁸ [58/14/10-15](#), [58/45/11-46/10](#)

⁴⁹ [INQ012418/1](#)

- 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 co-ordinated response to an emergency, it should be escalated to GMRF.⁵¹
- 12.29** Deputy Chief Fire Officer Argyle explained that GMRF did not audit or monitor all the activities of its members.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.⁵³

Membership, structure and funding of GMRF

- 12.30** The membership of GMRF comprised Category 1 responders including GMP, NWAS, GMFRS and BTP.⁵⁴ The Association of Greater Manchester Civil Contingencies and Resilience Unit represented the ten local authorities in Greater Manchester on GMRF.⁵⁵ Category 2 responders such as Network Rail and Transport for Greater Manchester, as well as other organisations, were also GMRF members.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.⁵⁷
- 12.31** GMRF had a wide membership of organisations across Greater Manchester. NWFC was not a member in its own right.⁵⁸ 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.⁵⁹
- 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*"⁶⁰ 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.⁶¹

⁵⁰ [58/120/3-121/8](#)

⁵¹ [58/120/3-121/8](#)

⁵² [58/118/19-119/8](#)

⁵³ [58/117/14-25](#)

⁵⁴ [58/60/21-61/5](#)

⁵⁵ [58/66/25-68/8](#)

⁵⁶ [58/66/2-8](#)

⁵⁷ [58/66/2-24](#)

⁵⁸ [58/62/9-16](#)

⁵⁹ [58/61/2-62/21](#)

⁶⁰ [58/64/19-65/21](#)

⁶¹ [58/64/19-65/21](#)

- 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.⁶² 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.
- 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
- 12.37** Usually, debriefs from training exercises would be passed through the Resilience Development Group.⁶⁸ It checked if it agreed with the learning points. If so, it would design a solution to deliver any resulting recommendations.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.⁷⁰ Deputy Chief Fire Officer Argyle did not accept that “*it was a bit pot luck*”⁷¹ whether issues that had come up during training exercises were referred to GMRF.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.

⁶² [INQ035431/1](#) at paragraph 2, [INQ041685/1](#) at paragraph 2

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](#)

⁶⁸ [58/121/12-122/12](#), [58/124/20-125/13](#)

⁶⁹ [58/121/12-123/8](#)

⁷⁰ [58/121/12-123/8](#), [58/124/20-125/13](#)

⁷¹ [58/123/17-124/19](#)

⁷² [58/123/17-124/19](#)

- 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.⁷³ Representatives from each responder or agency sat on the sub-groups.⁷⁴ The sub-groups reported upwards to GMRF top tier and received work downwards.⁷⁵
- 12.39** Local partners funded GMRF. There was no consistent or guaranteed budget from central government.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.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.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.⁷⁹ As with access to funding, it is important to ensure that local resilience forums have access to adequate staff and 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.⁸⁰ Contingency plans for those risks were reviewed and the results of each risk assessment recorded in the private Community Risk Register.⁸¹ Due to its sensitive nature, GMRF handled the risk of terrorism separately from other civil emergencies.⁸²
- 12.42** GMRF contingency plans focused on the arrangements for a multi-agency response to an emergency.⁸³ Each organisation had its own plans. GMRF multi-agency plans focused on arrangements for activation, command and control, and information-sharing between organisations.⁸⁴ Examples of GMRF multi-agency plans included a strategic recovery guidance plan, an emergency

⁷³ [INQ035309/34](#)

⁷⁴ [58/14/16-15/12](#)

⁷⁵ [58/15/2-18](#)

⁷⁶ [58/46/25-47/7](#)

⁷⁷ [58/46/22-48/20](#)

⁷⁸ [146/66/11-67/5](#)

⁷⁹ [58/48/21-49/11](#)

⁸⁰ [58/50/14-22](#)

⁸¹ [58/50/12-51/8](#)

⁸² [58/51/9-15](#), [58/138/6-140/10](#)

⁸³ [58/52/19-53/10](#)

⁸⁴ [58/52/19-53/10](#)

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 retired as Chair in August 2019.⁹¹ The top-tier meetings typically lasted half a day.⁹²
- 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.⁹³ Most work was done outside the meetings. This was normal practice.⁹⁴
- 12.46** The Cabinet Office reference document required that participants in local resilience forums be of a sufficiently senior level of responsibility.⁹⁵ This meant that they must be at Chief Officer level. Deputy Chief Fire Officer Argyle believed that “usually” GMRF achieved this.⁹⁶ As the evidence showed, this was not usually the case for either BTP or GMP.⁹⁷

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](#)

⁹¹ [58/49/12-24](#)

⁹² [58/135/1-4](#)

⁹³ [58/49/25-50/8](#)

⁹⁴ [58/133/14-134/12](#)

⁹⁵ [58/94/6-19](#), [INQ019376/12](#)

⁹⁶ [58/94/6-95/11](#)

⁹⁷ [146/68/18-69/1](#), [58/99/4-13](#), [INQ035309/55-56](#)

- 12.47** Participants in a local resilience forum must also be from the cadre of officers who can form a Strategic Co-ordinating Group.⁹⁸ 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.⁹⁹ Deputy Chief Fire Officer Argyle agreed with this analysis.¹⁰⁰
- 12.48** There were nine meetings of the GMRF top tier between 13th March 2015 and 27th March 2017, the latter being the final meeting before the Attack.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.¹⁰²
- 12.50** BTP was only present at three of those meetings in any capacity.¹⁰³ A Chief Inspector attended one meeting and two different Inspectors the other two meetings, one with a civilian member of staff.¹⁰⁴
- 12.51** Judged against the sensible standard expected by the Cabinet Office document, the participation 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"*.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.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"*.¹⁰⁷ Inevitably, that meant it did not fulfil its role to take part in joint planning.¹⁰⁸ ACC O'Callaghan said that his

⁹⁸ [58/95/12-20](#)

⁹⁹ [58/95/21-96/4](#)

¹⁰⁰ [58/94/21-96/5](#)

¹⁰¹ [58/97/12-99/8](#)

¹⁰² [58/97/12-99/8](#)

¹⁰³ [INQ035309/55-56](#)

¹⁰⁴ [139/8/24-9/10](#)

¹⁰⁵ [58/99/8-13](#), [58/100/7-16](#)

¹⁰⁶ [58/97/82-101/1](#)

¹⁰⁷ [139/9/11-10/10](#)

¹⁰⁸ [139/12/13-19](#)

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 sub-divisional 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 failing to do so risked a perception that GMP did not place enough emphasis on joint working.¹¹⁴ He stated that perception would be incorrect and that GMP *"were very much engaged with the process"*.¹¹⁵ He agreed GMP should have had better representation at Assistant Chief Constable level.¹¹⁶
- 12.57** GMP Inspector June Roby was Chair of the GMRF Training and Exercising Co-ordination Group.¹¹⁷ She was a regular member of the Resilience Development Group. She acted as an adviser to the GMP senior officer attending GMRF meetings.¹¹⁸ The evidence shows that she attended three of the nine meetings which preceded the Attack, once as the most senior officer from GMP.¹¹⁹ 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.¹²⁰

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](#)

¹¹⁴ [130/181/14-182/23](#)

¹¹⁵ [130/181/14-182/13](#)

¹¹⁶ [130/181/14-182/13](#)

¹¹⁷ [67/10/6-10](#)

¹¹⁸ [67/10/1-11/7](#)

¹¹⁹ [INQ035309/55-56](#)

¹²⁰ [67/22/19-25/25](#)

- 12.58** The Ambulance Service Experts noted that NWS 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 NWS. Taking the resources available to NWS into consideration, the Ambulance Service Experts considered NWS's participation to have been reasonable.¹²¹
- 12.59** I do not disagree with the Ambulance Service Experts' assessment that NWS'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 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.¹²³ 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.¹²⁴ A Strategic Co-ordinating Group co-ordinates the strategic response to an incident and the initial stages of the recovery.¹²⁵ 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.¹²⁶
- 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.¹²⁷ This 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.¹²⁸

¹²¹ [INQ041856/5](#)

¹²² [58/1/20-25](#)

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](#)

¹²⁸ [58/64/19-65/21](#)

In a terror-related incident, the police chair the Strategic Co-ordinating Group.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.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.¹³¹ The GMRF Generic Response Plan also stated that a Strategic Co-ordinating Group is activated where a catastrophic event has occurred or is imminent, or the Tactical Co-ordinating Group requests it.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.¹³³ Deputy Chief Fire Officer Argyle explained that a Strategic Co-ordinating Group should be convened as early as possible in an incident.¹³⁴ People needed to be warned to attend and be prepared to contribute to it effectively.¹³⁵
- 12.66** The first Strategic Co-ordinating Group after the Attack was not convened until 04:15 on 23rd May 2017.¹³⁶ 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 22nd May 2017, it may be that the importance of convening a Strategic Co-ordinating Group earlier in the emergency response would have been apparent.

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.¹³⁷ It used the Community Risk Register to plan exercises and training. Sometimes members of GMRF identified a new issue that required joint

¹²⁹ [58/39/2-41/7](#)

¹³⁰ [58/42/9-16](#)

¹³¹ [58/55/22-56/7](#), [INQ012487/1-3](#)

¹³² [58/56/8-15](#)

¹³³ [58/56/8-20](#)

¹³⁴ [58/58/17-59/8](#)

¹³⁵ [58/58/17-59/8](#)

¹³⁶ [105/206/4-14](#)

¹³⁷ [58/31/13-32/18](#), [58/74/24-75/13](#), [INQ018888/3](#)

training.¹³⁸ 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.¹³⁹

- 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 2017.¹⁴⁰ These exercises were designed to test joint working between the emergency services.¹⁴¹ Many focused on aspects of the multi-agency response to a terrorist incident.¹⁴²
- 12.69** Examples of these exercises include the following. In 2012, Exercise Joint Enterprise tested the joint response by GMP, NWS and GMFRS to an Operation Plato incident.¹⁴³ In 2013, tabletop Exercise Mars raised awareness of Tactical/Silver Commanders to respond to a Major Incident.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.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.¹⁴⁶
- 12.71** There were at least nine further multi-agency exercises in 2016 and 2017 in which GMRF was involved.¹⁴⁷ These tested different aspects of a multi-agency emergency response, including evacuation plans, disaster victim identification and mass casualty trauma training.¹⁴⁸ Exercise Hawk River in March 2017 was notable as it was focused on the response to a Marauding Terrorist 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

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](#)

¹⁴⁴ [58/79/5-19](#)

¹⁴⁵ [58/79/20-80/5](#)

¹⁴⁶ [58/81/6-19](#)

¹⁴⁷ [INQ023876/14-17](#)

¹⁴⁸ [58/82/24-83/2](#), [58/91/25-93/20](#)

¹⁴⁹ [58/92/17-93/4](#)

¹⁵⁰ [58/111/1-114/15](#), [124/124/3-23](#)

- 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.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.¹⁵⁴ He said that “*at any point an officer of any level could identify a significant issue*”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.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.*”¹⁵⁷
- 12.77 Deputy Chief Fire Officer Argyle said that a “*far stronger*”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.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.

¹⁵¹ [117/12/20-13/14](#)

¹⁵² [117/12/20-13/14](#)

¹⁵³ [58/26/13-27/19](#)

¹⁵⁴ [117/14/11-15/2](#)

¹⁵⁵ [117/15/18-16/3](#)

¹⁵⁶ [117/15/3-16/19](#)

¹⁵⁷ [117/16/20-17/25](#)

¹⁵⁸ [117/18/1-6](#)

¹⁵⁹ [117/18/1-20](#)

- 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.¹⁶⁰ Around the UK, some local 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.

¹⁶⁰ [146/70/17-22](#)

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.¹⁶¹ 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.¹⁶²

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.¹⁶³

12.85 BTP used the terms Bronze, Silver and Gold for its Operational, Tactical and Strategic Commanders.¹⁶⁴

¹⁶¹ [INQ042535/7](#) at paragraph 62

¹⁶² [36/5/1-24](#)

¹⁶³ [INQ025614/2](#) at paragraph 6

¹⁶⁴ [INQ025614/5](#) at paragraph 28

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.¹⁶⁵ In May 2017, the C Division Commander was Chief Superintendent Allan Gregory.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.¹⁶⁷
- 12.88** There was one explosives detection dog based in Manchester.¹⁶⁸ In 2017, BTP did not have a firearms capability outside London.¹⁶⁹

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.¹⁷⁰ On the night of the Attack, the Force Incident Manager was Inspector Benjamin Dawson¹⁷¹ and the Senior Duty Officer was Chief Inspector (CI) Antony Lodge. The Deputy Force Incident Manager operated from Birmingham.¹⁷²
- 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.¹⁷³
- 12.91** The Senior Duty Officer role was created by BTP in 2015.¹⁷⁴ It was not the subject of any specific training.¹⁷⁵ 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

¹⁶⁵ [36/10/21-25](#)

¹⁶⁶ [36/11/12-16](#)

¹⁶⁷ [36/12/16-13/1](#)

¹⁶⁸ [36/13/15-25](#)

¹⁶⁹ [36/16/18-20](#)

¹⁷⁰ [INQ025614/8](#) at paragraph 48

¹⁷¹ [53/33/8-13](#)

¹⁷² [92/39/20-40/1](#)

¹⁷³ [92/13/22-14/1](#)

¹⁷⁴ [93/2/10-11](#)

¹⁷⁵ [93/10/6-8](#)

¹⁷⁶ [93/6/3-7/7](#)

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 responding to the early stages of a Major Incident.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.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.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]. To declare a major incident (when appropriate)."¹⁸⁵ The predecessor to the METHANE mnemonic was again listed. That mnemonic also included consideration of a Major Incident declaration.¹⁸⁶

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

¹⁸² [73/37/9-17](#), [92/23/7-14](#)

¹⁸³ [139/66/10-13](#)

¹⁸⁴ [139/65/24-66/9](#), [INQ025700/24-25](#) at paragraph 4.2

¹⁸⁵ [INQ025700/64](#)

¹⁸⁶ [INQ025700/64](#)

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.¹⁸⁷

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.¹⁸⁸ 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.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.¹⁹⁴

¹⁸⁷ [INQ025700/24](#) at paragraph 4.1

¹⁸⁸ [INQ012913/1](#), [INQ013422/1](#)

¹⁸⁹ [INQ025700/14](#) at paragraph 2.4

¹⁹⁰ [INQ025700/16](#) at paragraph 2.8

¹⁹¹ [102/193/25-194/9](#)

¹⁹² [INQ026714/26](#) at paragraphs 112-113

¹⁹³ [INQ026714/31](#) at paragraph 140

¹⁹⁴ [92/124/1-9](#)

- 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 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.¹⁹⁵ 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."*¹⁹⁶ Inspector Dawson stated 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.

¹⁹⁵ [139/18/20-24](#)

¹⁹⁶ [INQ025700/14](#) at paragraph 2.5

¹⁹⁷ [92/15/7-12](#)

¹⁹⁸ [94/137/10-138/2](#)

¹⁹⁹ [93/27/21-25](#)

²⁰⁰ [186/113/7-23](#)

- 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 awareness is shared. In no circumstances during the early stages of a Major Incident should it require “*negotiation*”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.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,²⁰³ this should have been integrated into the Major Incident Manual so there was a single, unified plan.

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 21,000,²⁰⁴ and a go-karting track. In addition, there was office space, which increased the footfall further.²⁰⁵
- 12.115** The freehold interest in the Arena was owned by Network Rail. This meant it was within BTP’s jurisdiction.²⁰⁶ The only part of the Victoria Exchange Complex not policed by BTP was the Metrolink tram platforms. These were policed by GMP.²⁰⁷

²⁰¹ [INQ025700/14](#) at paragraph 2.5

²⁰² [92/140/23-25](#)

²⁰³ [INQ041112/8](#) at paragraph 3.2, [INQ041112/9](#) at paragraph 3.6.2

²⁰⁴ [1/22/3-10](#)

²⁰⁵ [37/58/20-59/1](#)

²⁰⁶ [52/36/15-22](#)

²⁰⁷ [36/72/3-11](#)

- 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.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.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.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. GMRP 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.²¹¹ BTP was the obvious organisation to take the lead in preparing this plan. GMRP 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.²¹² I will return to this plan when I address 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*".²¹³ 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.²¹⁴
- 12.121** Major Incident awareness training was delivered as part of the initial training package.²¹⁵
- 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

²⁰⁸ [INQ042535/7](#) at paragraph 52

²⁰⁹ [139/77/25-78/4](#)

²¹⁰ [94/100/6-7](#)

²¹¹ [INQ041870/1](#) at paragraph 5

²¹² [INQ007219](#)

²¹³ [INQ041870/38](#) at paragraph 172

²¹⁴ [INQ025614/11](#) at paragraphs 74-75

²¹⁵ [INQ025614/11](#) at paragraph 76

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.²¹⁶

- 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. This was well explained by CI Lodge, when he candidly said of his own experience of the JESIP training: *"[A]t 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."*²¹⁹ 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"*²²⁰ 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.²²¹ 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.²²² This is inevitable to a degree. This does not mean that improvements cannot be made.

²¹⁶ [INQ025614/11](#) at paragraph 72

²¹⁷ [53/22/22-23/7](#)

²¹⁸ [73/36/1-5](#), [74/7/25-8/4](#)

²¹⁹ [93/8/11-14](#)

²²⁰ [93/7/5-7](#)

²²¹ [INQ025614/11](#) at paragraph 79

²²² [73/41/8-16](#), [74/8/15-17](#), [74/110/21-111/5](#)

12.128 For unarmed officers, the first aid training given to BTP officers did not include the applications of tourniquets.²²³ The College of Policing course did not include this on its curriculum.²²⁴ 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.²²⁵ 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.²²⁶

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.²²⁷ I have included mention of leg restraints here because, without access to tourniquets, some officers on the night of 22nd May 2017 improvised using their standard issue leg restraints.²²⁸

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*”.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.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,²³¹ despite being an opportunity to consider how primacy in the response might quickly be established between BTP and GMP.

²²³ [139/38/2-6](#)

²²⁴ [139/39/3-16](#)

²²⁵ [INQ025614/21-22](#)

²²⁶ [INQ025614/22](#)

²²⁷ [INQ025614/23](#), [139/37/21-38/1](#)

²²⁸ [74/21/7-21](#), [91/54/12-14](#), [133/136/17-23](#)

²²⁹ [36/46/24-47/1](#)

²³⁰ [36/47/4-22](#)

²³¹ [36/52/8-13](#)

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 22nd 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 22nd 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 22nd 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 22nd May 2017 and 00:00 on 23rd 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 22nd May 2017 and 00:00 on 23rd 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 22nd May 2017 to 00:00 on 23rd 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 officers 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 22nd 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.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.²³³ 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.²³⁴ 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 using intersecting doors. One area was for the Strategic/Gold

²³² [2/115/3-14](#)

²³³ [99/170/4-14](#)

²³⁴ [99/169/2-170/25](#)

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).²³⁵

- 12.141** The Gold Control Room and Silver Control Room had allocated spaces within them for representatives of other emergency services and responders.²³⁶ 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.²³⁷
- 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.²³⁸ 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 Hopkins²³⁹ and DCC Pilling²⁴⁰ 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 £545,394,197.²⁴¹ The number of officers fell by 25 per cent from 8,219 to 6,159. Staff posts and PCSOs were also lost.²⁴² The decrease in income and personnel is striking.

²³⁵ [INQ029288/67-68](#) at paragraphs 351-359

²³⁶ [INQ029288/69](#) at paragraph 360

²³⁷ [129/22/1-23/11](#)

²³⁸ Speech made by David Cameron in Cheltenham to the Conservative Party, on Sunday 26th April 2009

²³⁹ [134/154/8-157/12](#)

²⁴⁰ [130/170/17-174/9](#)

²⁴¹ [INQ041506/3](#)

²⁴² [INQ041506/3-4](#)

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.

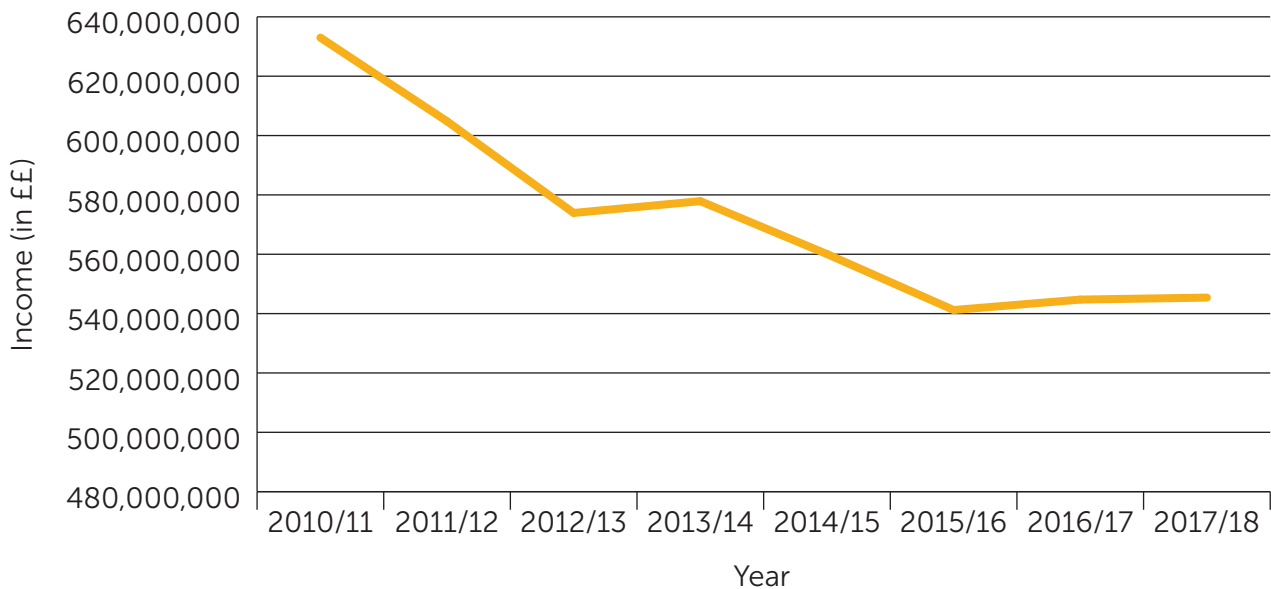


Figure 25: Reduction in GMP's total income from 2010/11 to 2017/18²⁴³

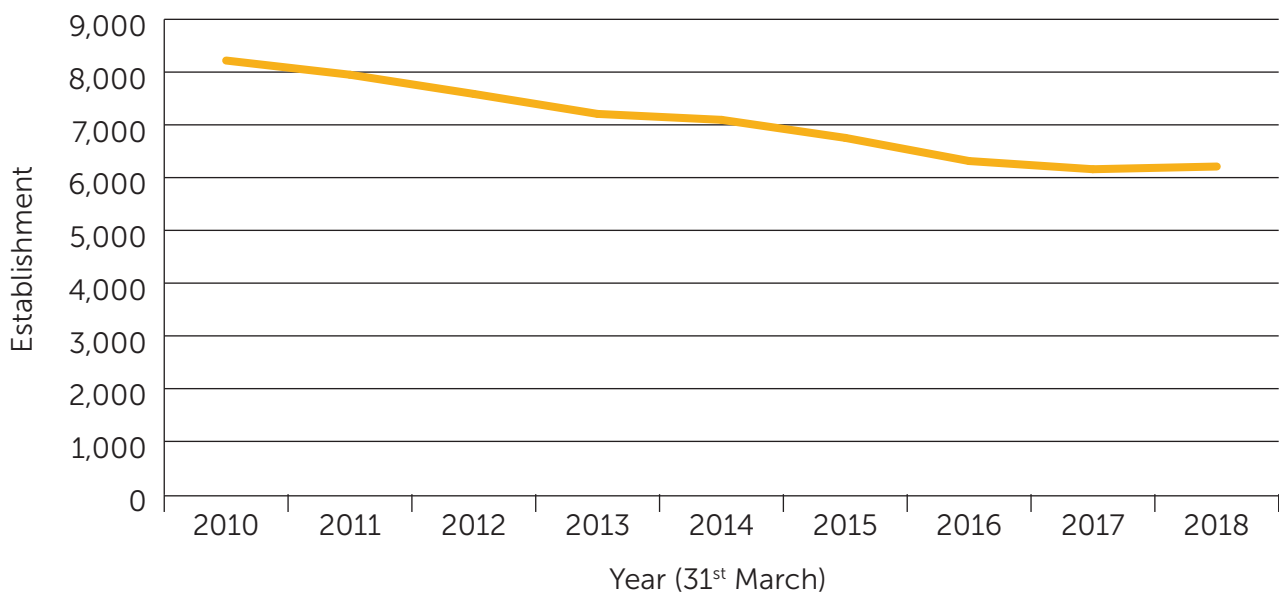


Figure 26: Year-on-year decrease in establishment figures (the number of officers for whom funding is available) from 2010 to 2018²⁴⁴

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

²⁴³ [INQ041506/3](#)

²⁴⁴ [INQ041506/3-4](#)

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.²⁴⁵

- 12.148** As a result, the reductions in central government funding hit GMP and the other metropolitan police services disproportionately hard.²⁴⁶ I do not know 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

²⁴⁵ [131/102/17-103/3](#)

²⁴⁶ [131/102/17-103/3](#)

²⁴⁷ [130/170/2-16](#)

²⁴⁸ [130/170/17-173/5](#)

²⁴⁹ [37/97/7-18](#)

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 conducting compliance checks on those policies.²⁵⁷ 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.²⁵⁸ 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.²⁵⁹ This was a very significant reduction in personnel.

²⁵⁰ [37/97/19-101/18](#)

²⁵¹ [37/101/19-102/13](#)

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](#)

²⁵⁷ [66/6/12-10/1](#)

²⁵⁸ [66/4/11-14](#)

²⁵⁹ [66/3/13-4/22](#)

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.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 2017.²⁶¹

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.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.²⁶³ When asked what he had done to address the pressure upon Inspector Lear, he said:

"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

²⁶⁰ [66/3/18-6/11](#)

²⁶¹ [66/11/25-12/4](#)

²⁶² [INQ034424/2](#) at paragraph 5

²⁶³ [84/140/8-20](#)

²⁶⁴ [84/142/24-143/12](#)

²⁶⁵ [84/117/6-118/4](#)

²⁶⁶ [65/61/9-63/9](#)

- 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*

²⁶⁷ [100/63/9-64/6](#)

²⁶⁸ [INQ007279/2](#)

²⁶⁹ [37/130/25-131/7](#)

²⁷⁰ [INQ007279/8](#) at paragraph 2.2

²⁷¹ [INQ007279/7](#) at paragraph 1.1

*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.²⁷⁶ 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 NAWAS’s preparedness.

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*

²⁷² [INQ007279/10](#) at paragraph 3

²⁷³ [INQ007279/70](#)

²⁷⁴ [INQ029288/57-59](#) at paragraphs 300-308

²⁷⁵ [37/128/17-129/8](#)

²⁷⁶ [INQ029288/58](#) at paragraph 301

*used to inform Gold Control and the partner organisations.*²⁷⁷ A number of JESIP concepts were set out on the following page.²⁷⁸ There were hyperlinks embedded in the text for those reading online.²⁷⁹

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.²⁸⁰ 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."*²⁸¹

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.²⁸² 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.²⁸³

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 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

²⁷⁷ [INQ007279/33](#) at paragraph 3.2.11

²⁷⁸ [INQ007279/34](#)

²⁷⁹ [37/130/6-18](#)

²⁸⁰ [INQ007279/17](#) at paragraph 3.1.2, [INQ007279/21](#) at paragraph 3.1.3, [INQ007279/50](#) at paragraph 5, [INQ007279/72](#), [INQ007279/73](#)

²⁸¹ [INQ004542/8](#)

²⁸² [INQ007279/72](#)

²⁸³ [INQ007279/73](#)

²⁸⁴ [INQ022399/11](#)

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).”*²⁸⁶

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 22nd 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.²⁸⁷

²⁸⁵ [INQ007279/35](#)

²⁸⁶ [INQ004542/6](#)

²⁸⁷ [INQ007279/10](#)

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."*²⁸⁸

12.188 This aim is achieved by, among other things, establishing "a common view of the situation between the responder agencies"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 situational awareness".²⁹⁰

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 2017.²⁹¹ He spoke to the FDO at 22:50.²⁹² He was relieved of the role of Tactical/Silver Commander at 00:00 on 23rd May 2017.²⁹³ 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 NWS Tactical Commander at around 23:15 failed to identify the differing approach to entry to the City Room by the two organisations.²⁹⁴ 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."²⁹⁵

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

²⁸⁸ [INQ007279/17](#) at paragraph 3.1.2

²⁸⁹ [INQ007279/17](#) at paragraph 3.1.2

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](#)

²⁹⁶ [INQ007279/25](#)

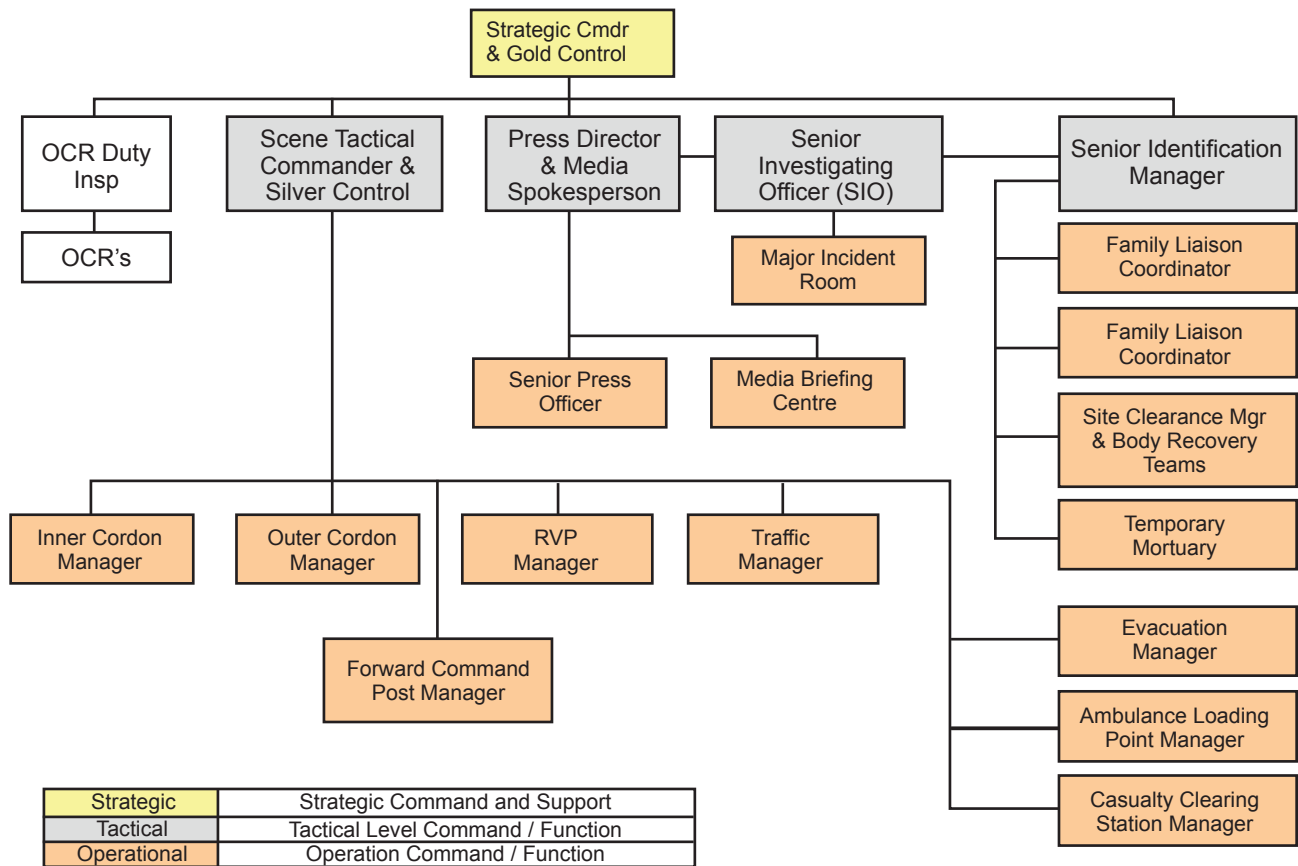


Figure 27: Annotated Command and Control diagram from the Major Incident Plan²⁹⁷

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 Plan²⁹⁸

²⁹⁷ INQ007279/25

²⁹⁸ INQ007279/73

12.193 The entry continued by stating: *“Wear your Incident Commander Tabard (JESIP) so that you can clearly be identified.”*²⁹⁹ 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.”*³⁰⁰

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.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.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.

12.197 The culture of going to GMP HQ rather than the scene was not something of which Temporary Superintendent Nawaz was aware.³⁰³ It is a matter of significant concern that the Night Silver on 22nd 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.³⁰⁴ The role of Operational/Bronze Commander was not identified in the list of *“core roles”* in the appendices.³⁰⁵ It should have been, as it was intended that laminated hard copies would be available for use during incidents. The roles of Inner Cordons

²⁹⁹ [INQ007279/73](#)

³⁰⁰ [INQ007279/75](#)

³⁰¹ [37/129/9-23](#)

³⁰² [37/126/13-128/8](#)

³⁰³ [104/9/2-8](#)

³⁰⁴ [INQ007279/21-22](#)

³⁰⁵ [INQ007279/70](#)

Manager and Outer Cordons Manager were included.³⁰⁶ 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.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*”.³⁰⁸ It identified seven responsibilities. While it did identify “[l]ife-saving through search and rescue”³⁰⁹ as the first responsibility, the Major Incident Plan should have been much clearer about GMFRS’s capability of working with NWS to treat and move casualties within an incident scene to an area in which they can receive care.

12.201 None of the GMP officers at the scene recognised that GMFRS was not present during the critical period of the response.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.*”³¹¹ He stated that he did not know that NWS’s Hazardous Area Response Team (HART) and GMFRS’s Specialist Response Team trained together.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.

³⁰⁶ [INQ007279/70](#)

³⁰⁷ [102/165/22-166/10](#)

³⁰⁸ [INQ007279/26](#) at paragraph 3.2.2

³⁰⁹ [INQ007279/26](#)

³¹⁰ [75/36/11-16](#), [75/154/17-155/3](#)

³¹¹ [102/149/12-151/20](#)

³¹² [102/149/12-151/20](#)

Site-specific plan

12.203 GMP held a plan entitled “Contingency Plan – Phones 4U Arena” (the GMP Arena contingency plan). It was dated June 2013.³¹³ It was updated to reflect the name change at the Arena in 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.”³²²

12.207 On the fourth and fifth pages, a Major Incident checklist was provided.³²³

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

³¹³ [INQ007219/2](#)

³¹⁴ [INQ007219/3](#)

³¹⁵ [INQ007219/2](#)

³¹⁶ [37/107/22-25](#)

³¹⁷ [37/108/17-109/9](#)

³¹⁸ [37/109/10-111/24](#)

³¹⁹ [37/109/24-110/7](#), [104/34/16-21](#)

³²⁰ [INQ007219/12](#)

³²¹ [INQ007219/4](#)

³²² [INQ007219/4](#)

³²³ [INQ007219/5-6](#)

Nawaz. He did not find it easy to locate.³²⁴ He was unable to recall how much of it he read.³²⁵ He did not use the Major Incident checklist. He did not refer to the suggested RVPs or the maps.³²⁶

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.

Silver Commanders Guide

12.211 All Superintendents in GMP were expected to be on the Night Silver rota.³²⁷ Being a qualified public order Silver Commander was not a mandatory requirement for being a Superintendent.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.³²⁹

12.212 GMP produced a document entitled 'Silver Commanders Guide'. The copyright date on this document was given as 2010.³³⁰ 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.³³¹

12.213 Before 22nd May 2017, Temporary Superintendent Nawaz had not read the Silver Commanders Guide.³³² He should have done, although it would not have given him assistance with some matters which were important on 22nd 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

³²⁴ [104/29/15-30/8](#)

³²⁵ [104/32/7-15](#)

³²⁶ [104/33/22-34/11](#)

³²⁷ [104/4/6-14](#)

³²⁸ [104/4/15-18](#)

³²⁹ [104/6/11-22](#)

³³⁰ [INQ034751/3](#)

³³¹ [INQ034751/8](#)

³³² [104/6/23-7/3](#)

³³³ [104/6/3-25](#)

³³⁴ [INQ034751/10](#)

- 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 scene. As with the Major Incident Plan, this should have been updated.
- 12.217** The Silver Commanders Guide had a section entitled “*Terrorism*”.³³⁵ 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).³³⁶
- 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.³³⁷
- 12.222** In 2012, as a result of that review, ACPO (TAM) issued guidance.³³⁸ 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

³³⁵ [INQ034571/118](#)

³³⁶ [60/7/1-12](#)

³³⁷ [INQ029823/34-35](#), [INQ013767/1](#)

³³⁸ [INQ013767](#)

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.³³⁹ 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 2013.³⁴⁰

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 2012.³⁴¹ 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 2013.³⁴²

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.³⁴³ 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.

³³⁹ [84/136/14-137/2](#)

³⁴⁰ [INQ031217/2](#)

³⁴¹ [INQ031286](#)

³⁴² [INQ031286/2](#)

³⁴³ [67/14/18-15/7](#)

- 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 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 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

³⁴⁴ [INQ024271/125](#)

³⁴⁵ [INQ029175/1](#) at paragraph 1

³⁴⁶ [67/4/1-19](#)

³⁴⁷ [67/6/1-6](#)

³⁴⁸ [67/6/19-24](#)

³⁴⁹ [65/74/1-75/4](#)

³⁵⁰ [67/15/20-16/12](#)

³⁵¹ [67/13/14-19/8](#)

- 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.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.4.³⁵³ He made only limited changes to v.3, although v.4 did give the FDO the additional responsibility of notifying particular assets of the incident.³⁵⁴
- 12.237** SOP 47 v.4 was given a review date of October 2015.³⁵⁵ That review did not occur. Superintendent Giladi said that was down to a lack of staff in the Policy Compliance Unit.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.³⁵⁷ He was responsible for a nationwide inspection known as Counter-Terrorism Policing Part 2 or CT2.³⁵⁸
- 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,

³⁵² [67/16/3-21](#)

³⁵³ [INQ040146/1-2](#)

³⁵⁴ [INQ040146/7](#)

³⁵⁵ [INQ040146/2](#)

³⁵⁶ [91/109/2-110/9](#)

³⁵⁷ [61/5/2-25](#)

³⁵⁸ [61/6/1-4](#)

including GMP. The visit to GMP was scheduled for between 31st October and 4th November 2016, and the evidence indicated that it did take place between those dates.³⁵⁹

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.³⁶⁰ 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:

*"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 ..."*³⁶¹

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 2016.³⁶² It appears, therefore, that he conducted his work over the course of Sunday 30th October 2016 and/or Monday

³⁵⁹ [61/13/10-24](#)

³⁶⁰ [127/75/14-79/1](#)

³⁶¹ [INQ040929](#)

³⁶² [INQ039970/2](#)

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.4.³⁶³

- 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.³⁶⁴
- 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.³⁶⁵ 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.

³⁶³ [84/173/17-181/13](#)

³⁶⁴ [84/154/3-156/12](#)

³⁶⁵ [84/181/8-13](#)

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.³⁶⁶ 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]."³⁶⁹

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

³⁶⁶ [61/72/22-73/15](#)

³⁶⁷ [INQ008345/2](#)

³⁶⁸ [INQ008345/2](#)

³⁶⁹ [INQ008345/5](#)

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.³⁷⁰

- 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 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.³⁷¹
- 12.255** SOP 47 v.5 also contained obvious errors. It contained a list of reference documents.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.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 Temporary ACC Hankinson. This took place on 3rd 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.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.³⁷⁵
- 12.257** Temporary ACC Hankinson was unable to recall this meeting with Andrew Buchan.³⁷⁶ She accepted, having regard to a handwritten note she had made³⁷⁷ and to an email she sent to her Chief Officer colleagues on 3rd November 2016,³⁷⁸ 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[?]"

³⁷⁰ [61/73/1-74/18](#)

³⁷¹ [61/74/19-76/19](#)

³⁷² [INQ039970/2](#)

³⁷³ [66/38/18-39/25](#)

³⁷⁴ [61/26/14-27/4](#), [61/149/3-155/11](#)

³⁷⁵ [61/79/13-80/5](#)

³⁷⁶ [127/67/18-22](#), [127/92/3-7](#), [127/170/20-23](#)

³⁷⁷ [INQ035779](#)

³⁷⁸ [INQ041272](#)

- 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.³⁷⁹ It was further her initial view that, in any event, she was not being told of something that required urgent attention.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.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.³⁸² 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 3rd 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:

“Is there enough resilience around the FDOs in the event we have an MTFA [Marauding Terrorist Firearms Attack] style incident? This 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

³⁷⁹ [127/67/24-68/5](#)

³⁸⁰ [127/165/12-15](#), [127/173/13-15](#)

³⁸¹ [127/89/11-91/20](#)

³⁸² [127/93/2-94/4](#), [127/168/23-170/3](#)

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."³⁸³

- 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 email³⁸⁴ 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.³⁸⁵ 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 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.

³⁸³ [INQ041272/2](#)

³⁸⁴ [127/92/6-7](#)

³⁸⁵ [127/64/10-66/4](#)

³⁸⁶ [127/170/25-171/5](#)

³⁸⁷ [127/69/4-72/17](#)

³⁸⁸ [127/98/23-99/6](#)

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.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 2nd 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.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 2017.³⁹¹ That was good practice.
- 12.273** In March 2017, CTPHQ published its refreshed Operation Plato guidance.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 23rd March 2017, the refreshed guidance was circulated to all UK police services.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.³⁹⁴ The National Police Chiefs' Council had by this stage succeeded to the role and responsibilities of ACPO. The day before the letter, the

³⁸⁹ [66/30/3-31/12](#)

³⁹⁰ [60/23/19-26/25](#), [61/11/11-14/23](#), [61/17/1-18/2](#)

³⁹¹ [INQ025071/1](#)

³⁹² [INQ007211/2](#)

³⁹³ [60/44/14-45/5](#)

³⁹⁴ [INQ016686](#), [60/44/13-45/11](#)

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:

*"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 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.³⁹⁸

12.278 Chief Constable Hopkins explained that the next meeting of the Chief Officer Group took place on 27th April 2017.³⁹⁹ 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.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.

³⁹⁵ [INQ016686/1](#)

³⁹⁶ [INQ040408/3](#)

³⁹⁷ [137/13/16-15/25](#)

³⁹⁸ [84/182/17-184/7](#)

³⁹⁹ [137/13/7-14/19](#)

⁴⁰⁰ [137/14/14-16/15](#)

- 12.280** Although not revealed by the email chain, Inspector Lear confirmed that, on 6th April 2017, he had received an email from Superintendent Giladi directing him to ask Sergeant Whittle to update the Operation Plato plan.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.⁴⁰²
- 12.281** At 12:05 on 29th 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.⁴⁰³
- 12.282** At 10:27 on 2nd May 2017, three days later, Superintendent Giladi raised with Inspector Lear the preparation of the plan.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.⁴⁰⁵ That is hardly surprising.
- 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 !!!!!*”.⁴⁰⁶ Inspector Lear explained in evidence that he understood the plan was required by 5th May 2017, three days later.⁴⁰⁷
- 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.⁴⁰⁸ For reasons that

⁴⁰¹ [66/46/1-47/19](#)

⁴⁰² [66/47/20-25](#)

⁴⁰³ [84/184/8-24](#)

⁴⁰⁴ [INQ040408/2](#)

⁴⁰⁵ [84/185/4-187/7](#)

⁴⁰⁶ [INQ040408/1-2](#)

⁴⁰⁷ [66/47/20-25](#)

⁴⁰⁸ [65/72/25-73/10](#)

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”.⁴⁰⁹

- 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.⁴¹⁰ 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.⁴¹¹ 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.⁴¹² GMP should have ensured 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.⁴¹³ An organisation called

⁴⁰⁹ [INQ029178](#)

⁴¹⁰ [66/18/4-28/12](#)

⁴¹¹ [66/18/4-11](#)

⁴¹² [65/96/17-24](#)

⁴¹³ [65/65/23-68/20](#)

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.⁴¹⁴
- 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.⁴¹⁵ Sergeant Whittle understood that he had 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.

⁴¹⁴ [INQ017233/1, 65/67/22-68/13](#)

⁴¹⁵ [66/49/1-50/8](#)

⁴¹⁶ [65/107/25-109/21](#)

⁴¹⁷ [65/177/22-179/10](#)

⁴¹⁸ [65/131/9-20](#)

⁴¹⁹ [INQ039970/6](#)

- 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 12th May 2017, Inspector Lear circulated the Whittle Plan and other documents to a variety of recipients, including all FDOs and some Chief Officers.⁴²² 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.⁴²³ 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.⁴²⁴ 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.⁴²⁵ This was a highly undesirable and confusing situation which had been allowed to develop.

Three plans

- 12.303** By 22nd 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.

⁴²⁰ [65/166/9-18](#)

⁴²¹ [65/110/3-113/25](#)

⁴²² [INQ039966](#)

⁴²³ [66/68/15-18](#)

⁴²⁴ [66/57/12-19](#)

⁴²⁵ [66/56/9-58/12](#)

⁴²⁶ [146/97/2-100/25](#)

⁴²⁷ [65/71/1-72/24](#)

- 12.306** I cannot be sure what effect this chaotic state of affairs had on the events of 22nd 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 22nd 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.⁴²⁸ Along with managing day-to-day business across the service, he had responsibility for the initial command and control of major critical incidents.⁴²⁹ 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.⁴³⁰
- 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.⁴³¹ 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.

⁴²⁸ [97/4/6-8/15](#)

⁴²⁹ [97/4/6-5/6](#)

⁴³⁰ [97/4/6-8/15](#)

⁴³¹ [97/6/11-25](#)

- 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.⁴³² 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 incidents.⁴³³ 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.⁴³⁴
- 12.314** 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.⁴³⁵
- 12.315** 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.⁴³⁶ 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.

⁴³² [97/15/15-16/14](#)

⁴³³ [97/19/23-20/11](#)

⁴³⁴ [97/15/15-32/17](#)

⁴³⁵ [98/112/4-18](#)

⁴³⁶ [99/21/2-23/2](#)

- 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.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.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.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.⁴⁴⁰ There is an expectation within GMP that officers can carry out command roles commensurate with their rank and experience.⁴⁴¹

⁴³⁷ [97/28/22-24](#)

⁴³⁸ [98/112/4-113/11](#)

⁴³⁹ [98/113/6-14](#)

⁴⁴⁰ [INQ035309/173](#) at paragraph 10.1.5

⁴⁴¹ [INQ029288/44](#) at paragraph 229

- 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.⁴⁴² The two key specialisms were firearms and public order.⁴⁴³ There was substantial overlap between the training provided on a public order commander training course and the Major Incident command roles.⁴⁴⁴ The public order course is focused on the Tactical/Silver Commander role for pre-planned, as opposed to spontaneous, events.⁴⁴⁵
- 12.324** Inspector Smith qualified as a public order Bronze Commander in 2012. He carried out the necessary refresher training to maintain this.⁴⁴⁶ He had undertaken Authorised Firearms Officer training. He had never operated in this role.⁴⁴⁷ 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.⁴⁴⁸
- 12.325** Temporary Superintendent Nawaz qualified as a public order Silver Commander in 2016.⁴⁴⁹ 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.⁴⁵⁰
- 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.⁴⁵¹ 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.⁴⁵²
- 12.327** ACC Ford qualified as a public order Gold Commander in 2015. This qualification included multi-agency commander of Major Incidents.⁴⁵³ She undertook the role of Strategic/Gold Commander on the night of the Attack. She had sufficient

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](#)

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](#)

⁴⁵² [INQ042531/102](#) at paragraph 255

⁴⁵³ [105/25/10-24](#)

training and was competent to operate as a Strategic/Gold Commander.⁴⁵⁴ 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.⁴⁵⁵ On the night of the Attack, he undertook the role of Operational Firearms Commander.⁴⁵⁶ He had sufficient training and was competent to operate as an Operational Firearms Commander.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.⁴⁵⁸ She was the on-call Tactical Firearms Commander on the night of the Attack.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 2015.⁴⁶⁰ The same year, he qualified as a Tactical Firearms Commander. Between 7th and 12th 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.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.⁴⁶² 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.⁴⁶³
- 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.⁴⁶⁴ Superintendent Thompson relieved Inspector Sexton of tactical firearms command at 00:18 on 23rd May 2017 and undertook the role of Tactical Firearms Commander from that point.⁴⁶⁵ He had sufficient training and was competent to operate as a Tactical Firearms Commander.

⁴⁵⁴ [105/24/21-25/18](#)

⁴⁵⁵ [101/3/22-4/21](#)

⁴⁵⁶ [101/3/3-6](#)

⁴⁵⁷ [101/23/14-26/22](#)

⁴⁵⁸ [100/107/10-24](#)

⁴⁵⁹ [100/112/6-20](#)

⁴⁶⁰ [106/107/8-11](#)

⁴⁶¹ [100/108/17-109/2](#), [106/110/8-21](#)

⁴⁶² [106/108/8-11](#)

⁴⁶³ [100/109/12-110/25](#), [106/110/9-111/23](#)

⁴⁶⁴ [108/4/10-19](#)

⁴⁶⁵ [108/2/3-6](#), [INQ024325/50-51](#)

By reason of his specialist firearms commander qualification, Superintendent Thompson was better qualified to act as Tactical Firearms Commander than Temporary CI Buckle.⁴⁶⁶

12.332 ACC Ford qualified as a Strategic Firearms Commander in 2015.⁴⁶⁷ She attended the same specialist firearms commander training as CI Dexter.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.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.⁴⁷⁰ JESIP was also included as an element of the public order commander training courses from the end of 2016.⁴⁷¹ All GMP officers had undertaken e-learning training in JESIP in 2015.⁴⁷²

12.334 The events of 22nd 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 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

⁴⁶⁶ [108/17/4-18/25](#), [100/110/1-111/1](#)

⁴⁶⁷ [105/27/1-4](#)

⁴⁶⁸ [105/27/8-13](#), [106/110/9-15](#)

⁴⁶⁹ [105/25/25-27/25](#), [105/28/21-29/19](#)

⁴⁷⁰ [INQ029288/44](#) at paragraph 230

⁴⁷¹ [INQ029288/45](#) at paragraph 234

⁴⁷² [INQ029288/44](#) at paragraph 230

⁴⁷³ [130/207/19-208/16](#)

⁴⁷⁴ [73/38/21-40/5](#), [74/84/9-16](#), [92/28/18-29/6](#)

- 12.337** As a result of the way GMP chose to approach Operation Plato, neither Inspector Smith⁴⁷⁵ nor Temporary Superintendent Nawaz⁴⁷⁶ knew that it 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.⁴⁷⁷ 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,⁴⁷⁸ did not know what Operation Plato was, beyond that it related to terrorism in some way.⁴⁷⁹
- 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.⁴⁸⁰ 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.⁴⁸¹ Their knowledge was found to be not good or reassuring.⁴⁸² The HMICFRS Inspector concluded: *"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."*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.⁴⁸⁴

⁴⁷⁵ [102/170/10-171/11](#)

⁴⁷⁶ [104/18/5-15](#)

⁴⁷⁷ [101/41/20-42/8](#), [101/62/14-18](#)

⁴⁷⁸ [99/187/15-188/2](#)

⁴⁷⁹ [99/166/21-167/11](#)

⁴⁸⁰ [99/167/2-6](#)

⁴⁸¹ [INQ008360/1](#)

⁴⁸² [61/169/3-12](#)

⁴⁸³ [INQ008355/4](#)

⁴⁸⁴ [61/86/13-87/22](#)

- 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 3rd November 2016.⁴⁸⁵ 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.”*⁴⁸⁶
- 12.344** The HMICFRS report based on the November 2016 visit is dated August 2017.⁴⁸⁷ 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.”*⁴⁸⁸ 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 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 22nd May 2017 revealed that the first aid training of frontline unarmed GMP officers could and should be improved.

⁴⁸⁵ [61/152/9-153/24](#)

⁴⁸⁶ [INQ041272](#)

⁴⁸⁷ [INQ025071/1](#)

⁴⁸⁸ [INQ025071/31](#)

⁴⁸⁹ [61/60/7-23](#)

⁴⁹⁰ [61/69/8-70/4](#)

- 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.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.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 2020.⁴⁹⁷ 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.⁴⁹⁸ GMP had drawn this to the attention of the College of Policing in 2014/15 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.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.

⁴⁹¹ [192/165/12-17](#)

⁴⁹² [192/170/6-20](#)

⁴⁹³ [192/170/21-172/5](#)

⁴⁹⁴ [192/171/24-172/14](#)

⁴⁹⁵ [192/174/13-176/6](#)

⁴⁹⁶ [192/172/24-173/22](#)

⁴⁹⁷ [192/176/7-178/11](#)

⁴⁹⁸ [192/178/12-180/11](#)

⁴⁹⁹ [192/179/1-181/9](#)

- 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.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.⁵⁰¹
- 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.⁵⁰² 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

⁵⁰⁰ [192/182/6-185/4](#)

⁵⁰¹ [INQ035309/10-11](#)

⁵⁰² [148/47/18-50/15](#)

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.⁵⁰³ 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 role to provide first responder interventions where possible.
- 12.364** As a result, despite their strong instinct to do so,⁵⁰⁴ 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
- 12.368** I am satisfied that GMP dedicated an appropriate level of resource, time and commitment to exercising.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.

⁵⁰³ [189/96/12-98/14](#)

⁵⁰⁴ [102/98/15-100/9](#)

⁵⁰⁵ [INQ035309/84](#) at paragraph 4.3.6

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 22nd 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 NWS had in place, the Ambulance Service Experts considered that NWS was compliant with the national standards for emergency preparedness at the time of the Attack.⁵⁰⁷ 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.⁵⁰⁸
- 12.373** While I accept that NWS met those national standards, I have concluded that there were areas where NWS's planning for an emergency could and should have been improved.
- 12.374** In this section, I shall set out NWS'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.

NWS Control

- 12.375** NWS 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.⁵⁰⁹ 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.⁵¹⁰
- 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 NWS. 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.⁵¹¹
- 12.377** I shall refer to these collectively as NWS Control.

NWS specialist personnel

- 12.378** I recognise that all personnel working for NWS were specialist in their particular roles. In my Report, I use the term 'specialist' in a particular way. When applied to NWS 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, NWS had two HART crews: one based in Greater Manchester (the GM HART crew) and one covering Cheshire and Merseyside

⁵⁰⁷ [INQ032665/11](#)

⁵⁰⁸ [INQ014221](#)

⁵⁰⁹ [INQ026738/29](#) at paragraph 206

⁵¹⁰ [INQ012913/43](#)

⁵¹¹ [INQ012913/18-20](#)

(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.

Core Capability	Tactical Options		Commissioning
HART <i>Hazardous Area Response Teams</i>	Hazardous Materials	<ul style="list-style-type: none"> • Working inside the inner cordon • Industrial accidents • High-risk infectious diseases • Complex transportation accidents 	Reference costs are set out in the National Standards produced by NARU. Then commissioned locally via the Ambulance Service baseline funding mechanism.
	CBRN(e) <i>Chemical Biological Radiological Nuclear Explosives</i>	<ul style="list-style-type: none"> • Specialist, inner cordon response to CBRN(e)/also a component part of the CBRN(e) capability 	
	MTFA <i>Marauding Terrorist Firearms Attack</i>	<ul style="list-style-type: none"> • Specialist support to the wider MTFA response/component part of the MTFA capability 	
	SWaH <i>Safe Working at Height</i>	<ul style="list-style-type: none"> • Man-made structures • Natural environment 	
	Confined Space	<ul style="list-style-type: none"> • Substantially enclosed spaces • Building collapses • Compromised atmospheres • Entrapments 	
	Unstable Terrain	<ul style="list-style-type: none"> • Active rubble piles • Rural access/difficult terrain 	

Core Capability	Tactical Options		Commissioning
HART Hazardous Area Response Teams	Water Operations	<ul style="list-style-type: none"> Swift water rescue Urban and rural flooding Boat operations 	
	Support to Security Operations	<ul style="list-style-type: none"> Support to security operations Support to police operations Illicit drug laboratories VIP close protection support 	

Table 3: Hazardous Area Response Team capabilities⁵¹²

12.382 NWS'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 NWS's wider operational staff.⁵¹³

12.383 On the night of the Attack, NWS 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 NWS'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 NWS'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 18th 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."*⁵¹⁶

⁵¹² [INQ032665/68](#)

⁵¹³ [INQ026738/34](#)

⁵¹⁴ [INQ013422/1](#)

⁵¹⁵ [INQ012913/1](#)

⁵¹⁶ [INQ012913/6](#)

- 12.388** The introduction continued: *“The Plan may be exercised alongside site specific plans (e.g. stadia)...”*.⁵¹⁷ 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)”*.⁵¹⁸ 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”*.⁵¹⁹ 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”*.⁵²⁰ 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.⁵²¹ 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.⁵²²

CSCATTT model

- 12.392** CSCATTT stands for ‘Command and Control; Safety; Communication; Assessment; Triage; Treatment; Transport’. The Major Incident Response Plan explained:

*“The CSCATTT 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. JESIP Principles for Joint Working must be reinforced throughout Command and Control process.”*⁵²³

- 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.

⁵¹⁷ [INQ012913/7](#)

⁵¹⁸ [INQ012913/8](#)

⁵¹⁹ [INQ012913/10-11](#)

⁵²⁰ [INQ012913/12](#)

⁵²¹ [INQ012913/12-13](#)

⁵²² [INQ041691](#)

⁵²³ [INQ012913/13](#)

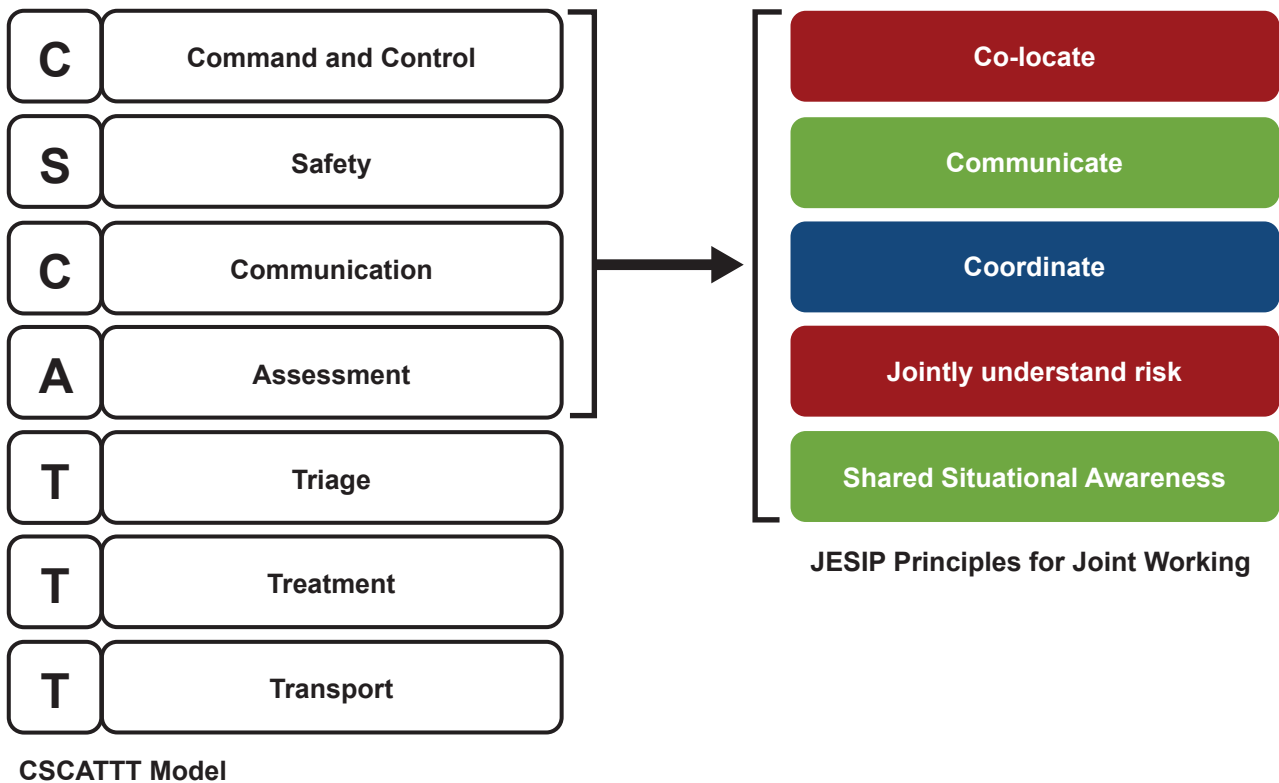


Figure 29: CSCATTT model and the JESIP five principles for joint working from the Joint Doctrine⁵²⁴

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 NAWAS 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 NAWAS commanders during their period of command. It should have been.
- 12.397** Under the heading “Operational Commander”, the Major Incident Response Plan stated:

⁵²⁴ INQ012913/13

⁵²⁵ INQ012913/15

⁵²⁶ INQ012913/14

⁵²⁷ INQ012913/14-16

*"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."*⁵²⁸

12.398 The Major Incident Response Plan is not the only place that guidance is given about where Operational Commanders should locate themselves. NWS'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."*⁵²⁹

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."*⁵³⁰ This important role was overlooked by the NWS 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 NWS 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."*⁵³³ Primary triage identified categories of casualty by reference to their level of injury.

⁵²⁸ [INQ012913/16](#)

⁵²⁹ [INQ023556/11](#)

⁵³⁰ [INQ012913/30](#)

⁵³¹ [INQ012913/32](#)

⁵³² [INQ012913/37-39](#)

⁵³³ [INQ012913/37](#)

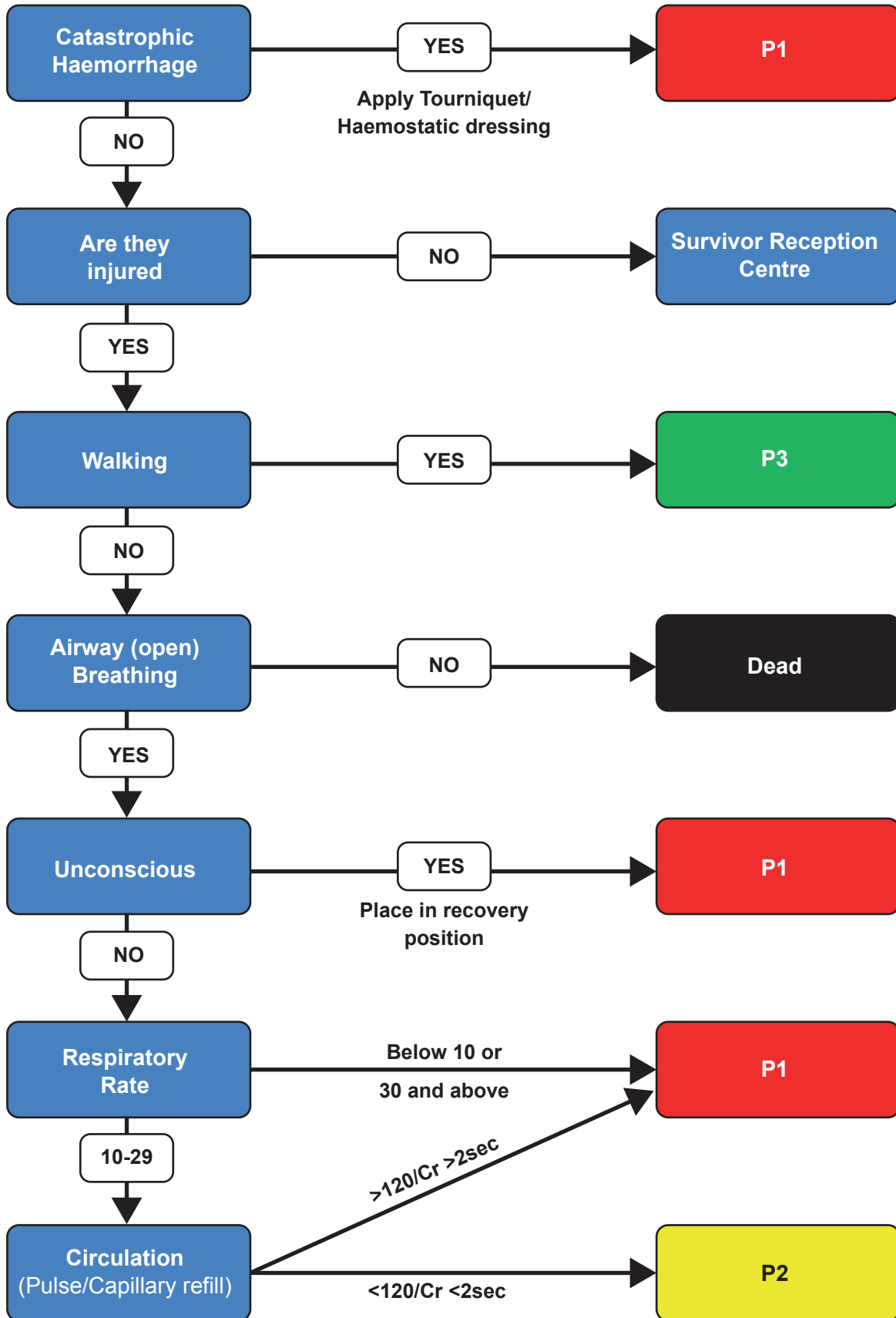


Figure 30: Primary triage (also known as the “triage sieve”)⁵³⁴

⁵³⁴ INQ012913/38

- 12.403** Patrick Ennis, who carried out primary triage initially on 22nd May 2017, did not have his SMART Triage Tags with him when he entered the City Room.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.⁵³⁶
- 12.405** There was a P4 category of “*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 P4.⁵³⁷
- 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.⁵³⁸
- 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.⁵³⁹
- 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.

⁵³⁵ [76/69/18-70/15](#)

⁵³⁶ [INQ013552/5-7](#)

⁵³⁷ [INQ012913/39](#)

⁵³⁸ [INQ012913/37](#)

⁵³⁹ [INQ012913/39](#)

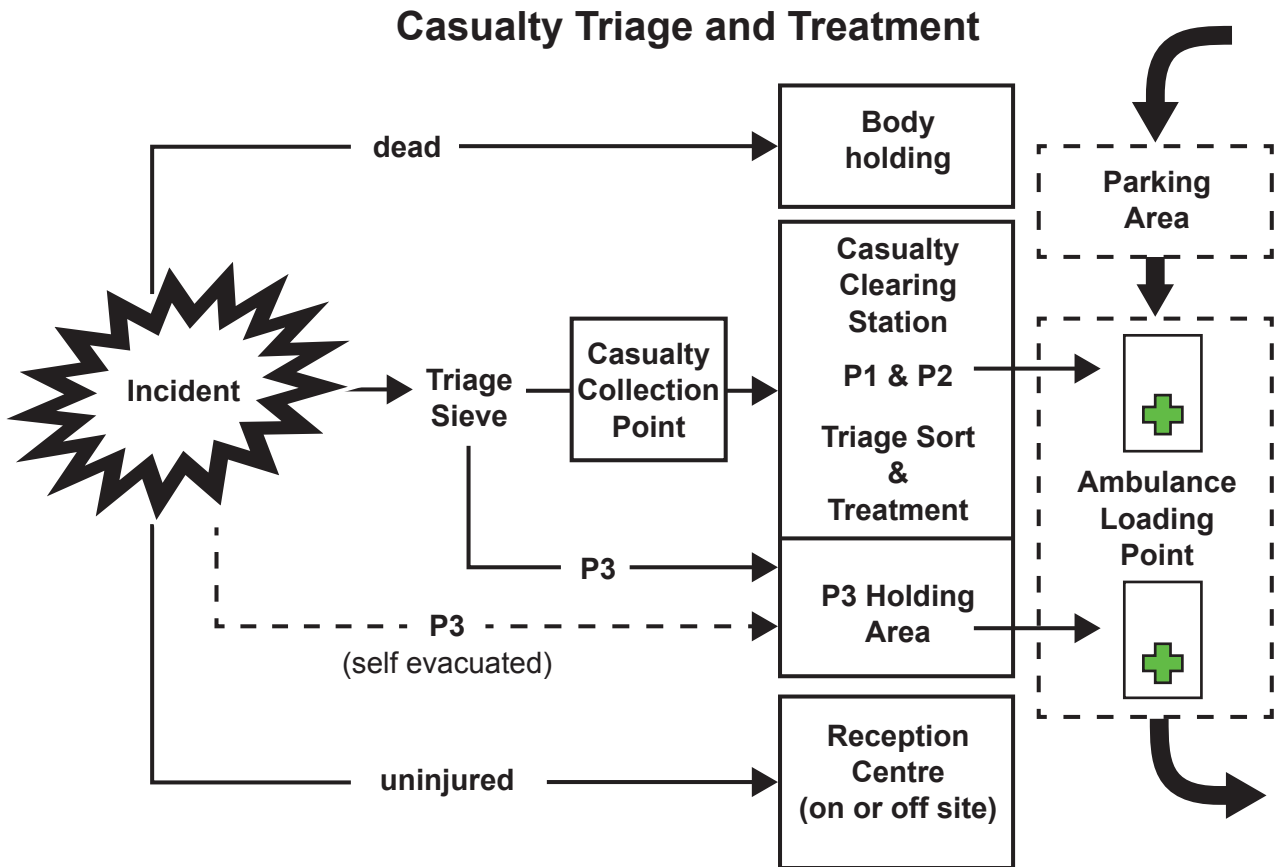


Figure 31: Structure of a Major Incident⁵⁴⁰

- 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”*⁵⁴¹ 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...”*⁵⁴² On the night of the Attack, several casualties remained in the Casualty Clearing Station for over two hours.
- 12.411** The Major Incident Response Plan stated that *“safety considerations such as the integrity of buildings or land, vehicular accessibility”*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”*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*

⁵⁴⁰ INQ012913/41

⁵⁴¹ INQ012913/42

⁵⁴² INQ012913/42

⁵⁴³ INQ012913/42

⁵⁴⁴ INQ012913/41

the CCP [Casualty Collection Point] is carried by the Hazardous Area Response Team.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 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.

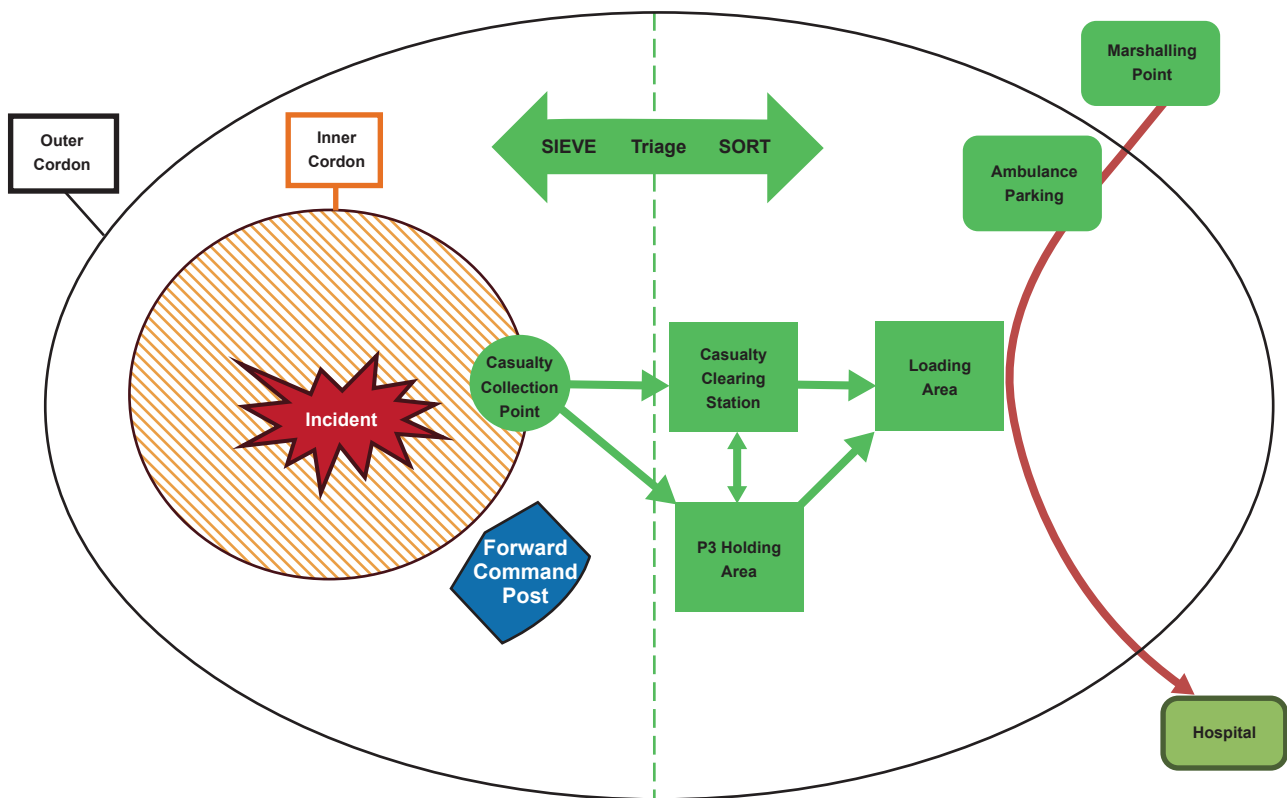


Figure 32: Incident diagram⁵⁴⁶

12.415 The Major Incident Response Plan stated: “Within the inner cordon, treatment is aimed at preventing further deterioration of life-threatening injuries.”⁵⁴⁷ It went on to state:

⁵⁴⁵ INQ012913/41

⁵⁴⁶ INQ012913/61

⁵⁴⁷ INQ012913/41

"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."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 NWS 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."⁵⁴⁹

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."⁵⁵⁰

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."⁵⁵¹* He stated it was a decision for the Operational Commander.⁵⁵² He described the risk assessment as needing to be *"quite ... robust"*.⁵⁵³

⁵⁴⁸ [INQ012913/43-44](#)

⁵⁴⁹ [110/141/16-24](#)

⁵⁵⁰ [110/142/10-18](#)

⁵⁵¹ [110/13/11-14/2](#)

⁵⁵² [110/13/11-14/2](#)

⁵⁵³ [110/43/25-44/11](#)

12.422 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.⁵⁵⁴ 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.”⁵⁵⁵

12.423 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 NWS protocols.”⁵⁵⁶*

12.424 Stephen Hynes was Deputy Director of Operations for NWS. 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.”⁵⁵⁷

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”*.⁵⁵⁸ His evidence was that the same approach applied to an Operation Plato warm zone.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.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.

⁵⁵⁴ [112/27/5-14](#)

⁵⁵⁵ [112/40/11-18](#)

⁵⁵⁶ [113/35/20-36/5](#)

⁵⁵⁷ [113/141/14-142/2](#)

⁵⁵⁸ [115/64/7-15](#)

⁵⁵⁹ [115/64/7-67/5](#)

⁵⁶⁰ [144/116/1-118/12](#)

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 NWS staff were familiar with hot, warm and cold zones being used in connection with Major Incidents that did not involve terrorism or an Operation 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.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.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 *NHS Service Specification 2016/17: Hazardous Area Response Teams (HART)* described HART operatives providing "care within the inner cordon or 'hot zone' of incidents".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.

⁵⁶¹ [144/115/11-23](#)

⁵⁶² [112/33/13-16](#), [INQ021481/3](#)

⁵⁶³ [INQ019179/6](#)

⁵⁶⁴ [112/32/18-33/9](#), [112/153/7-154/2](#)

⁵⁶⁵ [INQ008372/17](#) at paragraph 4.16

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 non-specialist paramedics to enter a [an Operation Plato] warm zone*" under paragraph 4.16 of JOPs 3.⁵⁶⁷
- 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*"⁵⁶⁸ not just police officers. In any event, JOPs 3 stated it was "*guidance*" and "*not prescriptive*".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. He stated that all other resources were confined to the cold zone.⁵⁷⁰ In its closing submission to me, NWAS said that this was the correct interpretation of JOPs 3.⁵⁷¹
- 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.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 "*quite rigid*".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.⁵⁷⁴

⁵⁶⁶ [144/195/7-25](#)

⁵⁶⁷ [185/170/17-23](#)

⁵⁶⁸ [INQ008372/17](#) at paragraph 4.16

⁵⁶⁹ [INQ008372/8](#)

⁵⁷⁰ [112/32/18-24](#)

⁵⁷¹ [INQ042544/20](#) at paragraph 44

⁵⁷² [69/130/11-22](#), [117/103/7-104/4](#)

⁵⁷³ [120/246/15-247/18](#)

⁵⁷⁴ [121/150/8-151/14](#), [133/54/17-55/10](#), [128/96/1-11](#)

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."*⁵⁷⁵

12.441 Bearing in mind that GMFRS specialists trained with NWS specialists, GMFRS's view is relevant to consideration of NWS'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 NWS 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 whether the person hearing them knows that Operation Plato has been declared. In the course of the response on 22nd 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.*"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."*⁵⁷⁷

⁵⁷⁵ [INQ042436/38](#) at paragraph 138

⁵⁷⁶ [INQ004542/7](#)

⁵⁷⁷ [INQ012913/17](#)

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’.”⁵⁷⁸

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.⁵⁷⁹ 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.⁵⁸⁰

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, NWS had adopted the action cards drafted by NARU. They were consistent with the national standard and requirements at the time. They were fit for purpose.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.⁵⁸⁶ The main issue with the action cards is that they were not used effectively on 22nd May 2017. As a result, not all necessary actions were undertaken. In Part 14, I will consider this in further detail.

⁵⁷⁸ [INQ012913/23](#)

⁵⁷⁹ [144/121/22-122/12](#)

⁵⁸⁰ [144/166/20-167/6](#)

⁵⁸¹ [144/23/2-7](#)

⁵⁸² [144/29/12-19](#)

⁵⁸³ [INQ013422/1](#)

⁵⁸⁴ [INQ012913/54](#)

⁵⁸⁵ [INQ032665/29-30](#)

⁵⁸⁶ [INQ042544/47-48](#)

- 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.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.⁵⁸⁸ When undertaking an exercise in 2016 as HART Team Leader, Simon Beswick did not refer to this action card.⁵⁸⁹
- 12.454** This was not Simon Beswick's fault. NWAS had not adopted this action card by 22nd May 2017.⁵⁹⁰ There is no good reason for this. I will return to 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.⁵⁹¹ There was only a "*site information sheet*" dated October 2011 for the Arena.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.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.⁵⁹⁴
- 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.⁵⁹⁵

⁵⁸⁷ [INQ019194](#)

⁵⁸⁸ [76/179/23-180/25](#)

⁵⁸⁹ [76/180/5-13](#)

⁵⁹⁰ [77/11/3-23](#)

⁵⁹¹ [INQ032665/14-15](#)

⁵⁹² [INQ041856/26](#)

⁵⁹³ [INQ032665/27-28](#)

⁵⁹⁴ [144/9/9-10/2](#)

⁵⁹⁵ [144/12/14-25](#)

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 NWS. This was a failure of all of the Category 1 responders in the Greater Manchester area. There was a failure to collaborate through GMRP. 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 GMRP mass casualty plan) was approved on 9th September 2013. It was a GMRP document.⁵⁹⁶ Responsibility for activating the GMRP mass casualty plan lay with the NWS incident commander in conjunction with the on-scene medical adviser.⁵⁹⁷ Once activated, the GMRP mass casualty plan set in train a multi-agency response focused on saving and protecting life.⁵⁹⁸

12.461 The GMRP mass casualty plan was scheduled for review on 1st October 2015.⁵⁹⁹ This review had commenced, but had not concluded, by the time of the Attack.⁶⁰⁰ The GMRP mass casualty plan was not formally activated during the critical period of the emergency response.

12.462 Complementing the GMRP 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'.⁶⁰¹ 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.⁶⁰²

12.464 Annemarie Rooney, the NWS 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 23:41.⁶⁰³

⁵⁹⁶ [INQ008123/1](#)

⁵⁹⁷ [INQ008123/4](#)

⁵⁹⁸ [INQ008123/6](#)

⁵⁹⁹ [INQ008123/1](#)

⁶⁰⁰ [INQ035309/116](#)

⁶⁰¹ [INQ008082/11-12](#)

⁶⁰² [INQ008082/12](#)

⁶⁰³ [INQ034333](#)

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.⁶⁰⁴
- 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.⁶⁰⁵

Commander training

- 12.467** NWS commanders attended a variety of multi-agency, single-agency and health service focused development courses specific to their role.⁶⁰⁶ The Ambulance Service Experts found: *"Based on the national standards and guidance in place at the time, the training programme provided to NWS Commanders was adequate."*⁶⁰⁷
- 12.468** The Ambulance Service Experts noted: *"At least two [NWS] individuals took on Command roles outside of what would be considered normal for incidents of this type and magnitude."*⁶⁰⁸ 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 NWS command structure did not function appropriately on the night of the Attack. 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 NWS 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 NWS commander training in 2013 and 2014. The latter of

⁶⁰⁴ [INQ012913/14](#) at paragraph 4.1

⁶⁰⁵ [INQ032665/53](#)

⁶⁰⁶ [2/151/19-152/3](#), [144/7/24-8/7](#)

⁶⁰⁷ [INQ041856/1](#)

⁶⁰⁸ [INQ041856/1](#)

⁶⁰⁹ [144/97/4-13](#)

⁶¹⁰ [INQ041856/1-3](#)

these was titled “JESIP multi agency (Bronze Commander) training course”.⁶¹¹ He did annual commander refresher training with NWS 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 2016.⁶¹²

12.472 NWS’s position was that, in May 2017, Daniel Smith was competent in the role of Operational Commander.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.”⁶¹⁴

12.473 Overall, I have concluded that Daniel Smith had been adequately trained to perform the Operational Commander role.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 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 sufficient annual training and was competent to function at the strategic command level.⁶¹⁹

⁶¹¹ [INQ042670/3](#)

⁶¹² [INQ041294](#), [INQ042670/1-4](#)

⁶¹³ [INQ042670/4](#)

⁶¹⁴ [145/1/25-2/19](#)

⁶¹⁵ [145/1/24-2/21](#)

⁶¹⁶ [INQ041856/12-13](#)

⁶¹⁷ [110/78/3-4](#)

⁶¹⁸ [INQ041856/2](#)

⁶¹⁹ [INQ041856/2](#)

- 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: “[I]t 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.”⁶²⁰
- 12.478** Stephen Hynes believed that he had maintained sufficient operational-level experience and competence to function in the operational command role.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 NWS issue commander bag, without which he may not have been suitably equipped to take on the role.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 NWS 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. The Ambulance Service Experts further noted that national standards have changed since the Attack. They require ambulance services to provide more comprehensive training.⁶²⁵

⁶²⁰ [INQ041856/13](#)

⁶²¹ [113/105/1-18](#)

⁶²² [INQ041856/13](#)

⁶²³ [INQ041856/3](#)

⁶²⁴ [INQ041856/3](#)

⁶²⁵ [INQ041856/3](#)

12.483 On 29th August 2017, a JESIP assurance visit stated that NWS had “*acceptable standards of preparedness*”.⁶²⁶ I accept that there was official approval for the belief that JESIP was properly understood and being implemented by NWS. However, what happened on 22nd May 2017 reveals that JESIP requirements had not been sufficiently embedded in NWS personnel.

Equipment

12.484 Significant supplies of NWS medical equipment were ready and available for emergency mobilisation to support a mass casualty emergency at the time of the Attack.⁶²⁷ The equipment was available both in vehicles at the scene and held elsewhere ready for deployment.⁶²⁸ This equipment was not all deployed effectively, and there seems no good reason why it was not.⁶²⁹ I will address this further in Part 14.

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 NWS 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 NWS 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

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

⁶²⁶ [INQ014239](#)

⁶²⁷ [INQ032665/77](#)

⁶²⁸ [INQ041856/14](#)

⁶²⁹ [INQ041856/4](#)

⁶³⁰ [INQ041856/14](#)

⁶³¹ [INQ041856/14](#), [109/199/13-16](#)

⁶³² [144/143/15-146/10](#)

⁶³³ [144/146/11-20](#)

delivery systems and a range of specialised drugs and equipment to be used by doctors if required.⁶³⁴ No consideration was given to deploying this vehicle on the night.⁶³⁵ 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 NWS area”* as significant and demonstrating a *“high level of preparedness”*.⁶³⁶
- 12.491** Each NWS 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.⁶³⁷
- 12.492** Analgesia and controlled drugs were available and could be accessed via the locked vehicle safes.⁶³⁸ Equipment was also available in *“Commander Bags”*.⁶³⁹

Exercising

- 12.493** Specific requirements for training and exercising were contained in the 2015 *NHS Emergency Preparedness, Resilience and Response Framework*⁶⁴⁰ and NARU documents.
- 12.494** NWS 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, NWS participated in around 30 exercises. Of these, 23 involved Marauding Terrorist Firearms Attack scenarios.⁶⁴¹
- 12.495** The Ambulance Service Experts commended NWS’s *“active participation in a number of large-scale multi-agency exercises in the two years prior to the Arena incident”*.⁶⁴²
- 12.496** I accept that NWS 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 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 NWS for over 11 years and, at the time of the Attack, being one of only three Advanced Paramedics in Greater Manchester.

⁶³⁴ [INQ012913/44](#)

⁶³⁵ [INQ042544/71](#)

⁶³⁶ [INQ041856/14](#)

⁶³⁷ [INQ041856/4](#)

⁶³⁸ [INQ041856/15](#)

⁶³⁹ [INQ041856/4](#)

⁶⁴⁰ [INQ019165](#)

⁶⁴¹ [INQ014028](#)

⁶⁴² [INQ032665/56](#)

- 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.⁶⁴³ 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 22nd May 2017."*⁶⁴⁴ 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.

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.⁶⁴⁷ 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.

⁶⁴³ [144/35/23-36/10](#)

⁶⁴⁴ [INQ041856/3](#)

⁶⁴⁵ [INQ032665/56](#), [INQ042544/7](#)

⁶⁴⁶ [INQ042544/9-10](#)

⁶⁴⁷ [INQ041856/31](#)

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.⁶⁴⁸ The national project was terminated in 2010,⁶⁴⁹ but some regional control centres were still set up. NWFC was one of them.⁶⁵⁰

12.507 NWFC was established in July 2007.⁶⁵¹ It began operating on 14th May 2014.⁶⁵² It was a local authority owned company.⁶⁵³ It was jointly owned by Cheshire Fire Authority, Cumbria County Council, Greater Manchester Combined Authority and Lancashire Combined Fire Authority.⁶⁵⁴ Each local authority was a shareholder. Merseyside Fire and Rescue Service withdrew from the project before it went live.⁶⁵⁵

12.508 NWFC had an Agreement for Services with each local authority.⁶⁵⁶ 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

⁶⁴⁸ [INQ042482/3](#) at paragraph 1.6

⁶⁴⁹ [INQ042482/3](#) at paragraph 1.6

⁶⁵⁰ [13/53/8-15](#)

⁶⁵¹ [INQ042482/3](#) at paragraph 1.6

⁶⁵² [INQ023879/1](#) at paragraph 2

⁶⁵³ [13/53/1-7](#)

⁶⁵⁴ [13/53/8-23](#)

⁶⁵⁵ [INQ023877/2](#) at paragraphs 1.4-1.5

⁶⁵⁶ [INQ035485/5](#) at paragraph 2.2

28th May 2014.⁶⁵⁷ 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.⁶⁵⁸ NWFC did not provide a command function.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.⁶⁶⁰ The Head of NWFC, Sarah-Jane Wilson, was appointed in October 2016.⁶⁶¹ She held responsibility for “*NWFC meeting its objectives and service standards*”, including management of people, financial resources and contracts.⁶⁶² As Head of NWFC, she reported directly to the board.⁶⁶³

12.511 There was no head of NWFC between 2014, when it began to operate, and Sarah-Jane Wilson’s appointment in 2016.⁶⁶⁴ She accepted that the lack of a head of the organisation for such a long period adversely affected the business of NWFC.⁶⁶⁵

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.⁶⁶⁶ Sarah-Jane Wilson said that opportunities to put in place a robust governance structure were missed.⁶⁶⁷

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.⁶⁶⁸ This is a point to which I will return in paragraphs 12.534 to 12.554.

⁶⁵⁷ [INQ035485/5](#) at paragraph 2.3

⁶⁵⁸ [13/53/24-54/9](#)

⁶⁵⁹ [INQ035485/8](#) at paragraph 5.1

⁶⁶⁰ [INQ023877/2](#) at paragraphs 1.6 and 1.7

⁶⁶¹ [135/9/9-12](#)

⁶⁶² [INQ032856/1](#)

⁶⁶³ [135/8/1-14](#)

⁶⁶⁴ [135/7/2-8/14](#)

⁶⁶⁵ [135/8/1-9/8](#)

⁶⁶⁶ [INQ042482/3](#)

⁶⁶⁷ [135/9/16-11/12](#), [135/10/17-11/12](#), [INQ042482/5](#) at paragraph 1.10

⁶⁶⁸ [135/10/17-11/12](#)

Operational roles

- 12.514** Sarah-Jane Wilson's role as Head of NWFC was not operational.⁶⁶⁹ 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.⁶⁷⁰
- 12.515** NWFC provided cover for a population in the North West of England of approximately 5.5 million people.⁶⁷¹ In the course of the six months between January and June 2017, it handled 60,123 emergency calls.⁶⁷² Shift patterns were organised based on anticipated peak and low demand.⁶⁷³ Demand was usually at its lowest after 22:00.⁶⁷⁴
- 12.516** When it was set up, NWFC managed its work through a regional operational group. This was known as the "Ops Group".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.⁶⁷⁶ The NWFC Single Point of Contact for GMFRS was Janine Carden, an Operations Manager.⁶⁷⁷ Her counterpart at GMFRS was Group Manager Levy.⁶⁷⁸ They had what was described as an "extremely good, professional relationship".⁶⁷⁹

Facilities

- 12.517** NWFC operated from a purpose-built facility in Warrington.⁶⁸⁰ The layout of the NWFC control room, as it was on the night of the Attack, is shown in Figure 33.

⁶⁶⁹ [135/14/7-23](#)

⁶⁷⁰ [125/187/14-19](#)

⁶⁷¹ <https://www.nwfirecontrol.com/about/>

⁶⁷² [INQ035485/5](#) at paragraph 2.5

⁶⁷³ [124/108/4-25](#)

⁶⁷⁴ [124/108/23-25](#)

⁶⁷⁵ [INQ023877/5](#) at paragraph 1.20

⁶⁷⁶ [135/87/2-89/14](#)

⁶⁷⁷ [124/174/10-15](#)

⁶⁷⁸ [124/174/10-24](#)

⁶⁷⁹ [124/174/25-175/8](#)

⁶⁸⁰ [13/53/3-5](#)

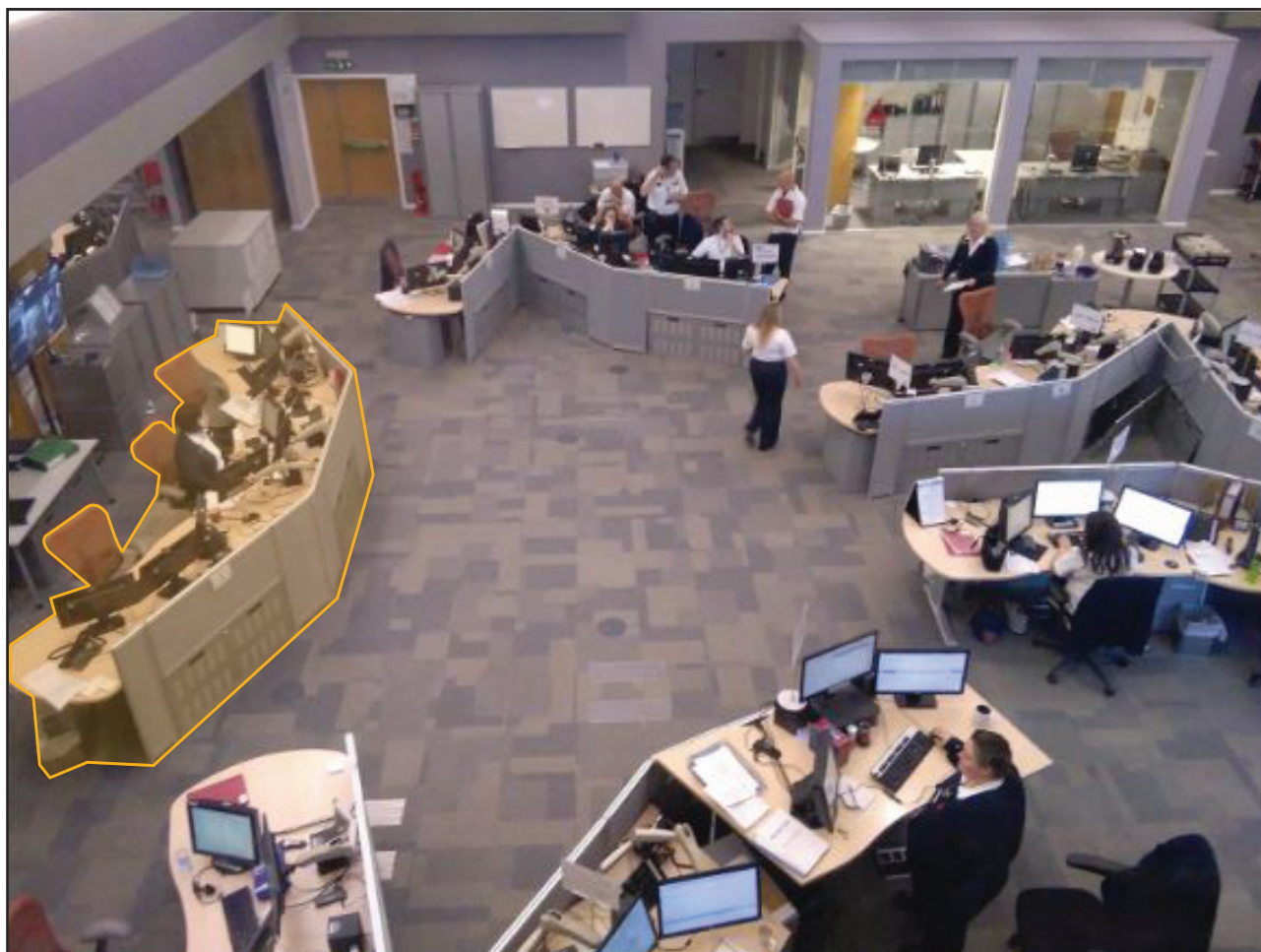


Figure 33: NWFC control room, with Team Leader and Operations Manager placement highlighted⁶⁸¹

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.⁶⁸² The Team Leaders and Operations Manager would sit at the pod to the left-hand side.⁶⁸³

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.⁶⁸⁴ 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.⁶⁸⁵ The Control Room Operators answered emergency calls from any area, irrespective of the pod where they were working.⁶⁸⁶ The Control Room Operator who answered an emergency

⁶⁸¹ [INQ100069](#)

⁶⁸² [124/69/8-13](#)

⁶⁸³ [122/173/7-17](#)

⁶⁸⁴ [124/68/3-71/7](#)

⁶⁸⁵ [INQ023877/20](#) at paragraph 4.4

⁶⁸⁶ [124/69/19-21](#)

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 fire and rescue resources.⁶⁹² 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.⁶⁹³ 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.⁶⁹⁴

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.⁶⁹⁵ Emergency calls appeared on a touchscreen.⁶⁹⁶ The Control Room Operator must answer the emergency call within five seconds.⁶⁹⁷ An emergency call had a high tone. It appeared as red or amber on the computer-aided dispatch system.⁶⁹⁸

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

⁶⁹² [INQ023877/6](#) at paragraph 1.24

⁶⁹³ [124/73/2-23](#)

⁶⁹⁴ [124/73/2-23](#)

⁶⁹⁵ [INQ023877/10](#) at paragraph 2.2.1

⁶⁹⁶ [INQ023877/21](#) at paragraph 4.6

⁶⁹⁷ [INQ023877/10](#) at paragraph 2.2.1

⁶⁹⁸ [INQ023877/21](#) at paragraph 4.10

- 12.524** The computer-aided dispatch system automatically generated a “*New Incident Form*” when an emergency call was answered.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.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,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.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.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 serious with a significant risk to life or property.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.⁷⁰⁵ Michelle Gregson explained that NWFC could not use discretion in its application of GMFRS action plans⁷⁰⁶ and that there was a lack of training about how to apply them.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.⁷⁰⁸

⁶⁹⁹ [INQ023877/22](#) at paragraph 4.12

⁷⁰⁰ [INQ023877/23](#) at paragraph 4.13

⁷⁰¹ [123/64/15-21](#)

⁷⁰² [123/220/9-12](#), [124/28/23-29/3](#), [124/32/22-33/7](#)

⁷⁰³ [INQ041857/13-14](#) at NWFC14

⁷⁰⁴ [INQ023877/25](#) at paragraphs 4.17-4.18

⁷⁰⁵ [INQ023877/27](#) at paragraph 4.26

⁷⁰⁶ [123/210/6-211/16](#)

⁷⁰⁷ [123/213/1-10](#)

⁷⁰⁸ [INQ023877/25](#) at paragraphs 4.20-4.22

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.⁷⁰⁹ 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 22nd May 2017.⁷¹⁰ 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.⁷¹¹ 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 that NWFC overlooked the practical application of training.⁷¹² I agree with her.

⁷⁰⁹ [135/43/21-44/4](#)

⁷¹⁰ [135/3/8-4/8](#)

⁷¹¹ [INQ023877/17](#) at paragraphs 3.1.1-3.1.7

⁷¹² [135/12/21-13/18](#)

- 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.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.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 of Policing. She then worked with colleagues in the ambulance and police services to deliver regular tri-service training in JESIP.⁷¹⁵
- 12.539** Tessa Tracey stated: *"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."*⁷¹⁶ She conceded, however, that *"JESIP on the night did not achieve what we were expecting it to achieve in lines of communication there had been practical exercises in"*.⁷¹⁷
- 12.540** Other NWFC witnesses echoed this failure in the application of their JESIP training.⁷¹⁸
- 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.⁷¹⁹ 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.⁷²⁰
- 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"*.⁷²¹ This was a sensible step to take. She reminded those in the control room that they needed to communicate any relevant information received.⁷²² Despite

⁷¹³ [123/145/17-146/11](#)

⁷¹⁴ [123/146/12-147/8](#)

⁷¹⁵ [125/194/6-196/16](#)

⁷¹⁶ [125/197/6-13](#)

⁷¹⁷ [125/224/12-23](#)

⁷¹⁸ [122/200/12-201/6](#), [122/217/1-218/6](#), [125/151/13-152/3](#)

⁷¹⁹ [123/213/1-10](#)

⁷²⁰ [122/216/10-19](#)

⁷²¹ [123/218/12-21](#)

⁷²² [122/196/17-197/9](#), [123/218/12-25](#), [124/89/21-90/14](#)

this, she recognised when giving evidence that there was an absence of sharing critical information in helping to manage the emergency response.⁷²³ 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 mind-set.⁷²⁴
- 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.⁷²⁵ 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 2011.⁷³² 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.⁷³³

⁷²³ [124/62/16-20](#)

⁷²⁴ [125/151/13-152/3](#)

⁷²⁵ [123/186/17-187/3](#), [123/188/3-8](#)

⁷²⁶ [122/170/22-171/7](#), [123/11/2-25](#)

⁷²⁷ [INQ041685/2](#) at paragraph 4

⁷²⁸ [135/55/3-22](#)

⁷²⁹ [124/169/15-21](#)

⁷³⁰ [135/74/11-14](#), [135/78/14-79/12](#)

⁷³¹ [135/57/10-58/11](#)

⁷³² [INQ033910/1](#) at paragraph 2

⁷³³ [117/115/10-24](#)

- 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.⁷³⁴
- 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.⁷³⁵ NWFC Team Leaders and Operations Managers were also present at Marauding Terrorist Firearms Attack training events.⁷³⁶ 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.⁷³⁷ 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".⁷³⁸
- 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.⁷³⁹ 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."⁷⁴⁰ 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 NWS 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 NWS on the night of 22nd May 2017 would have been clearer to her.⁷⁴⁴

⁷³⁴ [117/116/6-117/15](#)

⁷³⁵ [125/2/2-17](#), [125/4/13-22](#)

⁷³⁶ [125/9/11-23](#)

⁷³⁷ [119/21/12-20](#)

⁷³⁸ [125/3/12-25](#)

⁷³⁹ [125/5/13-24](#)

⁷⁴⁰ [125/5/25-6/20](#)

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](#)

- 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 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”*.⁷⁴⁶ 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.⁷⁴⁷ The audit findings commended Janine Carden for her knowledge of GMFRS’s mobilising procedures and wider Marauding Terrorist Firearms Attack incident implications.⁷⁴⁸
- 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 2017.⁷⁴⁹ 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 22nd 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.⁷⁵³ Nor was the NILO informed of GMP Control’s report to NWFC at 22:54 that the *“paramedic Bronze has just arrived*

⁷⁴⁵ [125/103/19-104/18](#)

⁷⁴⁶ [117/114/3-14](#)

⁷⁴⁷ [125/104/9-18](#)

⁷⁴⁸ [125/104/19-105/5](#), [INQ035485/19](#) at paragraph 12.1

⁷⁴⁹ [INQ041857/10](#)

⁷⁵⁰ [125/234/9-25](#), [125/137/10-15](#)

⁷⁵¹ [135/10/17-11/12](#)

⁷⁵² [123/213/1-10](#)

⁷⁵³ [125/198/3-199/3](#)

on scene”.⁷⁵⁴ 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.⁷⁵⁵

- 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*”.⁷⁵⁶ The action plans determined 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 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

⁷⁵⁴ [125/199/9-202/5, INQ001231/14](#)

⁷⁵⁵ [123/173/24-175/11](#)

⁷⁵⁶ [13/55/25-56/8](#)

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](#)

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.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...*".⁷⁶³ There was no Incident Type Action Plan specific to an explosion caused by a bomb.⁷⁶⁴ This was a failure by GMFRS given 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.⁷⁶⁵ An example was given of unexploded ordnance from the Second World War.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.⁷⁶⁷ This was to ensure the scene was safe of secondary devices and other hazards before personnel were deployed.⁷⁶⁸
- 12.566** The Fire and Rescue Service Expert stated that the action plans had the potential to confuse.⁷⁶⁹ I agree.
- 12.567** NWFC witnesses stated that they were uncertain about when each plan applied.⁷⁷⁰ Michelle Gregson stated that the information on the night of the Attack was "*vast*" and "*vague*".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 who could help with decision-making.⁷⁷² 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.⁷⁷³

⁷⁶² [122/62/11-64/5](#)

⁷⁶³ [INQ004404/1](#)

⁷⁶⁴ [124/181/8-186/4](#)

⁷⁶⁵ [119/169/7-12](#), [123/46/13-17](#), [124/181/14-24](#)

⁷⁶⁶ [124/181/17-22](#)

⁷⁶⁷ [119/169/13-170/1](#)

⁷⁶⁸ [INQ032856/3](#) at paragraphs 2.2 and 2.3

⁷⁶⁹ [INQ041857/8](#)

⁷⁷⁰ [135/61/22-62/23](#), [123/222/10-224/12](#), [123/46/6-24](#)

⁷⁷¹ [124/7/22-8/12](#)

⁷⁷² [124/7/22-8/12](#), [124/9/6-12](#)

⁷⁷³ [123/230/16-19](#)

- 12.568** Joanne Haslam explained that she had no training on the use of the ‘Bomb-general’ action plan.⁷⁷⁴
- 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.⁷⁷⁵ Another witness gave the example of a domestic gas explosion.⁷⁷⁶
- 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”*.⁷⁷⁷ Station Manager Gaskell acknowledged that there was the possibility for confusion.⁷⁷⁸ However, he said he did not have any feedback from NWFC that the ‘Bomb-general’ action plan was confusing.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.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.⁷⁸¹ The pre-determined attendance for an unexploded bomb is to send firefighters and assets to the incident ground, not to inform the duty NILO and obtain an RVP.⁷⁸² 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.⁷⁸³

⁷⁷⁴ [123/44/2-46/24](#)

⁷⁷⁵ [135/24/23-25/18](#)

⁷⁷⁶ [INQ035438/3](#) at paragraph 15

⁷⁷⁷ [128/127/5-12](#)

⁷⁷⁸ [117/32/16-33/2](#)

⁷⁷⁹ [117/132/6-134/4](#)

⁷⁸⁰ [INQ035482/28](#) at paragraph 78, [INQ042436/8](#) at paragraph 30

⁷⁸¹ [INQ032830/9](#)

⁷⁸² [INQ035438/4](#) at paragraph 28, [INQ035485/10](#) at paragraph 7.1(i)

⁷⁸³ [INQ035485/11](#) at paragraph 8.1

Operation Plato action plans

- 12.574** NWFC had three action plans for responding to an Operation Plato incident.⁷⁸⁴
- 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.⁷⁸⁵ The first prompt under this action plan was to contact the duty NILO.⁷⁸⁶
- 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."⁷⁸⁷
- 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.⁷⁸⁸
- 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.⁷⁸⁹
- 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".⁷⁹⁰
- 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."⁷⁹¹

⁷⁸⁴ [119/16/19-17/7](#)

⁷⁸⁵ [117/119/5-14](#)

⁷⁸⁶ [117/119/15-121/1](#)

⁷⁸⁷ [INQ004447/1](#)

⁷⁸⁸ [124/168/1-19](#)

⁷⁸⁹ [117/125/12-23](#)

⁷⁹⁰ [135/53/1-55/22](#)

⁷⁹¹ [117/121/13-122/1](#)

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.⁷⁹²

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.⁷⁹³

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 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".⁷⁹⁴ 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."⁷⁹⁵

12.587 Station Manager Gaskell stated that it would be "unusual" for NWFC to have information that an explosion was caused by a bomb.⁷⁹⁶ 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.⁷⁹⁷

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".⁷⁹⁸ A PowerPoint presentation entitled 'Marauding Terrorist Firearms Attack (MTFA)' was used.⁷⁹⁹ It focused on firearms attack methodology. It advised that, if fire and rescue assistance were needed, the duty NILO must be contacted first.⁸⁰⁰

⁷⁹² [119/16/13-18](#), [122/70/6-22](#)

⁷⁹³ [117/123/4-16](#)

⁷⁹⁴ [INQ001231/9](#)

⁷⁹⁵ [INQ008372/6](#)

⁷⁹⁶ [117/137/16-23](#)

⁷⁹⁷ [117/137/6-139/15](#)

⁷⁹⁸ [INQ033910/12](#) at paragraph 48

⁷⁹⁹ [INQ033925/1](#)

⁸⁰⁰ [INQ033925/16](#)

- 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"*.⁸⁰¹ 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.
- 12.590** On the information it was presented with on 22nd 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.⁸⁰² Station Manager Gaskell stated it contained *"cast iron mobilisation instructions for NWFC to follow"*.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.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 discretion by NWFC staff as permitted to GMFRS officers.⁸⁰⁵

Major Incident Plan

- 12.593** On 22nd 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 22nd 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

⁸⁰¹ [INQ001231/3](#)

⁸⁰² [INQ004213/1](#), [INQ004213/3](#)

⁸⁰³ [INQ033910/12](#) at paragraph 51, [117/177/15-178/20](#)

⁸⁰⁴ [117/136/21-137/5](#), [INQ004213/5](#)

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

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 should not have occurred. One witness described it as “*extraordinary*” that NWFC was not involved.⁸¹⁰ I agree.
- 12.596** Despite incidents usually starting with a telephone call to a control room, NWFC was “*overlooked*”.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.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.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.⁸¹⁴
- 12.599** Attending live exercises would have allowed NWFC staff a chance to practise in 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.⁸¹⁵ 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.⁸¹⁶
- 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.

⁸⁰⁹ [124/124/3-23](#)

⁸¹⁰ [123/213/11-25](#)

⁸¹¹ [123/213/11-25](#)

⁸¹² [63/125/21-126/9](#)

⁸¹³ [117/143/6-23](#)

⁸¹⁴ [125/20/1-21/14](#)

⁸¹⁵ [124/143/9-144/9](#)

⁸¹⁶ [123/45/2-19](#), [123/101/17-102/10](#)

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.

Greater Manchester Fire and Rescue Service preparedness

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.⁸¹⁷ It covers approximately 500 square miles and the ten boroughs of Greater Manchester, which has a population of 2.5 million.⁸¹⁸ 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, and for responding to other emergencies.⁸¹⁹ The latter was a broad function. GMFRS considered that it included a fire and rescue service responding to

⁸¹⁷ [INQ026714/18](#) at paragraph 70

⁸¹⁸ [Greater Manchester Fire and Rescue Service, 'Community Resource Brochure'](#)

⁸¹⁹ [Fire and Rescue Services Act 2004, Sections 6-9](#)

a terrorist incident.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.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.⁸²²

12.607 The *Fire and Rescue National Framework* set country-wide priorities and objectives for fire and rescue authorities.⁸²³ The framework in place in May 2017 dated from 2012. It required collaboration and interoperability with other emergency services.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.⁸²⁵

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.⁸²⁶

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”.⁸²⁷ 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.⁸²⁸

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.

⁸²⁰ [INQ026714/3-4](#), [INQ039409/42](#)

⁸²¹ [Fire and Rescue Services Act 2004, Sections 6-9](#)

⁸²² [72/16/15-35/22](#)

⁸²³ [INQ018922](#)

⁸²⁴ [INQ018922](#)

⁸²⁵ [INQ026714/9](#) at paragraphs 43-46 and 49

⁸²⁶ [INQ026714/8](#) at paragraphs 33-38

⁸²⁷ [INQ026702](#)

⁸²⁸ [INQ026714/12](#) at paragraphs 58-60

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 2017.⁸²⁹
- 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.⁸³⁰
- 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.⁸³¹
- 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.

⁸²⁹ [INQ026714/5](#) at paragraphs 22-28 and 64

⁸³⁰ [INQ026714/11](#) at paragraph 51

⁸³¹ [133/20/23-24/9](#)

⁸³² [121/3/16-4/4](#)

- 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 directly answerable to those in the Command Support Room in the way the Operational/Bronze Commanders of BTP, GMP and NWAS were to their respective Tactical/Silver Commanders.⁸³⁴
- 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.⁸³⁵
- 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.

⁸³³ [121/4/18-6/16](#)

⁸³⁴ [121/11/17-17/10](#)

⁸³⁵ [121/12/15-13/3](#)

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 NWS 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

12.629 Station Manager Lawlor explained that the role of the NILO was intended to be a Tactical Advisor to the Incident Commander.⁸⁴³ 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.⁸⁴⁴ 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.⁸⁴⁵ A key point of information for the NILO would be the police Tactical Firearms Commander.⁸⁴⁶

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.⁸⁴⁷

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](#)

⁸⁴³ [62/22/11-23](#)

⁸⁴⁴ [62/37/18-38/17](#), [62/46/3-15](#), [62/22/24-24/21](#)

⁸⁴⁵ [INQ026735/6](#) at paragraphs 22-23

⁸⁴⁶ [INQ026735/6](#) at paragraph 24, [62/37/18-38/7](#)

⁸⁴⁷ [INQ026714/25](#) at paragraph 110

- 12.631** GMFRS, together with London Fire Brigade, facilitated the NILO course at the Fire Service College.⁸⁴⁸ 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.⁸⁴⁹
- 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.⁸⁵⁰
- 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.⁸⁵¹
- 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.⁸⁵² 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.⁸⁵³

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.⁸⁵⁴ In May 2017, there were 41 fire stations with 56 frontline appliances and 44 specialist vehicles.⁸⁵⁵ Six of the GMFRS fire stations were within a 4km radius of the Arena, including

⁸⁴⁸ [INQ026735/9](#) at paragraph 40

⁸⁴⁹ [INQ026735/9](#) at paragraph 40

⁸⁵⁰ [INQ026735/7](#) at paragraphs 34-35

⁸⁵¹ [INQ026735/9](#) at paragraphs 43-44, [63/9/19-11/15](#)

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

Manchester Central Fire Station and Philips Park Fire Station.⁸⁵⁶ 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 Manchester⁸⁵⁷

12.638 A standard GMFRS fire appliance had a long board⁸⁵⁸ and a trauma bag⁸⁵⁹. 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

⁸⁵⁶ [INQ026714/16](#) at paragraph 68

⁸⁵⁷ [INQ026714/16](#)

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](#)

- 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 22nd May 2017 was that it had personnel specifically trained to respond to a Marauding Terrorist Firearms Attack.⁸⁶⁵ They received training for operating in an Operation Plato warm zone.⁸⁶⁶
- 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.⁸⁶⁷ Personnel on a Specialist Response Team vehicle had enhanced trauma training provided by NWS HART.⁸⁶⁸
- 12.642** Specialist Response Team personnel were trained to work with NWS 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.⁸⁶⁹ A Specialist Response Team vehicle had five SKED stretchers.⁸⁷⁰ A SKED stretcher was designed to permit casualties safely to be dragged away from danger and towards medical help.⁸⁷¹
- 12.643** GMFRS had three command support vehicles. They acted as a mobile command base during larger incidents.⁸⁷² They were not deployed on the night of the Attack.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.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.⁸⁷⁵

⁸⁶³ [INQ026714/18](#) at paragraphs 72-75

⁸⁶⁴ [INQ035482](#) at paragraph 14

⁸⁶⁵ [INQ026714/18](#) at paragraphs 73-74

⁸⁶⁶ [71/62/13-64/3](#)

⁸⁶⁷ [INQ004319](#), [63/69/7-14](#)

⁸⁶⁸ [71/8/7-18](#), [63/70/3-12](#)

⁸⁶⁹ [63/70/3-72/6](#), [INQ026714/19](#) at paragraph 76

⁸⁷⁰ [63/68/24-69/6](#)

⁸⁷¹ [INQ026714/19](#) at paragraphs 75-76, [63/70/13-19](#)

⁸⁷² [INQ026714/19](#) at paragraph 77

⁸⁷³ [71/103/22-104/2](#), [133/172/19-21](#)

⁸⁷⁴ [INQ026714/20](#) at paragraphs 81-83

⁸⁷⁵ [129/8/9-9/3](#), [129/28/14-29/5](#), [130/55/17-56/3](#), [131/117/9-11](#)

- 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.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 NWS.⁸⁷⁷
- 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.⁸⁷⁸ 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.⁸⁷⁹
- 12.649** Assistant Chief Fire Officer Keelan stated that JESIP was “*at the heart of all GMFRS training*”.⁸⁸⁰ 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.⁸⁸¹
- 12.650** All GMFRS firefighters and operational commanders must complete JESIP level 1 training. GMP and NWS 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, NWS 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

⁸⁷⁶ [INQ026714/47](#) at paragraph 205

⁸⁷⁷ [INQ026714/47](#) at paragraphs 205-207

⁸⁷⁸ [INQ026714/4](#) at paragraph 21

⁸⁷⁹ [INQ026714/55](#) at paragraph 236

⁸⁸⁰ [INQ026714/28](#), paragraph 124

⁸⁸¹ [INQ026714/28](#) at paragraph 124

⁸⁸² [INQ026714/53](#) at paragraphs 228-230

⁸⁸³ [70/2/15-4/5](#), [71/20/21-21/19](#), [71/109/4-11](#)

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.⁸⁸⁵

12.654 All levels of GMFRS command were trained in operational discretion. This underpinned the training for all safe operating procedures.⁸⁸⁶ This policy was introduced in 2014. GMFRS was one of the first fire and rescue services to introduce this.⁸⁸⁷ 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.⁸⁸⁸

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.⁸⁸⁹ The operational discretion policy 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.

⁸⁸⁴ [INQ041857/1](#)

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

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](#)

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 capability went live in late 2011.⁸⁹⁴ A chronology provided by Station Manager Gaskell set out the development of this capability prior to May 2017.⁸⁹⁵
- 12.658** Station Manager Gaskell described the preparation for the GMFRS Marauding Terrorist Firearms Attack capability as a “*very lengthy and intensive programme*”.⁸⁹⁶ It involved establishing a training programme and procuring equipment and vehicles. NWS played an important role, for example in developing trauma training, and obtaining SKED stretchers and dressings.⁸⁹⁷ By January 2016, GMFRS was assessed to have established a Marauding Terrorist Firearms Attack capability in all areas.⁸⁹⁸
- 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.⁸⁹⁹
- 12.660** Station Manager Gaskell ran various multi-agency courses to establish the Marauding Terrorist Firearms Attack capability across Greater Manchester.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.⁹⁰¹ All the GMFRS officers on duty on 22nd May 2017 had received training on JOPs 3. All the command officers had also attended multi-agency tabletop and live exercises.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.⁹⁰³ He stated it was too formalised and “*didn’t deal with the potential chaos that may ensue*”.⁹⁰⁴ The training reflected an incident that was stabilised

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](#)

⁹⁰⁰ [117/98/24-99/11](#)

⁹⁰¹ [INQ033910/11](#) at paragraph 45

⁹⁰² [INQ026714/35](#) at paragraph 160

⁹⁰³ [71/5/1-11](#)

⁹⁰⁴ [71/5/1-11](#)

with all the emergency services present. Watch Manager Nolan stated that more training focused on the start of an incident would have been beneficial.⁹⁰⁵ He did not consider that the training was too risk averse.⁹⁰⁶

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 NWS 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.⁹⁰⁷ 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'.⁹⁰⁸ 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.⁹⁰⁹ 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.⁹¹⁰ New Dimensions is now known as 'National Resilience'.⁹¹¹

12.664 The Contingency Planning Unit prepared Standard Operating Procedures (SOPs). It planned and organised exercises, including with other emergency service partners.⁹¹² 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."*⁹¹³

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',⁹¹⁴ a 'Firearms' guidance document,⁹¹⁵ 'Major Incident: Emergency Response'⁹¹⁶ and an

⁹⁰⁵ [71/9/23-10/24](#), [71/72/7-22](#)

⁹⁰⁶ [71/65/1-67/25](#)

⁹⁰⁷ [INQ042436/8](#) at paragraph 29, [63/125/21-126/9](#)

⁹⁰⁸ [62/8/16-10/20](#)

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](#)

⁹¹⁵ [INQ026714/36](#) at paragraph 163

⁹¹⁶ [INQ004544](#)

‘Emergency Response and Recovery’ guidance document.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 14th December 2012.⁹¹⁸ 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.⁹¹⁹

12.667 I have already commented in relation to BTP, GMP and NWS 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 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.

12.671 I will consider GMFRS’s involvement in multi-agency exercising and, in particular, Exercise Winchester Accord at the end of this Part.

⁹¹⁷ [INQ026714/36](#) at paragraph 164

⁹¹⁸ [INQ026714/37](#) at paragraph 169

⁹¹⁹ [INQ026714/37](#) at paragraph 169

⁹²⁰ [INQ035482/28-29](#) at paragraphs 78 and 79, [INQ042436/8](#) at paragraphs 30 and 31

⁹²¹ [INQ026735/9](#) at paragraphs 41-42

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 2000.⁹²² By 2010, 300 organisations had access to the Airwave network.⁹²³

12.674 Airwave was introduced to GMP in 2003 and to GMFRS and NWS in 2010/11.⁹²⁴

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 radio.⁹²⁵ Some talk groups were for use within an organisation. For example, a talk group may be used by all

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

⁹²³ [INQ041595/10](#) at paragraph 1.1.3

⁹²⁴ [INQ040999/2](#), [INQ040999/8](#) at paragraph 33

⁹²⁵ [108/127/11-22](#)

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.

- 12.676** A talk group can be accessed by individuals through handheld radios and by control rooms through their integrated communications system.⁹²⁶
- 12.677** 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”*.⁹²⁷
- 12.678** The SOP Guide stated that, to ensure consistency in its use, the Airwave system should be managed through local resilience forums.⁹²⁸ 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.⁹²⁹

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.⁹³⁰
- 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.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”*.⁹³²

⁹²⁶ [INQ040999/1](#) at paragraph 4

⁹²⁷ [INQ041595/6](#)

⁹²⁸ [INQ041595/14](#)

⁹²⁹ [58/150/18-151/12](#)

⁹³⁰ [108/119/23-120/5](#)

⁹³¹ [108/124/17-125/10](#)

⁹³² [INQ007279/79](#)

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."*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."*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 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.⁹³⁵

Existing Airwave talk groups

Monitored multi-agency talk groups

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 NWS 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.⁹³⁶

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

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.⁹³⁷ 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.⁹³⁸

⁹³³ [INQ007626/1](#)

⁹³⁴ [INQ000781/2](#)

⁹³⁵ [108/202/4-205/13](#)

⁹³⁶ [108/152/17-155/16](#)

⁹³⁷ [108/166/23-167/5](#)

⁹³⁸ [108/168/1-4](#)

- 12.688 There were three Operational/Bronze Commander talk groups available for use which were unmonitored.⁹³⁹ These talk groups were the subject of weekly testing by the emergency services in Greater Manchester.⁹⁴⁰
- 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”.⁹⁴¹
- 12.690 The third item on Inspector Sexton’s aide-memoire directed him to nominate a multi-agency 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]”.⁹⁴²
- 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.⁹⁴³

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 22nd May 2017, the arrangements had not been finalised. I shall refer to this as ‘the proposed multi-agency control room talk group’.

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.”⁹⁴⁴

- 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.”⁹⁴⁵

⁹³⁹ [INQ041227/1](#)

⁹⁴⁰ [INQ040999/3](#) at paragraph 13

⁹⁴¹ [INQ029178/4-5](#)

⁹⁴² [INQ040955/1](#)

⁹⁴³ [INQ040999/6](#) at paragraph 25

⁹⁴⁴ [INQ008372/10](#) at paragraph 4.4

⁹⁴⁵ [INQ008372/10](#)

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 NWS 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.⁹⁴⁶

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 NWS 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-NWS-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

⁹⁴⁶ [INQ032758/12](#)

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."*⁹⁵⁰

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."*⁹⁵¹

Joint Operating Principles third edition training (22nd February 2017)

12.702 On 22nd 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.⁹⁵²

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.⁹⁵³

Exercise Hawk River (1st March 2017)

12.704 Exercise Hawk River was hosted by GMFRS on 1st 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"*.⁹⁵⁴

⁹⁵⁰ [INQ034531/1](#)

⁹⁵¹ [128/107/20-108/4-13](#)

⁹⁵² [108/183/18-184/6](#)

⁹⁵³ [108/184/7-15](#)

⁹⁵⁴ [63/117/4-23](#)

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.⁹⁵⁵ 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.”⁹⁵⁶

12.708 As a result of Exercise Hawk River, it was agreed by GMP, NWS 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.⁹⁵⁷

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 NWS 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 NWS Control and NWFC on 10th April 2017.⁹⁶²

Westminster Bridge terrorist attack (22nd March 2017)

12.713 On 22nd March 2017, ISIS-inspired terrorist Khalid Masood carried out a terrorist attack on Westminster Bridge. He killed five people and injured many more.

⁹⁵⁵ [INQ004529/7](#)

⁹⁵⁶ [INQ004529/7](#)

⁹⁵⁷ [63/87/16-88/10](#)

⁹⁵⁸ [108/185/25-186/3](#)

⁹⁵⁹ [108/185/13-21](#)

⁹⁶⁰ [108/186/4-187/10](#)

⁹⁶¹ [108/187/11-188/11](#)

⁹⁶² [108/188/20-22](#)

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.⁹⁶³

Email from Sergeant Whittle (30th March 2017)

12.715 On 30th 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"*.⁹⁶⁴ Laura Lewis confirmed in evidence that this was a reference to using the existing Tactical/Silver talk group channel.⁹⁶⁵

12.716 The email went on: *"I have met with commanders from NWS Simon Watson and GMFRS Neil Gaskell and agreed a switch over date of Sunday 30th April 2017 with a test to be conducted by the duty FDO on that morning."*⁹⁶⁶ Laura Lewis replied later that day to confirm that she and PC Hoyte were attending NWS Control and NWFC on 10th April 2017.⁹⁶⁷

Following visits to NWFC and NWS Control (10th and 20th April 2017)

12.717 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.⁹⁶⁸

12.718 On 20th April 2017, PC Hoyte sent an email to Cally Fillingham, the Training Manager for Airwave Tactical Advisors at the College of Policing.⁹⁶⁹ 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."*⁹⁷⁰

12.719 Later that day, Sergeant Whittle emailed Laura Lewis asking about the visits to NWFC and NWS Control. He asked whether Laura Lewis thought it feasible for a "change over" to happen on 28th April 2017.⁹⁷¹ 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."*⁹⁷²

⁹⁶³ [108/189/4-18](#)

⁹⁶⁴ [INQ017994/6](#)

⁹⁶⁵ [108/189/23-190/11](#)

⁹⁶⁶ [INQ017994/6](#)

⁹⁶⁷ [INQ017994/5](#)

⁹⁶⁸ [INQ035164/3](#) at paragraph 9

⁹⁶⁹ [108/195/4-10](#)

⁹⁷⁰ [INQ018039/1](#)

⁹⁷¹ [INQ017994/4](#)

⁹⁷² [INQ017994/4](#)

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."*⁹⁷³

12.721 CI 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."*⁹⁷⁴

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.⁹⁷⁵ PC Hoyte suggested a meeting between the two of them on 24th 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 23rd 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.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

⁹⁷³ [INQ017994/2](#)

⁹⁷⁴ [INQ017957/1](#)

⁹⁷⁵ [INQ017971/1](#)

⁹⁷⁶ [108/163/3-18](#)

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, NWS 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 NWS with greater impact.

⁹⁷⁷ [INQ026734/14](#), [63/85/22-86/13](#)

⁹⁷⁸ [63/88/11-24](#)

⁹⁷⁹ [INQ017996/1](#)

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.⁹⁸⁰

12.736 The two types of exercise relevant to this Inquiry were: tabletop and live exercises.⁹⁸¹

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 GMRF Resilience Development Group.⁹⁸⁵ This was an example of a well-organised, inclusive exercise.

⁹⁸⁰ [Emergency planning and preparedness: exercises and training – GOV.UK \(www.gov.uk\)](http://www.gov.uk)

⁹⁸¹ [Emergency planning and preparedness: exercises and training – GOV.UK \(www.gov.uk\)](http://www.gov.uk)

⁹⁸² [Emergency planning and preparedness: exercises and training – GOV.UK \(www.gov.uk\)](http://www.gov.uk)

⁹⁸³ [INQ036860/2-3](#) at paragraph 10

⁹⁸⁴ [INQ036860/3](#) at paragraphs 12-13, [67/94/12-95/1](#)

⁹⁸⁵ [INQ036860/3-4](#) at paragraph 14, [67/95/2-20](#)

- 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."*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 2015.⁹⁸⁷ 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 NWS.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 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. NWS 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 exercises.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."*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.

⁹⁸⁶ [Emergency planning and preparedness: exercises and training – GOV.UK \(www.gov.uk\)](https://www.gov.uk/guidance/emergency-planning-and-preparedness-exercises-and-training)

⁹⁸⁷ [INQ033916/1](#), [63/104/15-105/3](#), [62/90/12-16](#)

⁹⁸⁸ [INQ033916](#)

⁹⁸⁹ [INQ035309/80](#) at paragraph 4.1.4

⁹⁹⁰ [INQ035372/4](#) at paragraph 9

⁹⁹¹ [INQ014100/7](#)

⁹⁹² [INQ035309/84](#) at paragraph 4.3.6

⁹⁹³ [INQ032665/56](#) at paragraph 10.2

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.⁹⁹⁴

12.748 As all the Emergency Response Experts noted, GMP, GMFRS and NWS recognised the real importance of exercising. They dedicated an appropriate level of resource, time and commitment to it.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.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.⁹⁹⁷

12.750 BTP should have been included in the programme for Greater Manchester multi-agency exercising but was not. The Policing Experts concluded: *“Control Room structures, arrangements and the training of staff in a response to serious emergency may have been compromised.”*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 GMRP to ensure that there was a robust debrief process in place.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 *“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

⁹⁹⁴ [INQ041506/2-4](#)

⁹⁹⁵ [INQ035309/81-82](#), [INQ032665/55-56](#), [INQ032503/11-12](#), [144/7/24-8/3](#)

⁹⁹⁶ [117/143/6-23](#)

⁹⁹⁷ [INQ033916/2](#)

⁹⁹⁸ [INQ041870/2-3](#) at paragraph 13

⁹⁹⁹ [117/69/15-74/14](#)

¹⁰⁰⁰ [INQ029288/80](#) at paragraph 434

¹⁰⁰¹ [INQ033917/1](#)

¹⁰⁰² [INQ040131/4](#)

“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

- 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.¹⁰⁰⁵ 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.¹⁰⁰⁶ 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.¹⁰⁰⁷
- 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 2016.¹⁰⁰⁸ 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 22nd 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.

¹⁰⁰³ [INQ040131/4](#)

¹⁰⁰⁴ [INQ026735/11-12](#), [62/79/22-80/20](#)

¹⁰⁰⁵ [INQ035309/82](#) at paragraph 4.2.9

¹⁰⁰⁶ [INQ012579/15-19](#)

¹⁰⁰⁷ [INQ012579/11-12](#)

¹⁰⁰⁸ [INQ032665/58-62](#)

12.759 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 22nd May 2017, not their rank at the date of the exercise.

Aims and objectives of Exercise Winchester Accord

12.760 On 2nd November 2015, GMP received a request to host Exercise Winchester Accord in Greater Manchester.¹⁰⁰⁹ 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 22nd May 2017.

12.761 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.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 22nd May 2017.¹⁰¹¹

12.762 Exercise Winchester Accord took place over three days from 9th to 11th May 2016. It was a “live-play” exercise with over 1,000 “players” and 160 “casualties”.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.¹⁰¹³ This commenced at 00:00 and went on into the early morning of 10th May 2016.¹⁰¹⁴

12.763 The primary aim of Exercise Winchester Accord was the relicensing of military assets for domestic purposes.¹⁰¹⁵ Additionally, GMP and other agencies were invited to set their own objectives for the exercise.¹⁰¹⁶ Inspector Roby was the exercise co-ordinator. She led the discussions aimed at setting the local objectives.¹⁰¹⁷ She described how those objectives were “bolted on” to test

¹⁰⁰⁹ [INQ040633/2](#) at paragraph 4

¹⁰¹⁰ [84/70/17-22](#)

¹⁰¹¹ [INQ042531/21](#)

¹⁰¹² [INQ013559/5](#)

¹⁰¹³ [117/50/11-51/12](#)

¹⁰¹⁴ [117/148/14-22](#)

¹⁰¹⁵ [67/27/10-13](#)

¹⁰¹⁶ [67/29/17-19](#)

¹⁰¹⁷ [INQ034427/4](#) at paragraph 17

particular issues.¹⁰¹⁸ 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.¹⁰¹⁹

12.764 About 70 different local objectives were set.¹⁰²⁰

12.765 NWS objectives included demonstrating the effective evacuation of patients from the Operation Plato warm zone to a Casualty Clearing Station, testing communication links between NWS 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.¹⁰²¹

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 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.¹⁰²⁸

12.769 In an email dated 25th March 2016, Group Manager Levy explained to NWFC Operations Manager Janine Carden that he had enquired about NWFC involvement in the exercise, *“both for operational / logistic mobilising, and also*

¹⁰¹⁸ [67/29/22-30/9](#)

¹⁰¹⁹ [67/28/24-29/13](#)

¹⁰²⁰ [146/104/21-105/3](#)

¹⁰²¹ [INQ013559/7](#)

¹⁰²² [INQ033920/5](#)

¹⁰²³ [INQ035494/4](#) at paragraph 19

¹⁰²⁴ [INQ007693/1](#)

¹⁰²⁵ [INQ007694](#)

¹⁰²⁶ [123/213/11-25](#)

¹⁰²⁷ [INQ033920/6](#)

¹⁰²⁸ [117/143/9-145/8](#), [INQ001250/2](#)

as a training / assurance opportunity for you".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.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.¹⁰³¹ Station Manager Gaskell explained that the view was that Exercise Winchester Accord did not "*lend itself to a dynamic mobilisation exercise*".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.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 NWS planning document for the exercise described it as "*one of the largest staged in the UK*".¹⁰³⁵ Yet, despite its size, Exercise Winchester Accord was organised as a Tier Three exercise.¹⁰³⁶ This meant that the exercise was organised, run and debriefed at a regional level, not nationally.¹⁰³⁷
- 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.¹⁰³⁸ A Tier One exercise would receive central government support, and there would be a rigorous focus on the evaluation of each exercise objective.¹⁰³⁹ In contrast, in a Tier Three exercise the debrief process would be more open and generic, without evaluating specific objectives.¹⁰⁴⁰

¹⁰²⁹ [INQ040330](#)

¹⁰³⁰ [122/170/22-171/7](#)

¹⁰³¹ [117/169/23-170/25](#)

¹⁰³² [117/169/5-170/25](#)

¹⁰³³ [117/169/5-170/6](#)

¹⁰³⁴ [INQ034427/3-4](#) at paragraph 16

¹⁰³⁵ [INQ013559/5](#)

¹⁰³⁶ [146/113/8-115/18](#)

¹⁰³⁷ [146/112/21-113/7](#)

¹⁰³⁸ [146/113/20-115/5](#)

¹⁰³⁹ [146/104/4-20](#)

¹⁰⁴⁰ [146/105/4-9](#)

- 12.774** The Policing Experts believed that Exercise Winchester Accord was probably too large to be managed as a Tier Three exercise.¹⁰⁴¹ This is a view with which I agree. The NWS planning document noted: “[T]here is national interest in the outcomes.”¹⁰⁴² That national interest was not matched by the required planning and support to capture the learning from such a large and complex exercise.¹⁰⁴³
- 12.775** Exercise Winchester Accord had a mix of national and local objectives.¹⁰⁴⁴ Inspector Roby acknowledged that planning and policy-making were “hit very badly” by budget cuts from 2011.¹⁰⁴⁵ She said it impacted on the ability of her planning team to do their jobs.¹⁰⁴⁶ CI 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.¹⁰⁴⁷
- 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”.¹⁰⁴⁸ It was the responsibility of GMRF and the agencies involved in planning multi-agency exercises to plan exercises in an effective and coherent way.¹⁰⁴⁹ 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.¹⁰⁵⁰
- 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.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”.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.¹⁰⁵³

¹⁰⁴¹ [146/113/20-115/5](#)

¹⁰⁴² [INQ013559/5](#)

¹⁰⁴³ [146/112/11-113/7](#)

¹⁰⁴⁴ [67/29/22-30/9](#)

¹⁰⁴⁵ [67/68/21-69/5](#)

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](#)

¹⁰⁵¹ [58/86/17-87/16](#)

¹⁰⁵² [117/50/12-51/18](#)

¹⁰⁵³ [117/62/13-63/19](#)

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 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.¹⁰⁵⁴ 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.¹⁰⁵⁵ 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.¹⁰⁵⁶

12.780 Inspector Roby explained that a purpose of the FDO objectives was to replicate what would happen in real life.¹⁰⁵⁷ 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.¹⁰⁵⁸ Inspector Roby said she asked them, “*what was going to cause problems if we had this type of incident in reality*”.¹⁰⁵⁹ The answers fed into the type of objectives that were set.¹⁰⁶⁰ 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.¹⁰⁶¹ The calls were scripted and included press queries, and calls from GMP officers, other police and emergency services, members of the public and others.¹⁰⁶²

¹⁰⁵⁴ [INQ007693/1](#)

¹⁰⁵⁵ [INQ007693/1](#)

¹⁰⁵⁶ [INQ007693/1](#)

¹⁰⁵⁷ [67/62/13-63/2](#)

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](#)

- 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.*”¹⁰⁶³ The FDO was expected to declare Operation Plato at 00:09, while the calls were being received.¹⁰⁶⁴ Inspector Roby said this was “*to replicate the sheer volume of calls that would be coming in.*”¹⁰⁶⁵ She emphasised that the FDO’s telephone line was like a switchboard system with flashing lights.¹⁰⁶⁶ It was expected that other staff would be in a position to answer calls.¹⁰⁶⁷
- 12.783** 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.¹⁰⁶⁸ 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.¹⁰⁶⁹ Inspector Roby said that it was a test of proposed capacity in the event that the FDO moved to GMP HQ.¹⁰⁷⁰
- 12.784** Inspector Roby said she did not think that proposal would work.¹⁰⁷¹ She believed that, if the FDO were moved out of the Operational Control Room, it would vastly reduce their ability to delegate.¹⁰⁷² She said that, if the FDO were working remotely, they would not get a feel for the room; they would have to be told that something was happening.¹⁰⁷³
- 12.785** CI Booth, who was involved in planning the exercise, similarly said: “*Winchester Accord, from an FDO perspective, had been about testing the FDO in a new location, FHQ [Force Headquarters – GMP HQ], with reduced support.*”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’.¹⁰⁷⁵ CI Booth was concerned that, by reducing the number of staff, the “*criticality around being overwhelmed was more likely to bear fruition [sic].*”¹⁰⁷⁶ As a result, a local objective was added to Exercise Winchester Accord to test the proposed Force Hub.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

¹⁰⁶³ [INQ034454/3](#)

¹⁰⁶⁴ [INQ034454/3](#)

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](#)

¹⁰⁷³ [67/31/4-32/3](#)

¹⁰⁷⁴ [186/79/3-19](#), [83/201/13-25](#)

¹⁰⁷⁵ [83/175/11-24](#)

¹⁰⁷⁶ [83/175/25-176/12](#)

¹⁰⁷⁷ [83/176/23-177/1](#)

of the Attack. Rather, the exercise placed the FDO in an unfamiliar environment at GMP 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

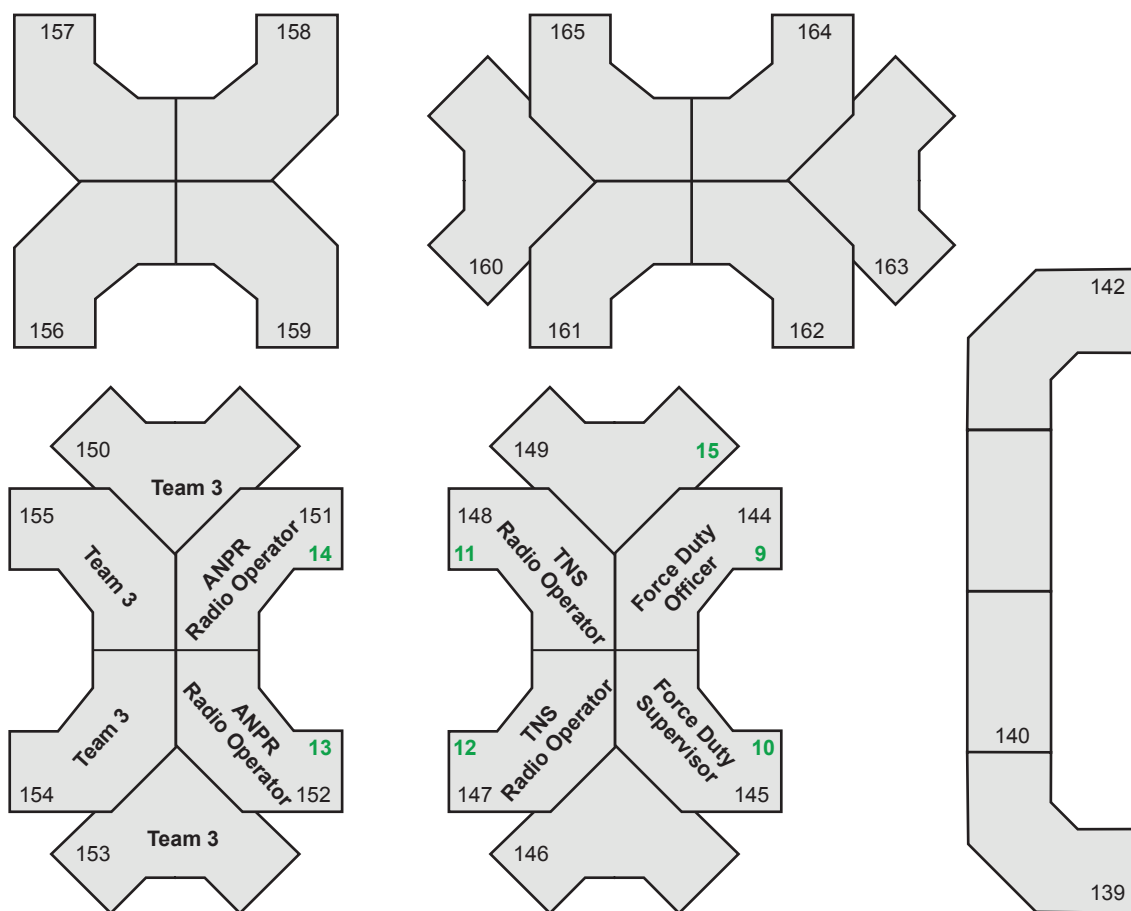


Figure 35: Force Duty Officer team on Exercise Winchester Accord¹⁰⁸²

¹⁰⁷⁸ [131/2/21-4/18](#)

¹⁰⁷⁹ [INQ034417/3](#)

¹⁰⁸⁰ [INQ042531/30](#) at paragraph 84

¹⁰⁸¹ [INQ035494/6](#) at paragraph 27

¹⁰⁸² [INQ034417/3](#)

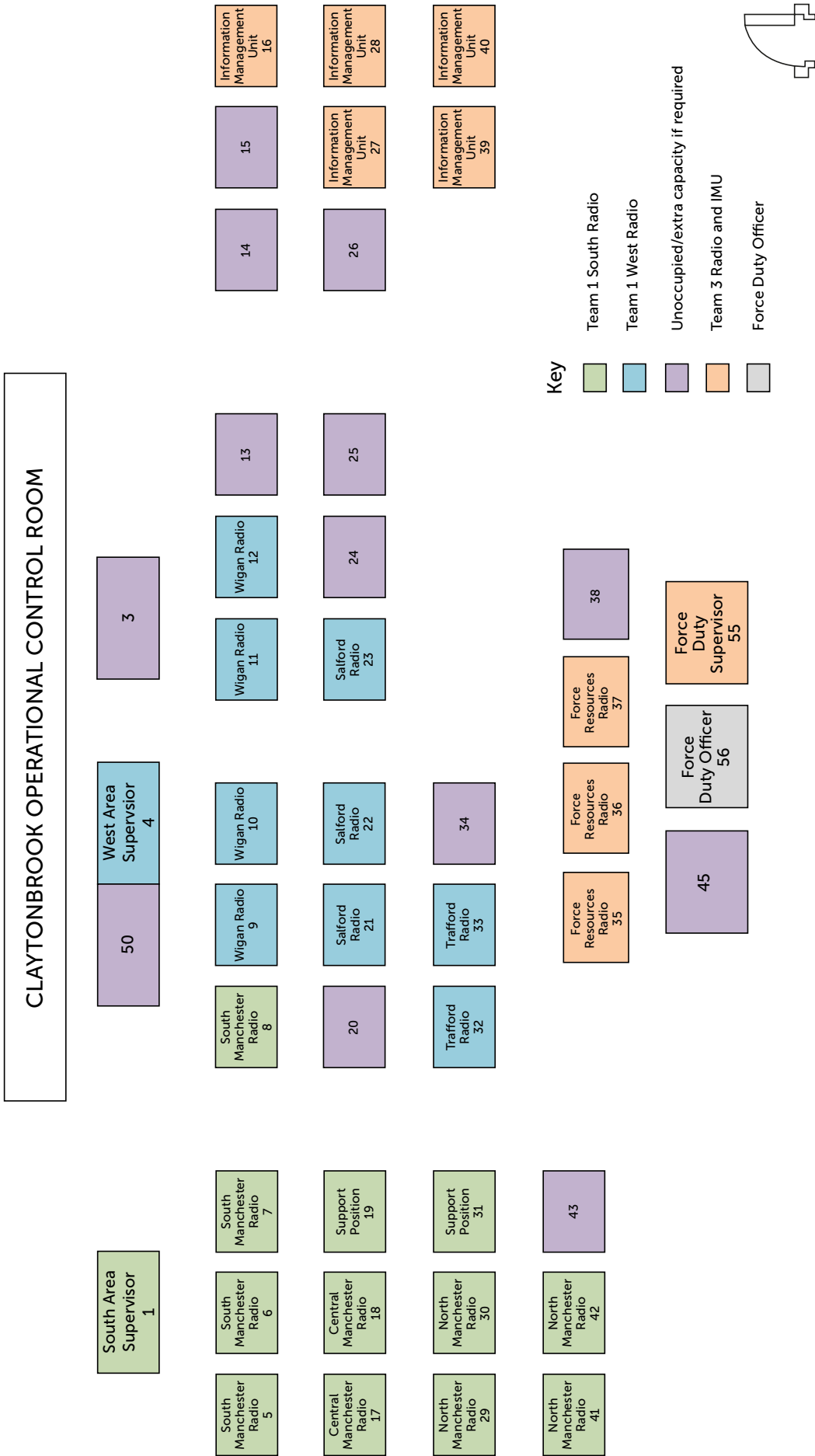


Figure 36: GMP Operational Control Room as at 22nd May 2017¹⁰⁸³

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.¹⁰⁸⁴ To understand that, it is important to look at Exercise Winchester Accord in its wider context.
- 12.791** GMP accepted that it was “*well known*”¹⁰⁸⁵ that the FDO would be under pressure during a Marauding Terrorist Firearms Attack.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*”.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.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 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

¹⁰⁸⁴ [INQ034427/7](#) at paragraph 40

¹⁰⁸⁵ [INQ042531/32](#) at paragraph 88

¹⁰⁸⁶ [INQ042531/32](#) at paragraph 88

¹⁰⁸⁷ [60/29/24-30/4](#)

¹⁰⁸⁸ [148/84/19-85/12](#)

there was such a failure of the FDO during that exercise.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.¹⁰⁹⁰ He said that it was "*undoubtedly*" an important skill for an FDO to have the ability to communicate with other emergency services.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 Advisor, decide how best to deploy firearms officers to deal with the incident.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.¹⁰⁹³ On the assessment questionnaire, it was noted that control room staff had "*no specific training around the identification of MTFAs [Marauding Terrorist Firearms Attack] attacks*" but had received situational awareness inputs around the current threat level.¹⁰⁹⁴ For the FDO, it was said that they had "*received limited training ... around MTFAs scenarios*".¹⁰⁹⁵ CI Booth agreed that this was less than ideal. Prior to the Attack, GMP had done nothing to remedy the situation.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.¹⁰⁹⁷ CI Booth was given the task to produce action cards for the Operational Communications Branch that could be used by staff during a Marauding Terrorist Firearms Attack and in other Major Incidents.¹⁰⁹⁸ A rough first draft of the action cards was produced by 12th April 2016, just under four weeks before Exercise Winchester Accord.¹⁰⁹⁹ A further draft was circulated by email to the senior leadership team of the

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](#)

¹⁰⁹² [83/146/2-11](#)

¹⁰⁹³ [83/152/8-17](#), [INQ032758/1](#)

¹⁰⁹⁴ [83/153/6-154/2](#)

¹⁰⁹⁵ [83/154/6-20](#), [INQ032758/7](#) at paragraph 9

¹⁰⁹⁶ [83/154/21-155/1](#)

¹⁰⁹⁷ [83/155/18-20](#)

¹⁰⁹⁸ [83/157/7-12](#)

¹⁰⁹⁹ [83/159/1-17](#)

Operational Communications Branch on 26th April 2016, just under two weeks before Exercise Winchester Accord.¹¹⁰⁰ Feedback on the action cards was invited. CI Booth could not recall that any was received.¹¹⁰¹

- 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.¹¹⁰² He felt that there was more being asked of the FDO in the initial co-ordination with firearms officers.¹¹⁰³ 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*”.¹¹⁰⁴ It was intended that the action cards would be circulated to communications staff who were working on Exercise Winchester Accord and refined as a result.¹¹⁰⁵
- 12.799** On 3rd 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.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.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.

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](#)

¹¹⁰⁵ [83/169/4-18](#), [83/173/24-174/13](#)

¹¹⁰⁶ [INQ032753](#)

¹¹⁰⁷ [83/189/8-193/15](#)

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 NWS 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 NWS 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
- 12.803** Superintendent Graeme Openshaw was the Ground Assigned Tactical Firearms Commander for Exercise Winchester Accord.¹¹¹¹ The FDO was Inspector Marcus Williams. He was a very experienced firearms officer but relatively new to the FDO role.¹¹¹²
- 12.804** The exercise sequence of events indicated that, at 01:00, the Ground Assigned Tactical Firearms Commander would “*take control of staff*” at the Trafford Centre and “*attend scene, direct firearms assets accordingly*”.¹¹¹³ 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.¹¹¹⁴ It is uncontested 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.¹¹¹⁵ The planning started in late 2015.¹¹¹⁶ 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.¹¹¹⁷ It was something he felt he ought to have known about, particularly

¹¹⁰⁸ [67/54/9-15](#)

¹¹⁰⁹ [67/54/25-55/12](#)

¹¹¹⁰ [INQ041661/2](#) at paragraph 7

¹¹¹¹ [INQ041661/4](#) at paragraph 14

¹¹¹² [67/35/17-21](#)

¹¹¹³ [INQ034454/6](#)

¹¹¹⁴ [INQ034454/6-7](#)

¹¹¹⁵ [INQ033910/13](#) at paragraph 53, [117/151/25-152/19](#)

¹¹¹⁶ [INQ033910/13](#) at paragraph 53

¹¹¹⁷ [117/151/16-24](#)

if it was going to have a significant effect on the exercise.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 NWS were told in advance the location of the RVP and the FCP.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”*.¹¹²⁰ He said this was because neither the FDO nor the Ground Assigned Tactical Firearms Commander were in contact with other agencies.¹¹²¹ The FDO was provided with contact numbers for the GMFRS NILOs.¹¹²² 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 00:00.¹¹²⁴ 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 NWS 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.¹¹²⁸ Stretford Fire Station was used as the GMFRS RVP and muster point.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 NWS who would mobilise from their RVP to the FCP.¹¹³⁰

¹¹¹⁸ [117/151/16-152/3](#)

¹¹¹⁹ [INQ033910/13-14](#) at paragraph 57, [INQ026735/11](#) at paragraph 55

¹¹²⁰ [62/77/7-22](#)

¹¹²¹ [62/77/7-22](#)

¹¹²² [INQ033910/14](#) at paragraph 59

¹¹²³ [INQ033910/14](#) at paragraph 60

¹¹²⁴ [INQ033910/13](#) at paragraph 52

¹¹²⁵ [117/148/14-149/15](#)

¹¹²⁶ [62/77/23-79/12](#)

¹¹²⁷ [INQ033910/13-14](#) at paragraph 57

¹¹²⁸ [INQ033910/13](#) at paragraph 55

¹¹²⁹ [62/84/22-85/16](#)

¹¹³⁰ [INQ033910/13-14](#) at paragraph 57

- 12.810** Station Manager Gaskell stated: "*In fact we [GMFRS] were not notified of the declaration of Operation Plato at all.*"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 NWS 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.¹¹³²
- 12.811** Station Manager Lawlor explained that there was an agreement between the GMFRS and NWS exercise players to "*run with it*" when they were not informed by the FDO about the need to move to the FCP.¹¹³³ He said that it would have been a "*false response*"¹¹³⁴ 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.¹¹³⁵
- 12.812** At that point in the exercise, Station Manager Lawlor recalled that either he, or someone from NWS, contacted the GMP exercise planner to confirm the decision to move forward.¹¹³⁶ Station Manager Lawlor said that this meant there were "*very lengthy delays*" in deploying resources.¹¹³⁷ 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.¹¹³⁸
- 12.813** Station Manager Gaskell stated that GMFRS personnel spoke to NWS personnel while GMFRS personnel were still at their muster point. He stated it was discovered that NWS 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 time, were also unsuccessful. Station Manager Gaskell's recollection was that it was at this point that both NWS and GMFRS decided to move forward.¹¹³⁹
- 12.814** Station Manager Lawlor stated that once NWS 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.¹¹⁴⁰ However, he stated

¹¹³¹ [INQ033910/14](#) at paragraph 59

¹¹³² [62/86/5-19](#)

¹¹³³ [62/77/23-79/12](#)

¹¹³⁴ [62/77/23-79/12](#)

¹¹³⁵ [62/77/23-79/12](#)

¹¹³⁶ [62/77/23-79/12](#)

¹¹³⁷ [INQ026735/11-12](#) at paragraphs 54-57

¹¹³⁸ [62/79/22-80/20](#)

¹¹³⁹ [INQ033910/14-15](#) at paragraph 60

¹¹⁴⁰ [62/77/23-79/12](#)

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.¹¹⁴¹

- 12.815** Station Manager Gaskell said that the fact that GMFRS and NWS did not deploy for “*two hours meant that some of the police functions on that exercise had been completed*”.¹¹⁴² He recalled that as GMFRS and NWS 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.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.¹¹⁴⁴ His recollection was that at the request of GMFRS and NWS, 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 NWS and GMFRS deploying into the Trafford Centre.¹¹⁴⁵
- 12.817** Station Manager Lawlor said that a Police Inspector at the inner cordon would not allow GMFRS and NWS to enter.¹¹⁴⁶ However, Station Manager Gaskell said: “*[O]nce the actual commanders got together at the FCP, then the exercise actually went very well.*”¹¹⁴⁷
- 12.818** Station Manager Gaskell said that GMFRS was left “*disgruntled*” by the experience of Exercise Winchester Accord.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.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.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

¹¹⁴¹ [62/79/22-80/20](#)

¹¹⁴² [117/148/14-149/15](#)

¹¹⁴³ [117/148/14-149/15](#)

¹¹⁴⁴ [INQ026735/11-12](#) at paragraph 56

¹¹⁴⁵ [INQ026735/11-12](#) at paragraphs 54-57

¹¹⁴⁶ [INQ026734/12](#) at paragraph 57

¹¹⁴⁷ [117/147/16-148/6](#)

¹¹⁴⁸ [INQ033910/16](#) at paragraph 66

¹¹⁴⁹ [INQ033910/16](#) at paragraphs 65-67

¹¹⁵⁰ [121/145/7-18](#)

ambulance and fire and rescue teams to the scene.¹¹⁵¹ Group Manager Levy said he was unaware of any problem with the FDO¹¹⁵² until March 2018, when the independent review of the preparedness for and emergency response to the Attack by Lord Kerslake was published.¹¹⁵³

12.820 Group Manager Carlos Meakin was one of the development NIOs who observed Exercise Winchester Accord.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.¹¹⁵⁵ Group Manager Meakin said that there was a “*substantial delay*” of around an hour in deploying GMFRS and NWS responders into the Trafford Centre.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 “*cutting himself off from face-to-face communications*”.¹¹⁵⁷ This was evidence that Superintendent Openshaw disputed.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.¹¹⁵⁹ He said that could potentially have resulted in the loss of life in a real-world scenario.¹¹⁶⁰ A lot of preparation had gone into the exercise, but it did not play out as expected because of the lack of communication.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.¹¹⁶² Area Manager Etches initially said his perception was that there was a “*lengthy delay*” in asking the fire and rescue and ambulance responders to move forward.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.¹¹⁶⁴

12.823 With the benefit of hindsight, Area Manager Etches said that, rather than “*delay*”, he thought a better description was that the police moved forward to carry out their primary objective, but GMFRS and NWS services did not get

¹¹⁵¹ [121/146/2-25](#)

¹¹⁵² [121/146/15-25](#)

¹¹⁵³ [INQ000009](#)

¹¹⁵⁴ [121/17/11-19](#)

¹¹⁵⁵ [INQ026731/7](#), [INQ026731/8](#) at paragraphs 34-35

¹¹⁵⁶ [121/18/14-19/2](#), [INQ026731/8](#) at paragraph 36

¹¹⁵⁷ [INQ026731/8](#) at paragraph 36

¹¹⁵⁸ [INQ041661/5](#) at paragraph 19

¹¹⁵⁹ [121/18/14-19/2](#)

¹¹⁶⁰ [121/19/3-14](#)

¹¹⁶¹ [121/18/10-21/10](#)

¹¹⁶² [129/158/23-160/15](#)

¹¹⁶³ [129/160/16-161/3](#)

¹¹⁶⁴ [129/161/4-20](#)

an opportunity to move behind them to carry out the recovery procedures.¹¹⁶⁵ He did not think that the communication had gone well between GMP and GMFRS. The problem was a gap in the communications on scene, but there was also an opportunity in the Silver Control Room to have better communications.¹¹⁶⁶

12.824 Group Manager Fletcher was an observer on Exercise Winchester Accord. He was based in the management suite at the Trafford Centre.¹¹⁶⁷ He said he was “surprised” by the length of time it took to deploy GMFRS and NWS 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 NWS crews into the cordon.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.¹¹⁶⁹ The JESIP lead at Merseyside told him that JESIP did not work on the night.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.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 NWS.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 2017.¹¹⁷³ Station Manager Lawlor said the training was also targeted at GMFRS and NWS NILOs, the Tactical Firearms Commander, and commanders and Tactical Advisors from all three agencies.¹¹⁷⁴

NWS’s view

12.827 The NWS planning document for the exercise set out an anticipated timetable of events. On day one, it was planned that the FDO would contact the NWS Exercise Co-ordinator, Paul Bailey, to declare Operation Plato at approximately 00:05.¹¹⁷⁵ HART crews, the Ambulance Intervention Team Commander and the Operational Commander were to mobilise to the Trafford Centre at

¹¹⁶⁵ [129/161/24-162/8](#)

¹¹⁶⁶ [129/164/10-165/15](#)

¹¹⁶⁷ [63/97/22-98/11](#)

¹¹⁶⁸ [63/98/12-24](#)

¹¹⁶⁹ [63/98/21-99/4](#)

¹¹⁷⁰ [63/100/11-22](#)

¹¹⁷¹ [128/184/1-19](#)

¹¹⁷² [INQ026734/13](#) at paragraph 58

¹¹⁷³ [62/86/23-88/16](#)

¹¹⁷⁴ [INQ026735/12](#) at paragraph 60

¹¹⁷⁵ [INQ013559/10-11](#)

00:25. At 01:00, NWAS senior commanders were to support the Tactical Co-ordinating Group and Strategic Co-ordinating Group.¹¹⁷⁶ 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 2016.¹¹⁷⁷ 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"*.¹¹⁷⁸ 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.¹¹⁷⁹

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"*.¹¹⁸⁰ The NWAS debrief said that NWAS and GMFRS personnel should have 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."*¹¹⁸¹

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."*¹¹⁸² This in turn was said to have led to a time delay in getting to patients.¹¹⁸³

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.¹¹⁸⁴ It was agreed that the fact an FDO might be overwhelmed was widely known.¹¹⁸⁵

¹¹⁷⁶ [INQ013559/11](#)

¹¹⁷⁷ [INQ013847/1](#)

¹¹⁷⁸ [INQ013847/13](#)

¹¹⁷⁹ [INQ013675/1](#)

¹¹⁸⁰ [INQ013669/1](#)

¹¹⁸¹ [67/46/4-24](#)

¹¹⁸² [INQ013727/33](#) at Recommendation 7

¹¹⁸³ [INQ013727/33](#) at Recommendation 7

¹¹⁸⁴ [12/118/19-119/11](#)

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.¹¹⁸⁶ It was also said that there was no delay in deploying NWS and GMFRS into the Operation Plato warm zone to treat casualties, and there was no JESIP failure detrimental to the wellbeing of casualties.¹¹⁸⁷ 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.¹¹⁸⁸
- 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.
- 12.835** 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.¹¹⁸⁹ 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:¹¹⁹⁰ it had been "overlooked".¹¹⁹¹ 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.¹¹⁹² 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.¹¹⁹³
- 12.836** Superintendent Openshaw said that he then made his way to the FCP. This took a couple of minutes.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 01:00.¹¹⁹⁵
- 12.837** When he arrived at the FCP, Superintendent Openshaw said he could hear gunfire coming from the direction of the Trafford Centre. NWS and GMFRS commanders were already present. There were no senior GMP officers.¹¹⁹⁶

¹¹⁸⁶ [INQ042531/9](#) at paragraph 21(iv)

¹¹⁸⁷ [INQ042531/9](#) at paragraph 21(iii)

¹¹⁸⁸ [INQ042531/32](#) at paragraph 89

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

¹¹⁹⁴ [INQ041661/2](#) at paragraph 6

¹¹⁹⁵ [INQ034454/6](#)

¹¹⁹⁶ [INQ041661/2](#) at paragraph 7

Superintendent Openshaw said about the GMFRS and NWS 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.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 ground*”.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 NWS 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 NWS specialist responders moved in to treat and extract the casualties.¹²⁰² NWS 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 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 NWS moving forward to casualties. That was because, at the point of his arrival, the Trafford Centre was still an Operation Plato hot zone.¹²⁰⁷

¹¹⁹⁷ [INQ041661/3](#) at paragraph 8

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

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

- 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. However, Superintendent Openshaw's statement does not address the timing of NWS and GMFRS being notified of the Operation Plato declaration or the calling forward of NWS 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 NWS 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*".¹²⁰⁸
- 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.¹²⁰⁹ This role was to ensure that certain actions on the exercise happened at particular points and to ensure that, if the FDO failed to complete a task, he could step in to allow the exercise to continue.¹²¹⁰ If an error was made which needed to be corrected during the exercise, that could be dealt with later through feedback.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.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.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.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.¹²¹⁵ He was not informed in the planning for the exercise that the FDO was expected to contact the GMFRS and NWS NILOs within the first nine minutes. CI Booth said that did not "*sound an unreasonable element of the exercise*".¹²¹⁶

¹²⁰⁸ [INQ034454](#)

¹²⁰⁹ [83/173/6-10](#)

¹²¹⁰ [83/179/1-23](#), [84/65/12-66/2](#)

¹²¹¹ [84/66/8-25](#)

¹²¹² [83/180/2-16](#)

¹²¹³ [83/181/4-14](#)

¹²¹⁴ [83/181/20-182/1](#)

¹²¹⁵ [83/182/17-183/22](#)

¹²¹⁶ [84/38/11-39/2](#)

- 12.847** CI Booth agreed that, in simple terms, the FDO was overwhelmed during the exercise.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.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.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.¹²²⁰ It was only after the exercise he became aware of such a huge delay.¹²²¹ He accepted that the failures in Exercise Winchester Accord were very similar to those that occurred 12 months later in the response to the Attack.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.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.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.¹²²⁵ She understood that communication between agencies went wrong at some point during the exercise, and this identified a need for more JESIP training.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*

¹²¹⁷ [83/182/12-16](#)

¹²¹⁸ [83/180/21-182/11](#)

¹²¹⁹ [84/67/7-17](#)

¹²²⁰ [84/69/9-21](#)

¹²²¹ [84/67/22-68/9](#)

¹²²² [84/70/17-22](#)

¹²²³ [67/26/11-25](#)

¹²²⁴ [67/26/11-25](#)

¹²²⁵ [67/86/14-87/1](#)

¹²²⁶ [67/43/22-44/8](#)

¹²²⁷ [67/44/9-16](#)

*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.¹²²⁹ He agreed that there was no guarantee that more people would make it any better.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*”.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.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 NWS about them not being deployed into the warm zone within 30 minutes and the delay potentially leading to an unnecessary loss of life.¹²³³ She agreed that was a learning point from the exercise.¹²³⁴ There were no surprises in the outcome of the exercise for Inspector Roby. It established that the FDO could not work in isolation.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

¹²²⁸ [67/87/7-20](#)

¹²²⁹ [83/183/23-184/23](#)

¹²³⁰ [83/186/19-187/19](#)

¹²³¹ [83/184/24-186/12](#)

¹²³² [83/188/17-189/7](#)

¹²³³ [67/46/4-24](#)

¹²³⁴ [67/46/25-47/2](#)

¹²³⁵ [67/37/21-39/3](#)

¹²³⁶ [67/39/4-10](#)

¹²³⁷ [83/210/3-18](#)

¹²³⁸ [67/41/12-19](#)

- 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 NWS and GMFRS. The extent of those problems needed to be more thoroughly 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.¹²³⁹ JESIP promoted a framework of hot debriefs led by commanders immediately after an event and formal, structured debriefs co-ordinated by lead agencies.¹²⁴⁰ The Policing Experts said that debriefs should “capture aspects that were positive alongside those aspects that did not go so well”.¹²⁴¹ The debrief process on Exercise Winchester Accord fell below these aspirations.
- 12.858** On 11th May 2016, CI Booth received an email from an Operational Communications Branch Trainer, Kelly Chilton, with feedback on the performance of call handlers. She said: “The stress levels in the room were intense.”¹²⁴² She said that call handlers needed a reference document to help them to know what to do during a Marauding Terrorist Firearms Attack.¹²⁴³ CI Booth agreed that this feedback appeared to indicate that the action cards were not tested by call handlers during Exercise Winchester Accord.¹²⁴⁴
- 12.859** On 13th May 2016, Group Manager Fletcher emailed GMP Superintendent Giladi about Exercise Winchester Accord. Joe Barrett from NWS was on copy.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/NWS Commanders”.¹²⁴⁶ It said that only a marshalling officer was deployed to the initial RVP and linkage with the Tactical

¹²³⁹ [INQ024271/66](#) at paragraph 4.15.3

¹²⁴⁰ [INQ024271/66](#) at paragraph 4.15.3

¹²⁴¹ [INQ024271/66](#) at paragraph 4.15.4

¹²⁴² [83/189/13-190/21](#)

¹²⁴³ [83/190/22-25](#)

¹²⁴⁴ [83/191/1-11](#)

¹²⁴⁵ [INQ004520](#)

¹²⁴⁶ [63/100/11-102/5](#)

Firearms Commander was very limited. This led to an “excessive delay” in GMFRS and NWS resources moving forward. The email said this delay was approximately two and a half hours.¹²⁴⁷ Group Manager Fletcher later stated that it was a “*slip of the keyboard*” and the email should have said one and a half hours.¹²⁴⁸ He suggested arranging a one-day joint awareness course for commanders.¹²⁴⁹

- 12.860** Inspector Williams emailed CI Booth on 14th May 2016 with his “[t]houghts re Ex Winchester Accord”.¹²⁵⁰ He said, “*you have to know your limits ... what you can achieve before you become overloaded*”.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*”.¹²⁵² CI Booth accepted that this was a reference to the overloading and overwhelming of the FDO.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.¹²⁵⁴ CI Booth agreed that this was a further indication that the draft action cards he had prepared were not used or tested during the exercise.¹²⁵⁵
- 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*”.¹²⁵⁶ 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”.¹²⁵⁷
- 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.¹²⁵⁸ 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.¹²⁵⁹ 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.

¹²⁴⁷ [INQ004520](#)

¹²⁴⁸ [63/100/23-102/5](#)

¹²⁴⁹ [63/102/18-103/17](#)

¹²⁵⁰ [INQ034457/2](#)

¹²⁵¹ [83/191/12-22](#)

¹²⁵² [83/192/12-19](#)

¹²⁵³ [83/192/12-19](#)

¹²⁵⁴ [INQ034457/3](#)

¹²⁵⁵ [83/192/21-193/9](#)

¹²⁵⁶ [84/72/21-73/5](#)

¹²⁵⁷ [INQ034457/2](#)

¹²⁵⁸ [84/74/11-75/4](#)

¹²⁵⁹ [84/75/23-76/5](#)

- 12.864** The GMP structured debrief took place on 16th May 2016.¹²⁶⁰ 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.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 *"[c]onfusion between the role of TFC [Tactical Firearms Commander] in Silver and ground TFC"* and that there was *"[n]ot enough information at the FCP as to what was happening inside the building"*.¹²⁶² There was also a comment that the Tactical Firearms Commander was called in too late and *"always playing catch up"* as the military assets had already deployed before the Ground Assigned 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

- 12.866** 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.
- 12.867** The questionnaire from a Ground Assigned Tactical Firearms Commander, CI Sarah Morton, who shadowed Superintendent Openshaw,¹²⁶⁶ 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

¹²⁶⁰ [INQ007697](#)

¹²⁶¹ [INQ007697/1](#)

¹²⁶² [INQ007697/4-5](#)

¹²⁶³ [INQ007697/4](#)

¹²⁶⁴ [INQ007697/5](#)

¹²⁶⁵ [INQ034462/2](#)

¹²⁶⁶ [INQ041661/1](#) at paragraph 3

¹²⁶⁷ [INQ034462/11-12](#)

- 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 NWS 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: *"[I]mmediate actions completed by FDO, however slow to contact. TFC [Tactical Firearms Commander] – I had to contact."*¹²⁷⁰ 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.¹²⁷¹
- 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."*¹²⁷² 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"*.¹²⁷³

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.

¹²⁶⁸ [INQ034462/16](#)

¹²⁶⁹ [INQ034462/16](#)

¹²⁷⁰ [INQ034462/108](#)

¹²⁷¹ [INQ034462/108](#)

¹²⁷² [INQ034462/108](#)

¹²⁷³ [INQ034462/110](#)

¹²⁷⁴ [INQ007697/7-8](#)

¹²⁷⁵ [INQ007697/8](#)

¹²⁷⁶ [83/202/1-13](#)

- 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 “*know your limits*”, and that the FDO would be “*frazzled*” and “*overloaded*”.¹²⁷⁹ 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.¹²⁸⁰
- 12.877** Six participants in the GMRF debrief commented they had been “*informed late into the incident*”¹²⁸¹ and two participants said they “*[n]ever received a call out*”.¹²⁸² Three participants said that an effective assessment of risk was hampered by a “*lack of tri-service commanders coming together*” and poor communication at the scene.¹²⁸³ GMFRS was not aware of the set-up of the warm zone, and it was noted: “*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]*.”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.¹²⁸⁵ Nineteen recommendations were made. None of the recommendations focused on the role of the FDO or JESIP working at the

¹²⁷⁷ [INQ007697/1](#)

¹²⁷⁸ [184/90/7-24](#)

¹²⁷⁹ [INQ034457/2](#)

¹²⁸⁰ [INQ012539/1-5](#)

¹²⁸¹ [INQ012539/2](#)

¹²⁸² [INQ012539/3](#)

¹²⁸³ [INQ012539/3](#)

¹²⁸⁴ [INQ012539/4](#)

¹²⁸⁵ [INQ012539/5](#), [INQ012539/6](#)

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.¹²⁸⁶

- 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 NWS 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** NWS provided the Inquiry with “*debrief points*” from the exercise.¹²⁸⁷ These were undated and have previously been summarised to set out the NWS 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 NWS and GMFRS to triage and treat. It was said that there was a lack of direct police on-site liaison with NWS and GMFRS. The negatives also included issues that arose between GMFRS and NWS in respect of co-ordination and leadership around triage, treatment and recovery of casualties.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 28th June 2016. This was attended by representatives from GMP, GMFRS and NWS.¹²⁸⁹ The minutes from the Forum noted that “*[t]he main issue was the delay in getting NWS and Fire Service resources to the incident scene*”.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.¹²⁹¹
- 12.882** The following day, a meeting was arranged between Superintendent Giladi, Joe Barrett from NWS and Group Manager Fletcher. This was to discuss Group Manager Fletcher’s email sent shortly after the exercise on 13th May 2016.¹²⁹² 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 NWS.¹²⁹³ Superintendent Giladi’s daybook recorded a brief note

¹²⁸⁶ [INQ012539/7-8](#)

¹²⁸⁷ [INQ013669](#)

¹²⁸⁸ [INQ013669](#)

¹²⁸⁹ [INQ007602/1](#)

¹²⁹⁰ [INQ007602/3](#)

¹²⁹¹ [INQ007602/3](#)

¹²⁹² [INQ004520/1](#)

¹²⁹³ [84/161/23-162/10](#)

of the meeting.¹²⁹⁴ A note with an asterisk read: *“Co-location!! – same mistake every time.”*¹²⁹⁵ He said that this point was *“clearly of concern”* and that it had been an issue during several exercises.¹²⁹⁶

- 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, *“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”*.¹²⁹⁷ Superintendent Giladi said that such an excessive delay would have had potentially *“horrendous consequences”*.¹²⁹⁸ 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 2017.¹²⁹⁹
- 12.884** The NWCTU debrief report from Exercise Winchester Accord was finalised on 5th July 2016.¹³⁰⁰ 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.¹³⁰¹ It was said that, at this stage, the FDO handed over command to the Cadre Tactical Firearms Commander, but they were uncontactable.¹³⁰²
- 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.¹³⁰³ At this point, *“JESIP partners deployed in a casualty management role”*.¹³⁰⁴ 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.

¹²⁹⁴ [INQ040927](#)

¹²⁹⁵ [INQ040927/3](#)

¹²⁹⁶ [INQ040922/11](#) at paragraph 49

¹²⁹⁷ [84/158/18-160/14](#)

¹²⁹⁸ [84/160/15-21](#)

¹²⁹⁹ [INQ040922/12](#)

¹³⁰⁰ [INQ007233/1](#)

¹³⁰¹ [INQ007233/2](#)

¹³⁰² [INQ007233/4](#)

¹³⁰³ [INQ007233/4-5](#)

¹³⁰⁴ [INQ007233/5](#)

- 12.887** On 7th July 2016, Superintendent Giladi chaired GMP's Major Incident Public Order and Events Group meeting.¹³⁰⁵ 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".¹³⁰⁶ 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.¹³⁰⁷ 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 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.

¹³⁰⁵ [INQ007615/1](#)

¹³⁰⁶ [66/161/24-162/10](#)

¹³⁰⁷ [INQ012471/1](#), [INQ012416/1](#)

¹³⁰⁸ [INQ012471/5](#)

¹³⁰⁹ [INQ042283/1](#)

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 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 NWS 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 NWS and GMFRS had at the time. An effective debrief process would have resolved this. It had a direct 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.

¹³¹⁰ [147/121/2-5](#)

¹³¹¹ [INQ034427/7](#) at paragraph 40

¹³¹² [INQ042531/16](#) at paragraph 43

- 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.¹³¹³ 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.

¹³¹³ [117/65/7-24](#)

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.

British Transport Police response

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 23rd 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 22nd 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.

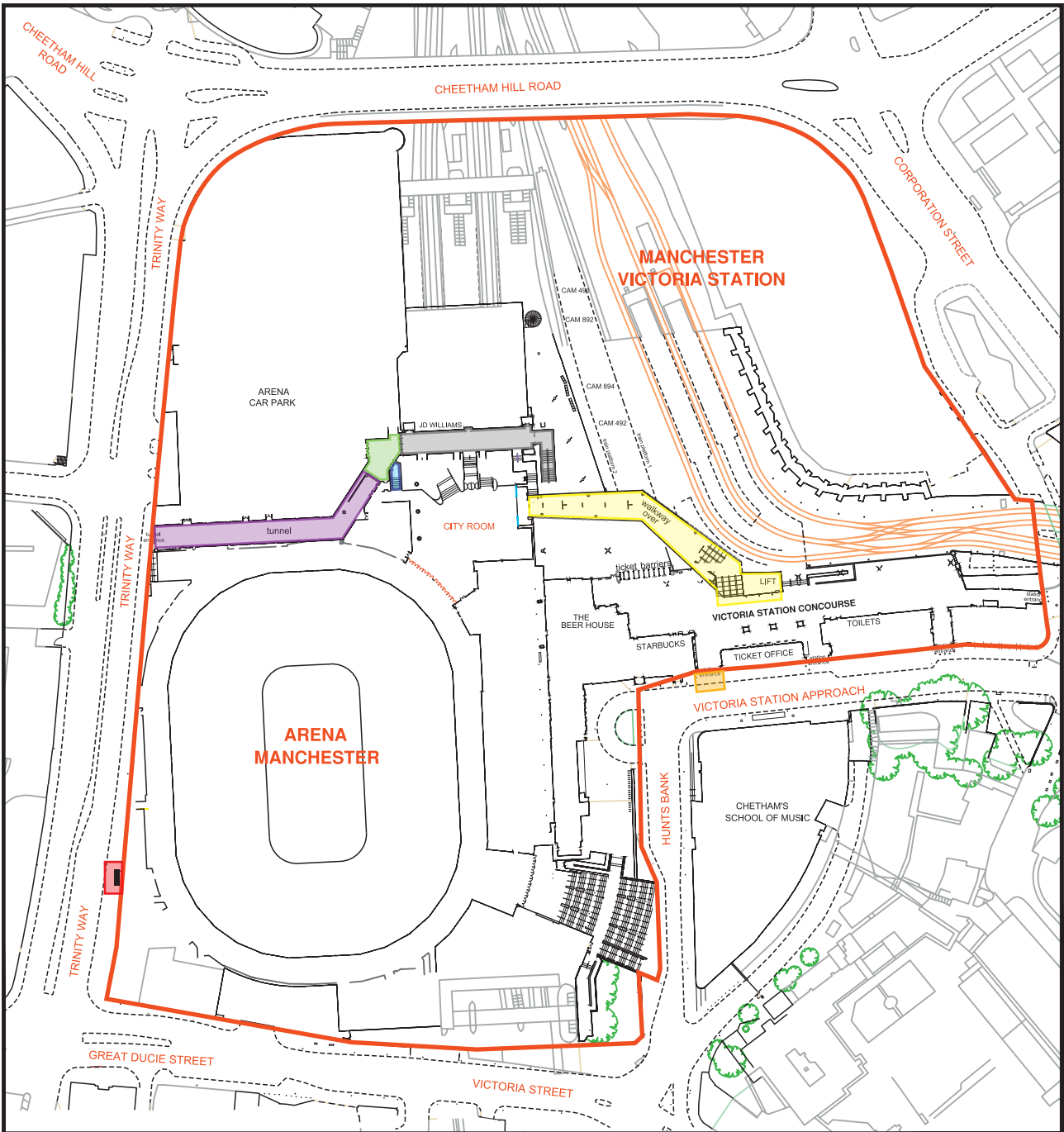
- 13.7 BTP did not have a firearms capability in Greater Manchester in 2017. It had one explosives detection dog in the Greater Manchester area.

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

¹ [INQ035612/3](#)

² [INQ035612/3-7](#)











Victoria Exchange Complex		Platform overbridge	
Raised walkway and staircase		Fifty Pence staircase	
Fifty Pence Piece		Trinity Way link tunnel	
Lower Trinity Way entrance		War Memorial entrance	

Figure 37: The Victoria Exchange Complex³

³ INQ033841

- 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."*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."*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 22:34.¹³
- 13.14** Realising that first aid equipment was needed, PCSO Renshaw and PCSO Brown left the City Room¹⁴ and retrieved first aid kits from the patrol car parked on Station Approach.¹⁵ At 22:37, as they were re-entering the City Room with first aid kits,¹⁶ PCSO Renshaw broadcast to BTP Control: *"In the box office, we need as much first aid as you can bring."*¹⁷

⁴ [73/46/17-47/4](#)

⁵ [INQ028932/1](#), [52/62/11-16](#)

⁶ [INQ035612/14-16](#)

⁷ [73/41/23-42/7](#), [73/43/11-18](#)

⁸ [73/43/11-44/3](#)

⁹ [INQ028932/1](#), [73/46/9-47/10](#)

¹⁰ [INQ028932/2](#)

¹¹ [INQ028932/2](#)

¹² [INQ028932/2](#)

¹³ [INQ035612/21](#)

¹⁴ [INQ035612/20](#)

¹⁵ [INQ035612/32](#)

¹⁶ [INQ035612/48](#)

¹⁷ [INQ028932/6](#)

- 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."*¹⁸ 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 NWS Control for ambulances to go to Victoria Exchange Complex was nearly 20 minutes later.¹⁹
- 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.²⁰ 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"*.²¹
- 13.18** One minute later, Sergeant Neil Wildridge, who was in Liverpool,²² 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."*²³ 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."*²⁴ 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.²⁵
- 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.²⁶ He had then run down the Trinity Way link tunnel to wait for an ambulance on Trinity Way.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.

¹⁸ [INQ028932/7](#)

¹⁹ [INQ028932/36-38](#)

²⁰ [INQ035612/48](#), [INQ035612/49](#), [INQ035612/50-51](#)

²¹ [INQ028932/8](#)

²² [74/96/1-8](#), [INQ005627/1](#)

²³ [INQ028932/8](#)

²⁴ [INQ028932/9](#)

²⁵ [INQ035612/59](#)

²⁶ [INQ028932/5](#), [73/49/17-50/3](#)

²⁷ [73/49/17-50/14](#)

- 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 NWS 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 NWS 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 Complex.²⁸ 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]."*²⁹
- 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).³⁰
- 13.25 PC Bullough was the first officer on scene in the City Room.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.

²⁸ [INQ015145T](#)

²⁹ [INQ025700/24](#)

³⁰ [INQ025700/64](#)

³¹ [INQ035612/14](#)

- 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 *"to take a step back and be my eyes and ears there and give me updates"*.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: *"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 inputs, so basically under the pressure and the different inputs I was getting at the time, I didn't think to do that."*³³ 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."*³⁴ Real life is different.³⁵ 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.

³² [INQ028932/61-62](#)

³³ [73/76/12-22](#)

³⁴ [73/77/7-25](#)

³⁵ [73/77/20-25](#)

³⁶ [INQ035612/113](#)

- 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.³⁷ This was in response to a repeated request by Sergeant Wildridge.³⁸ Having nominated the Fishdock car park, PC Roach asked *"[i]f we can get that checked as well just for secondary devices."*³⁹ He did this as part of *"the natural course of procedure. You don't assume anything."*⁴⁰
- 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 ...?"*⁴¹ 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.⁴² 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.⁴³ 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.

³⁷ [74/97/1-99/3](#)

³⁸ [INQ028932/15](#)

³⁹ [INQ028932/15](#)

⁴⁰ [74/99/4-11](#)

⁴¹ [INQ028932/16](#)

⁴² [74/107/3-16](#), [INQ002000/53](#)

⁴³ [INQ035612/122](#)

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.⁴⁴ Junior BTP officers worked well with others and did their best.
- 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.⁴⁵
- 13.44** PC Bullough can be seen on video footage standing over Marcin Klis.⁴⁶ Sergeant John Whitaker was shown on video footage appearing to check Marcin Klis for a pulse.⁴⁷ PC Corke also checked Marcin Klis for a pulse.⁴⁸
- 13.45** PC Bridgewater⁴⁹ and PC Trow⁵⁰ 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

⁴⁴ [158/151/16-153/13](#)

⁴⁵ [152/12/16-25](#)

⁴⁶ [150/108/5-11](#)

⁴⁷ [150/109/3-15](#)

⁴⁸ [150/108/14-21](#)

⁴⁹ [156/48/4-50/6](#)

⁵⁰ [156/48/4-50/6](#)

⁵¹ [155/19/11-22/13](#)

⁵² [151/29/19-32/22](#)

⁵³ [151/34/13-19](#)

- 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 Owen⁶² and PC Johnson also assisted Kelly Brewster.⁶³ Later, PC Johnson⁶⁴ and PC Corke⁶⁵ 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

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

⁵⁴ [151/9/3-24](#)

⁵⁵ [158/18/18-24](#)

⁵⁶ [158/25/12-24](#)

⁵⁷ [158/27/13-19](#)

⁵⁸ [158/38/14-22](#)

⁵⁹ [154/9/1-13/18](#)

⁶⁰ [154/10/17-18](#)

⁶¹ [154/11/4-13/4](#)

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](#)

commander.⁷⁵ 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.⁷⁶ 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.⁷⁷ This declaration was recorded on the BTP incident log. It was passed on to NWS in a call which began at 22:41.⁷⁸ It was not passed on to GMP or Greater Manchester Fire and Rescue Service (GMFRS). It should have been.
- 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?"*⁷⁹ Sergeant Cawley replied saying he was available. Following some difficulty connecting on a different radio channel because it was *"too busy"*,⁸⁰ Inspector Dawson decided that Sergeant Cawley should use his mobile phone. This was unsuccessful.⁸¹
- 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.⁸² Inspector 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."*⁸³ 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*

⁷⁵ [INQ002000/27](#)

⁷⁶ [INQ025700/15](#) at paragraph 2.7

⁷⁷ [INQ002000/30](#)

⁷⁸ [INQ028932/11](#)

⁷⁹ [INQ028932/21](#)

⁸⁰ [INQ028932/26](#)

⁸¹ [INQ028932/36](#), [INQ028932/43](#)

⁸² [INQ028932/43](#), [73/67/14-68/4](#)

⁸³ [INQ028932/43-44](#)

ambulances and fire and all that to you as we can."⁸⁴ The METHANE message was entered into BTP's incident log by Inspector Dawson three minutes later, at 23:04.⁸⁵ 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'.⁸⁶ 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.*"⁸⁷ Sergeant Cawley provided 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.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 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.

⁸⁴ [INQ032071/3](#)

⁸⁵ [INQ002000/46](#)

⁸⁶ [INQ004542/9](#)

⁸⁷ [INQ032071/2](#)

⁸⁸ [73/48/14-16](#), [73/51/23-52/6](#), [73/56/10-15](#), [73/61/4-9](#)

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, NWS, NWFC or GMFRS could have been 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 me as being a thoughtful witness, who was candid about where improvements could be made. In a number of important respects, CI 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

⁹¹ [INQ002000/46](#)

⁹² [INQ032071](#)

⁹³ [93/4/6-7/2](#)

⁹⁴ [INQ041112/1](#), [93/2/8-3/7](#)

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 NWS commanders.

- 13.72 CI 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
- 13.74 Chief Superintendent Gregory was the divisional commander for C Division, within which the Victoria Exchange Complex was located.⁹⁷ He was on call that night.⁹⁸ At 22:44, he was telephoned by CI Lodge.⁹⁹ He was in his hotel room in Birmingham, having concluded an Office of Rail and Road stakeholders' event at the same venue.¹⁰⁰
- 13.75 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.¹⁰¹ He made his way to Force Control Room Birmingham, which was approximately ten minutes from his hotel.¹⁰² 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.¹⁰³ 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.¹⁰⁴
- 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.¹⁰⁵ 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.

⁹⁵ [93/13/21-14/8](#)

⁹⁶ [92/124/1-9](#)

⁹⁷ [93/21/9-22/7](#)

⁹⁸ [93/163/3-6](#)

⁹⁹ [93/106/9-107/10](#)

¹⁰⁰ [93/162/12-16](#)

¹⁰¹ [93/164/12-16](#)

¹⁰² [93/164/19-165/16](#)

¹⁰³ [93/165/10-16](#)

¹⁰⁴ [93/165/24-166/13](#)

¹⁰⁵ [94/79/7-20](#)

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.¹⁰⁶ Superintendent Wylie was the subdivisional commander for the Pennine subdivision. The Arena fell into this subdivision. Superintendent Wylie lived about 25 miles from Manchester.¹⁰⁷ Superintendent Wylie did not answer the call, and Chief Superintendent Gregory left a message.¹⁰⁸
- 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. Chief Superintendent Gregory's intention was to appoint Superintendent Gordon as the Bronze Commander.¹⁰⁹
- 13.79** Chief Superintendent Gregory recognised: *"[T]here was a need to move quickly to establish a command structure."*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.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.¹¹² I agree with these statements.
- 13.80** Chief Superintendent Gregory knew that Superintendent Gordon was in Blackpool.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.¹¹⁴ Chief Superintendent Gregory should have considered appointing someone more junior than a Superintendent as Bronze Commander.¹¹⁵ 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.¹¹⁶ This would mean that he would not arrive before 00:15.¹¹⁷ 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.

¹⁰⁶ [93/167/19-168/24](#)

¹⁰⁷ [93/173/9-12](#)

¹⁰⁸ [93/167/19-168/24](#)

¹⁰⁹ [93/169/4-12](#), [95/33/6-19](#)

¹¹⁰ [93/170/15-19](#)

¹¹¹ [93/143/7-144/2](#), [93/127/23-129/8](#)

¹¹² [93/143/7-144/2](#)

¹¹³ [93/171/9](#), [95/39/15-24](#)

¹¹⁴ [93/172/8-20](#)

¹¹⁵ [93/173/18-176/6](#)

¹¹⁶ [93/172/8-20](#)

¹¹⁷ [93/172/21/24](#)

Taking up the Silver Commander role

- 13.82** Having spoken to Superintendent Gordon, Chief Superintendent Gregory again spoke to ACC Smith.¹¹⁸ He also spoke to the Force Incident Manager, Inspector Dawson.¹¹⁹ At 23:34, BTP's incident log records that Chief Superintendent Gregory became the Silver Commander, relieving Inspector Dawson.¹²⁰ This was at the very end of what I have described as the critical period of the response.
- 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"*.¹²¹ The Major Incident Manual also stated: *"Bronze Commanders must have a clear understanding of the Silver Commander's tactical plan."*¹²²
- 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"*.¹²³ 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.
- 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.¹²⁴ 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.¹²⁵

¹¹⁸ [INQ041120/1](#)

¹¹⁹ [93/189/18-190/23](#)

¹²⁰ [92/123/10-20](#), [INQ002000/60](#)

¹²¹ [INQ025700/66](#)

¹²² [INQ025700/16](#)

¹²³ [93/221/21-25](#)

¹²⁴ [95/9/17-11/17](#)

¹²⁵ [INQ025700/66](#)

- 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 to speak to that person. This did not result in any contact between the two commanders.¹²⁶
- 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 NWS 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.¹²⁷
- 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.¹²⁸ His sole focus was on contacting GMP. This was an unacceptable omission.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 NWS 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.

¹²⁶ [93/201/22-202/11](#)

¹²⁷ [94/1/19-3/1](#)

¹²⁸ [93/152/18-22](#)

¹²⁹ [93/152/18-153/4](#)

13.94 In due course, at 00:40 on 23rd May 2017, Chief Superintendent Gregory directed that CI Susan Peters should attend GMP Headquarters (GMP HQ) to act in a liaison capacity.¹³⁰ CI Peters was recorded as arriving at GMP HQ and being “imbedded in” the Silver Control Room at GMP HQ at 01:53.¹³¹

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.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.¹³³ This was over twice as long as Chief Superintendent Gregory assumed it would take when he appointed him.
- 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.¹³⁴ He booked himself a taxi to take him to Manchester.¹³⁵ Superintendent Gordon then called Superintendent Wylie and left a voicemail message when he did not answer.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.¹³⁷ Superintendent Gordon thought he had mentioned it, but deferred to Chief Superintendent Gregory’s recollection.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

¹³⁰ [INQ002000/82, 93/224/13-17](#)

¹³¹ [INQ002000/102](#)

¹³² [93/177/3-179/12](#)

¹³³ [95/33/7-19, 95/65/18-66/4](#)

¹³⁴ [95/26/12-27/12](#)

¹³⁵ [95/30/3-21](#)

¹³⁶ [95/31/7-11](#)

¹³⁷ [93/199/18-200/2](#)

¹³⁸ [95/39/9-40/5](#)

regarded the use of a taxi as not being acceptable in the circumstances.¹³⁹ I accept 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 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.¹⁴⁸ 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.¹⁴⁹
- 13.104** At no point in the journey to Manchester did Superintendent Gordon speak to Chief Superintendent Gregory.¹⁵⁰ 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*".¹⁵¹
- 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

¹³⁹ [93/180/5-16](#)

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](#)

¹⁴⁸ [95/44/10-23](#)

¹⁴⁹ [95/50/10-12](#)

¹⁵⁰ [95/53/10-16](#)

¹⁵¹ [INQ041111/1](#)

as *"briefed as possible"*.¹⁵² 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.¹⁵³ His reply, at 01:23, was that Superintendent Gordon should speak to CI Andrea Graham.¹⁵⁴

- 13.106** Superintendent Gordon spoke to CI Graham shortly after he sent his email at 00:19.¹⁵⁵ 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.¹⁵⁶ 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.¹⁵⁷ This further compromised his ability to gain situational awareness. He was still able to use his personal mobile phone.¹⁵⁸
- 13.108** Superintendent Gordon rightly accepted the Policing Experts' opinion that: *"There is little evidence that [he] was able to influence BTP actions or operational decisions during [his] journey."*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 23rd May 2017¹⁶⁰ and at the Victoria Exchange Complex at approximately 01:20.¹⁶¹ CI Graham conducted a briefing shortly after he arrived.¹⁶² He considered that he assumed the role of Bronze Commander after this briefing.¹⁶³ At 01:57, he supplied a briefing to Chief Superintendent Gregory, who informed him that his role was to co-ordinate BTP assistance of GMP at the scene.

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](#)

¹⁵⁸ [95/77/13-17](#)

¹⁵⁹ [95/80/17-23](#)

¹⁶⁰ [94/132/24-133/7](#)

¹⁶¹ [95/65/9-66/4](#)

¹⁶² [95/66/17-25](#)

¹⁶³ [95/67/13-18](#)

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.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.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*”.¹⁶⁶ She got ready and drove to the Peninsula Building, arriving at 23:38.¹⁶⁷ She collected some equipment and went from there to the Victoria Exchange Complex.¹⁶⁸ At 23:56, she was captured on the CCTV on the raised walkway.¹⁶⁹ Very shortly before that image was taken, CI Graham spoke to Sergeant Cawley, who gave her a situation report.¹⁷⁰
- 13.113** CI Graham viewed herself as becoming on-scene commander at the point at which she arrived at the Victoria Exchange Complex.¹⁷¹ She stated that she did not view herself as relieving anyone of incident command.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*”.¹⁷³ CI Graham does not recall being informed that she was Bronze Commander.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.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 between her and Chief Superintendent Gregory at 00:13 on 23rd May 2017.¹⁷⁶ Chief Superintendent Gregory asked her to be his “*eyes and ears*” on the

¹⁶⁴ [96/2/3-9](#)

¹⁶⁵ [96/19/7-14](#)

¹⁶⁶ [96/19/19-20/17](#)

¹⁶⁷ [96/20/18-22/4](#)

¹⁶⁸ [96/21/15-22/9](#)

¹⁶⁹ [INQ035612/429](#)

¹⁷⁰ [96/24/13-25/15](#)

¹⁷¹ [96/16/5-7](#), [96/26/15-20](#)

¹⁷² [96/26/18-20](#)

¹⁷³ [INQ002000/71](#)

¹⁷⁴ [96/31/5-7](#)

¹⁷⁵ [96/31/23-32/12](#)

¹⁷⁶ [96/38/13-39/3](#)

ground. He accepted he did not make clear in the conversation that he had appointed her the Bronze Commander pending Superintendent Gordon's arrival.¹⁷⁷

- 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.¹⁷⁸ At 00:20 on 23rd May 2017, she liaised with the bomb disposal technicians from the Army.¹⁷⁹ At 01:00, she spoke to the Ground Assigned Tactical Firearms Commander, GMP CI Mark Dexter.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.
- 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 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.¹⁸¹ She accepted that JESIP did not work without an FCP,¹⁸² that she should have set one up¹⁸³ and that there were "*learning points in relation to liaison with commanders*".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 NWS 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.¹⁸⁵ She was an ideal candidate to act as Bronze Commander. She should have been clearly instructed to act in that role. It was for the Silver Commander, Chief Superintendent Gregory, to make this clear to her. He failed to ensure this occurred.

¹⁷⁷ [93/195/4-10, 93/196/5-8](#)

¹⁷⁸ [96/36/8-37/2](#)

¹⁷⁹ [INQ035612/444](#)

¹⁸⁰ [INQ035612/538](#)

¹⁸¹ [96/66/22-67/9](#)

¹⁸² [96/71/3-5](#)

¹⁸³ [96/64/3-23](#)

¹⁸⁴ [96/70/23-71/2](#)

¹⁸⁵ [INQ025700/70](#)

Gold command

- 13.121** ACC Smith was the on-call Chief Officer on the night of 22nd May 2017.¹⁸⁶ He had joined BTP in September 2016 and was a qualified Gold Commander.¹⁸⁷ Prior to the Attack, he had not read or received any training on BTP's Major Incident Manual.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.¹⁸⁹ At this point, ACC Smith became Gold Commander for BTP.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.¹⁹¹ At no stage did he ask whether a tactical plan had been developed.¹⁹² This was something ACC Smith should have done as it was his responsibility under the Major Incident 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 Co-ordinating Group.¹⁹⁷ At 23:31, CI Lodge made a record of the command structure, which ACC Smith had ratified: "*From SDO [Senior Duty Officer] – for GSB [Gold – Silver – Bronze] command structure – Superintendent Gordon is Bronze, Chief Superintendent Gregory Silver, and ACC Smith Gold.*"¹⁹⁸

¹⁸⁶ [94/102/7-9](#)

¹⁸⁷ [94/73/14-16](#), [94/74/4-7](#)

¹⁸⁸ [94/75/7-9](#)

¹⁸⁹ [94/102/10](#), [94/103/1-6](#)

¹⁹⁰ [94/107/11-14](#)

¹⁹¹ [INQ041119/3](#)

¹⁹² [94/88/3-6](#)

¹⁹³ [INQ025700/65](#)

¹⁹⁴ [94/88/9-14](#)

¹⁹⁵ [94/87/17-88/2](#)

¹⁹⁶ [94/113/9-114/19](#)

¹⁹⁷ [94/117/2-118/3](#)

¹⁹⁸ [INQ002000/59](#), [94/124/7-23](#)

- 13.127** At 00:37 on 23rd May 2017, ACC Smith was in a police vehicle being driven under blue lights to Manchester.¹⁹⁹
- 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.²⁰⁰ 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.²⁰¹ 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 NWS 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 NWS 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 major failure by BTP was that NWS 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.

¹⁹⁹ [94/129/8-18](#)

²⁰⁰ [94/133/15-136/4](#)

²⁰¹ [94/136/5-138/12](#)

²⁰² [94/139/9-19](#)

²⁰³ [94/85/2-86/17](#)

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 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.

²⁰⁴ [94/145/5-149/1](#)

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.²⁰⁵ The very first thing he said was: *“There’s been an explosion at Manchester Arena.”*²⁰⁶ He went on to clarify that this had happened in *“the foyer where the entrance is ... near where MacDonald’s [sic] used to be.”*²⁰⁷ He explained that there were *“loads injured ... 30 or 40 injured”*.²⁰⁸

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.²⁰⁹ In the course of the evidence, John Atkinson’s family praised Ronald Blake for his humanity.²¹⁰ 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

²⁰⁵ [INQ023493T/19-22](#)

²⁰⁶ [INQ023493T/19](#)

²⁰⁷ [INQ023493T/19](#)

²⁰⁸ [INQ023493T/19-20](#)

²⁰⁹ [158/61/19-20](#)

²¹⁰ [158/73/11-16](#)

at 22:32:40,²¹¹ and the caller said: *"I'm at the MEN²¹² Arena in Manchester. There's been gunshots and explosion ... There's loads of people bleeding. There's been gunshots and explosion."*²¹³

- 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.
- 13.143** Inspector Sexton came on duty at 21:00 on 22nd May 2017.²¹⁴ 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.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 22nd 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 incident logs.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]"*.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.²¹⁸ This was also the point at which Inspector Sexton

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](#)

²¹⁴ [97/132/17-19](#)

²¹⁵ [97/21/22-23/25](#)

²¹⁶ [INQ007214/2](#), [97/153/9-154/9](#)

²¹⁷ [INQ007214/8](#)

²¹⁸ [97/152/10-153/6](#)

took command of the incident,²¹⁹ including command of the initial firearms response in his role as the Initial Tactical Firearms Commander.²²⁰ All this happened just three minutes after the explosion.

- 13.147** Inspector Sexton began to deploy firearms officers to the Arena immediately.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 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 a false alarm.²²⁴ At 22:39:30, PC Richardson communicated that impression over the radio to the FDO.²²⁵ News of a 'false alarm' was a relief for Inspector Sexton,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: *"Boss. It's become a different story now ... they've got major casualties."*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.²²⁸

²¹⁹ [97/150/11-15](#)

²²⁰ [97/4/11-7/10](#)

²²¹ [97/151/9-12](#)

²²² [98/4/11-23](#)

²²³ [101/57/10-18](#)

²²⁴ [101/55/8-56/13](#)

²²⁵ [101/57/11-24](#)

²²⁶ [97/173/16-22](#)

²²⁷ [102/90/13-91/2](#)

²²⁸ [97/175/24-176/9](#)

- 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.²²⁹ PC Roach had firsthand knowledge of the position there. The information that PC Moore provided to Inspector Sexton was 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.²³⁰
- 13.154** By this stage, Inspector Sexton had authorised an Emergency Search.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.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.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."*²³⁴
- 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.²³⁵ He was successful in that aim because that is what Inspector Sexton understood PC Moore to be communicating.²³⁶

²²⁹ [102/84/2-85/25](#)

²³⁰ [INQ035612/75](#)

²³¹ [97/157/19-25](#)

²³² [97/160/2-8](#)

²³³ [INQ035612/78](#), [102/85/6-22](#)

²³⁴ [102/91/1-6](#)

²³⁵ [102/96/6-18](#)

²³⁶ [97/177/22-178/15](#)

- 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*”,²³⁷ had asked him to contact her. Temporary CI Buckle said that she would make her way “*in*”.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.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.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 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.²⁴²

²³⁷ [97/185/23](#)

²³⁸ [97/185/5-186/13](#)

²³⁹ [INQ035612/89](#)

²⁴⁰ [99/14/1-4](#)

²⁴¹ [INQ016688/9](#)

²⁴² [97/187/6-16](#)

- 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.²⁴³
- 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 00:18.²⁴⁴ 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:

"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."²⁴⁵

- 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.²⁴⁶
- 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

²⁴³ [97/192/18-20, 98/1/23-25](#)

²⁴⁴ [98/1/24-2/8](#)

²⁴⁵ [INQ024325/1-2](#)

²⁴⁶ [60/6/10-7/17](#)

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 a “*gunshot wound to the leg*” at the entrance to the railway station.²⁴⁹ Inspector Sexton understood that this report had been made by an experienced firearms officer and it therefore carried weight with him.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.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.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

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

²⁴⁹ [INQ007214/13](#), [INQ018457T/6](#)

²⁵⁰ [INQ029021/12](#)

²⁵¹ [146/161/22-25](#)

²⁵² [141/47/9-23](#)

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 2017.²⁵³ It defined a Major Incident as *"[a]n event or situation, with a range of serious consequences, which requires special arrangements to be implemented by one or more emergency responder agencies."*²⁵⁴
- 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, *"[I]t was obvious what people were dealing with."*²⁵⁵ 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."*²⁵⁶
- 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.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.²⁵⁸ Temporary Superintendent Christopher Hill, to whom silver command was transferred from Temporary Superintendent Arif Nawaz shortly after 00:00 on 23rd 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."*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.

²⁵³ [INQ007279/2](#)

²⁵⁴ [INQ007279/7](#)

²⁵⁵ [99/44/20-22](#)

²⁵⁶ [INQ024325/11](#)

²⁵⁷ [146/136/17-137/16](#)

²⁵⁸ [108/53/19-54/9](#)

²⁵⁹ [104/191/16-23](#)

- 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.
- 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 Hill²⁶² and Superintendent Thompson²⁶³ 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.
- 13.186** It was not until 00:57, nearly two and a half hours after the explosion, that GMP declared a Major Incident.²⁶⁴ 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

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](#)

²⁶⁴ [INQ022399/11](#)

government departments.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: *"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."*²⁶⁶ Within GMP, the "FCR" (Force Control Room) Inspector was the FDO.

13.191 The CTPHQ guidance of March 2017 stated:

*"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 order to support an effective response, it is important that the relevant partner agencies and specialist national assets are informed as a priority."*²⁶⁷

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."*²⁶⁸

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.

²⁶⁵ [INQ016688/3](#)

²⁶⁶ [INQ013767/4](#)

²⁶⁷ [INQ016688/7](#)

²⁶⁸ [INQ016688/22](#)

- 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 NWS 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 NWS 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.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"*²⁷² for a Marauding Terrorist Firearms Attack.²⁷³ He had first prepared this in January 2016.²⁷⁴ On 6th June 2016, Inspector Sexton updated his aide-memoire in light of learning from Exercise Winchester Accord and circulated it to his FDO colleagues.²⁷⁵
- 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

²⁶⁹ [INQ039970/7](#)

²⁷⁰ [INQ029178/5](#)

²⁷¹ [97/54/24-56/1](#)

²⁷² [INQ040955](#)

²⁷³ [97/57/3-22](#)

²⁷⁴ [97/135/20-21](#)

²⁷⁵ [97/136/10-23](#)

²⁷⁶ [INQ040955/1](#)

- 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 NWS and GMFRS that he had done so.
- 13.204** On 22nd May 2017, Inspector Sexton did not communicate his declaration of Operation Plato to NWS 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.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.²⁷⁹
- 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."²⁸⁰

²⁷⁷ [97/138/6-23, 99/28/16-21](#)

²⁷⁸ Days 97 to 99

²⁷⁹ [97/111/8-114/19](#)

²⁸⁰ [INQ029021/16](#)

- 13.208** In evidence to me, Inspector Sexton confirmed that this represented his reasoning at the time.²⁸¹ 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.²⁸²
- 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.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.²⁸⁴ In fact, this call was to the 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.

²⁸¹ [98/118/19-119/18](#)

²⁸² [99/41/6-42/21](#), [99/123/7-12](#)

²⁸³ [98/142/24-143/2](#), [99/118/10-17](#)

²⁸⁴ [INQ024325/3](#)

²⁸⁵ [INQ018839T/11-13](#)

²⁸⁶ [INQ024325/13](#)

²⁸⁷ [98/138/9-140/12](#)

- 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 moments earlier.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.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 “Plato” is heard 23 times in the Dictaphone recording. On 17 of those occasions, the speaker is Inspector Sexton.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.
- 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.

²⁸⁸ [INQ024325/4](#)

²⁸⁹ [INQ024325/12-13](#)

²⁹⁰ [INQ024325/1-5](#), [INQ024325/15](#), [97/111/8-115/22](#)

²⁹¹ [INQ024325/1-48](#)

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?”*²⁹⁶ 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 NWS 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.²⁹⁷ He was Participant 6.²⁹⁸ He recorded:

*“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.”*²⁹⁹

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.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.³⁰¹ 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.”*³⁰²

²⁹⁶ [INQ024325/14](#)

²⁹⁷ [INQ000790](#)

²⁹⁸ [99/121/7-18](#)

²⁹⁹ [INQ000790/5](#)

³⁰⁰ [99/121/7-122/1](#)

³⁰¹ [INQ041168](#)

³⁰² [INQ041168/2](#)

- 13.225 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.
- 13.226 Inspector Sexton was interviewed on 10th January 2018 as part of Lord Kerlake's independent review of the preparedness for and emergency response to the Attack.³⁰³ 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."³⁰⁴*

- 13.227 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 Kerlake process 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.

³⁰³ [99/122/2-7, INQ000009](#)

³⁰⁴ [INQ023523T/37, INQ023523T/38](#) (emphasis added)

³⁰⁵ [99/116/25-125/18](#)

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 NWS and GMFRS, just as he overlooked the need to declare a Major Incident. No one reminded him that he should do 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."*³⁰⁶

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

³⁰⁶ [99/42/16-21](#)

*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.*³⁰⁷

- 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.³⁰⁸ 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 00:18.³⁰⁹ 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.³¹⁰ That was a mistake.
- 13.241** The officer who replaced Ian Randall, Sergeant Andrew Core, lacked Ian Randall's experience.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.³¹² David Myerscough, who had been a GMP radio operator since 2014,³¹³ assumed that responsibility.³¹⁴

³⁰⁷ [INQ035309/18](#)

³⁰⁸ [107/13/21-14/4](#)

³⁰⁹ [97/150/11-15](#), [98/2/2-8](#)

³¹⁰ [99/202/-208/25](#), [INQ034432/4](#)

³¹¹ [INQ033297/1-4](#)

³¹² [INQ024325/7](#)

³¹³ [100/57/5-7](#)

³¹⁴ [97/81/2-5](#)

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."*³¹⁵

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:

<i>"[David Myerscough]</i>	<i>Boss, do you want media enquiries cancelling or do you want me to answer them?</i>
<i>[Inspector Sexton]</i>	<i>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."</i> ³¹⁷

13.246 The enquiries from the media nonetheless kept coming, including calls from the international media.³¹⁸

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.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

³¹⁵ [100/69/21-70/2](#), [100/71/7-10](#)

³¹⁶ [INQ024325/30](#), [INQ024325/48](#)

³¹⁷ [INQ024325/10](#)

³¹⁸ [INQ018834T/1-2](#)

³¹⁹ [98/62/3-16](#)

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.³²⁰ Inspector Sexton said the same.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.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 underestimated across the emergency services. I will return to this topic in the recommendations in Part 21 in Volume 2-II.

³²⁰ [100/63/12-64/6](#)

³²¹ [97/131/4-22](#)

³²² [100/64/8-65/11](#)

- 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.³²³ I will consider their roles later in this Part, at paragraphs 13.478 and 13.444.
- 13.255** 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,³²⁴ but he did not arrive at the scene until 23:23.³²⁵

Consequences of the Force Duty Officer's failures

- 13.256** 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.
- 13.257** Other failures flowed from those omissions.
- 13.258** 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.³²⁶ He failed to do so.³²⁷
- 13.259** 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. 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,³²⁸ establishing an FCP is critical to the emergency response.³²⁹ 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.³³⁰ Inspector Sexton failed to ensure there was an FCP.³³¹ 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.

³²³ [99/46/13-47/1](#)

³²⁴ [99/153/9-154/24](#)

³²⁵ [106/156/3-6](#)

³²⁶ [INQ040955/1](#)

³²⁷ [98/148/20-149/21](#)

³²⁸ [98/100/15-101/12](#)

³²⁹ [INQ040955/1](#)

³³⁰ [INQ018900/9-10](#)

³³¹ [99/44/12-19](#)

- 13.261** Third, the Policing Experts confirmed that the concept of zoning is critical to Operation Plato.³³² At the time of the Attack, the third edition of the Joint Operating Principles (JOPs 3) was applicable and defined Operation Plato zones as cold, warm and hot.³³³ 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.³³⁴ 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.³³⁵ 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.³³⁶ That the failure to engage with this vital issue was so widespread indicates strongly that there 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.

³³² [146/176/14-21](#)

³³³ [INQ008372/4-5](#)

³³⁴ [97/39/23-40/21](#)

³³⁵ [INQ024325](#)

³³⁶ [98/13/6-15](#)

- 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.³³⁷ Such reviews of zoning decisions are critical, given their impact on deployment. JOPs 3 made that clear,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.³³⁹ That was also the position of GMP in its closing statement to me.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.
- 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.

³³⁷ [99/45/2-46/6](#)

³³⁸ [INQ008372/15](#)

³³⁹ [130/178/7-179/3](#), [137/235/4-236/15](#)

³⁴⁰ [186/52/14-22](#)

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 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.³⁴⁶
- 13.280** By 22:43:35, PC Moore and PC Simpkin had almost reached the doors to the City Room.³⁴⁷ Seconds later, they entered. They emerged at 22:44:37,³⁴⁸ having spent almost exactly a minute at the seat of the explosion. When he gave

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](#)

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](#)

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 Commander in late 2016. By 22nd May 2017, PC Moore was an experienced firearms officer.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.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.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).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 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.³⁵³ He added, "... *Operation Plato, Operation Plato*".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: "[E]very second counts."³⁵⁵ Therefore, he sought to communicate his message to the FDO quickly by using the shorthand operational name for a Marauding Terrorist Firearms Attack.³⁵⁶
- 13.285** PC Moore's thinking was clear and appropriate. He communicated his assessment to the FDO promptly and effectively.

³⁴⁹ [102/75/5-25](#)

³⁵⁰ [102/76/19-78/24](#)

³⁵¹ [102/79/14-81/2](#)

³⁵² [102/132/25-133/12](#)

³⁵³ [102/93/6-94/6](#)

³⁵⁴ [102/94/16-17](#)

³⁵⁵ [102/133/9-10](#)

³⁵⁶ [102/96/5-97/8](#)

'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.³⁵⁷ 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.³⁵⁸
- 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.³⁵⁹ 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.³⁶⁰ The CCTV footage shows that this took almost one minute.³⁶¹ 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.³⁶²
- 13.290** At the conclusion of the raw check, PC Moore was satisfied that there was no "imminent threat of an active shooter".³⁶³ 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,³⁶⁴ but nothing of concern within the City Room itself.³⁶⁵

³⁵⁷ [102/98/2-6](#)

³⁵⁸ [102/98/7-100/1](#)

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

³⁶⁵ [102/101/5-102/11](#)

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.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.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”,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 assessments³⁶⁹ 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.”³⁷⁰

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:

<i>[PC Moore]</i>	<i>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.</i>
<i>[Inspector Sexton]</i>	<i>To the Victoria entrance to the Arena?</i>
<i>[PC Moore]</i>	<i>That’s correct boss. We’re talking upwards of 30 or 40 casualties.</i>
<i>[PC Deponeo]</i>	<i>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?</i>
<i>[PC Moore]</i>	<i>Can we have all available trauma kit to the top of Victoria Station?”³⁷¹</i>

³⁶⁶ [102/104/2-6](#)

³⁶⁷ [102/105/10-106/6](#)

³⁶⁸ [102/104/19](#)

³⁶⁹ [102/104/16-105/12](#)

³⁷⁰ [102/105/21-24](#)

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: [102/140/8-19](#)

- 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 Depono 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 at 22:54. CCTV captured those officers in the building at 22:57.³⁷⁴ 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,³⁷⁵ and PC Tyldesley and PC Dalton,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.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.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 2008.³⁷⁹ In November 2016, he transferred to GMP for career development reasons.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

³⁷² [102/108/17-109/5](#)

³⁷³ [INQ035612/90](#), [INQ035612/100](#)

³⁷⁴ [INQ035612/155](#)

³⁷⁵ [INQ035612/87](#), [INQ035612/98](#), [INQ035612/101](#)

³⁷⁶ [INQ035612/97](#), [INQ035612/101](#)

³⁷⁷ [INQ035612/103](#)

³⁷⁸ [102/110/13-20](#)

³⁷⁹ [101/3/3-4/7-21](#)

³⁸⁰ [101/26/8-22](#)

³⁸¹ [101/41/20-42/8](#), [101/62/14-18](#)

³⁸² [101/31-36/9-19](#)

³⁸³ [101/30/21-23](#)

- 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 GMP³⁸⁵ 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 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 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.³⁹⁰ 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.³⁹¹
- 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.³⁹² 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

³⁸⁴ [101/2/24-3/6](#)

³⁸⁵ [101/3/10-15](#), [101/24/13-23](#)

³⁸⁶ [101/44/2-49/20](#)

³⁸⁷ [101/57-60/10-15](#)

³⁸⁸ [INQ024445T/1](#)

³⁸⁹ [101/71/1-8](#)

³⁹⁰ [101/74/1-22](#)

³⁹¹ [INQ035612/103](#)

³⁹² [101/75/23-76/25](#)

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.³⁹³

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 of what he said.³⁹⁹ 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*".⁴⁰⁰ 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.⁴⁰¹

13.308 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:

<i>"[PC Richardson]</i>	<i>OFC [Operational Firearms Commander] to FDO."</i>
<i>"[Inspector Sexton]</i>	<i>Go ahead."</i>

³⁹³ [101/76/1-77/12](#)

³⁹⁴ [101/79/1-80/2](#)

³⁹⁵ [INQ032362/14](#)

³⁹⁶ [INQ024325/1-2](#)

³⁹⁷ [INQ032362/14](#)

³⁹⁸ [101/85/4-89/17](#)

³⁹⁹ 11th May 2021

⁴⁰⁰ [101/88/11-21](#)

⁴⁰¹ [101/88/11-89/9](#)

"[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."⁴⁰²

13.309 PC Richardson's reference to paramedics was incorrect. The people he thought were paramedics were staff of Emergency Training UK.⁴⁰³

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 2019.⁴⁰⁴ 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 2020,⁴⁰⁵ 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.

⁴⁰² [INQ024325/2](#)

⁴⁰³ [101/80/1-25](#)

⁴⁰⁴ [INQ025000](#)

⁴⁰⁵ [INQ032362/14](#)

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.

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.⁴⁰⁶ PC Richardson considered that it would "*definitely*" be beneficial for all firearms officers to be deployed with body-worn video cameras in future.⁴⁰⁷ 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 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.⁴⁰⁸ He remained there until he left with CI Dexter at 23:30.⁴⁰⁹ CI Dexter had arrived and assumed the role of Ground Assigned Tactical Firearms Commander seven minutes earlier.⁴¹⁰ 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*".⁴¹¹

⁴⁰⁶ [101/99/24-100/11](#)

⁴⁰⁷ [101/99/24-100/11](#)

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"*.⁴¹³ 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.⁴¹⁴

13.322 The College of Policing document set out the role of the Operational Firearms Commander under a number of bullet points.⁴¹⁵ 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"*.⁴¹⁶

13.323 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.⁴¹⁷ 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.

⁴¹² [INQ004140](#)

⁴¹³ [INQ004140/3](#)

⁴¹⁴ [98/2/2-8](#)

⁴¹⁵ [INQ004140/5-6](#)

⁴¹⁶ [INQ004140/5-6](#)

⁴¹⁷ [101/12/1-22](#)

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 NWS staff were needed in the City Room.
- 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."*⁴¹⁹ In evidence, he clarified that he was referring to a need for medically trained staff in the City Room.⁴²⁰ Inspector Sexton replied: *"Yes, I've obviously declared Operation Plato and I'm trying to get as many NWS down there as possible."*⁴²¹
- 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.⁴²² 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.⁴²³
- 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 NWS 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."*⁴²⁴

⁴¹⁸ [INQ004140/5-6](#)

⁴¹⁹ [INQ024325/5](#)

⁴²⁰ [101/101/23-104/13](#)

⁴²¹ [INQ024325/5](#)

⁴²² [101/90/5-20](#)

⁴²³ [101/104/7-20](#)

⁴²⁴ [INQ024325/3-4](#)

- 13.329** PC Adams had been in the City Room with PC Richardson.⁴²⁵ 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.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 NWS resources and then did nothing about it.⁴²⁷ He said that he assumed that NWS 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.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 NWS.
- 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 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 NWS 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

⁴²⁵ [101/71/4-8](#)

⁴²⁶ [98/46/14-47/15](#)

⁴²⁷ [98/48/1-5](#)

⁴²⁸ [98/48/1-20](#)

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 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.⁴³⁶ Making the right Operation Plato zoning decision in relation to the City Room was critical to that aim.
- 13.341** 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.⁴³⁷
- 13.342** 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.
- 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.

⁴³² [102/126/23-127/24](#)

⁴³³ [INQ024325/2](#)

⁴³⁴ [INQ024325/2](#)

⁴³⁵ [INQ024325/2](#)

⁴³⁶ [INQ039970/6-7](#), [INQ000781/1-2](#)

⁴³⁷ [101/156/23-158/7](#)

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 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 In 2017, that PPE provided no reliable protection from an explosion.⁴⁴³ 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.

⁴³⁸ [INQ008372/4-5](#)

⁴³⁹ [60/6/10-7/17](#)

⁴⁴⁰ [INQ008372/4-5](#)

⁴⁴¹ [INQ016688/7-8](#)

⁴⁴² [105/67/1-25](#), [114/181/21-182/13](#), [119/104/17-105/14](#)

⁴⁴³ [112/194/10-195/21](#)

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 13.174.⁴⁴⁴ 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.”⁴⁴⁵

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 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 NWS and GMFRS

⁴⁴⁴ [141/16/3-21](#)

⁴⁴⁵ [141/70/23-71/11-21](#)

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 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

⁴⁴⁶ [99/45/2-46/6](#)

⁴⁴⁷ [106/175/14-177/5](#)

⁴⁴⁸ [INQ001405/1](#)

⁴⁴⁹ [101/81/10-82/18](#)

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.⁴⁵⁰

- 13.359** From an early stage, PC Richardson made requests for an explosives detection dog. He made such requests of the FDO at 22:53⁴⁵¹ and 23:01.⁴⁵² He made direct contact with a GMP dog handler, PC Mark Kay, at 23:04.⁴⁵³ 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.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 23:47:01.⁴⁵⁵ By 23:47:24, the handler and dog were conducting a search in the City Room.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 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.

⁴⁵⁰ [102/117/7-25](#)

⁴⁵¹ [INQ024325/5](#)

⁴⁵² [INQ024325/10](#)

⁴⁵³ [INQ018840T/4](#), [101/106/2-10](#)

⁴⁵⁴ [101/83/9-84/7](#)

⁴⁵⁵ [INQ035612/391](#)

⁴⁵⁶ [INQ035612/392](#)

⁴⁵⁷ [INQ018858T/4](#)

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 22nd 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 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.⁴⁵⁹

13.367 In their report, the Policing Experts described Inspector Smith as *"an officer with considerable experience, command ability and fortitude"*.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.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."*⁴⁶² 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.⁴⁶³

⁴⁵⁸ [INQ006990/1](#)

⁴⁵⁹ [102/141/14-148/12](#)

⁴⁶⁰ [INQ035309/15](#)

⁴⁶¹ [102/175/20-176/17](#)

⁴⁶² [102/176/18-177/15](#)

⁴⁶³ [102/176/18-177/15](#)

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.⁴⁶⁴ 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.⁴⁶⁵
- 13.371** At 22:36, on his way to the Arena, Inspector Smith made contact with GMP Control, to seek an update.⁴⁶⁶ The operator asked him to nominate an RVP and Inspector Smith selected the *"parking area outside the cathedral"*.⁴⁶⁷ 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"*.⁴⁶⁸
- 13.372** During this same conversation with the Control Room Operator, Inspector Smith asked the operator to do two things:⁴⁶⁹ 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.⁴⁷⁰ 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 22:50.⁴⁷¹
- 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.⁴⁷² 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.⁴⁷³ As a result, Inspector Smith instructed the operator to direct all officers directly to Manchester Victoria

⁴⁶⁴ [102/176/5-178/5](#)

⁴⁶⁵ [102/177/23-178/5](#)

⁴⁶⁶ [102/178/6-17](#)

⁴⁶⁷ [102/178/6-17](#)

⁴⁶⁸ [102/178/18-180/15](#), [INQ007214/10](#)

⁴⁶⁹ [102/180/3-19](#)

⁴⁷⁰ [102/180/3-19](#)

⁴⁷¹ [102/180/20-181/25](#)

⁴⁷² [102/182/1-184/2](#)

⁴⁷³ [102/182/1-184/2](#)

Railway Station.⁴⁷⁴ 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.⁴⁷⁵

- 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 22:40.⁴⁷⁶ 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.⁴⁷⁷ Any police officer may declare a Major Incident on behalf of the police.⁴⁷⁸ The events in the City Room were indisputably a Major Incident within the parameters of the GMP Major Incident Plan.⁴⁷⁹
- 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.”⁴⁸⁰

⁴⁷⁴ [102/182/1-184/2](#)

⁴⁷⁵ [102/182/1-184/2](#)

⁴⁷⁶ [102/182/1-184/2](#), [INQ001136/1](#)

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](#)

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 Smith.⁴⁸¹ The Night Silver only made contact once, and even then only for an update.⁴⁸² 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 22:44:31.⁴⁸³ On leaving their patrol car, they stopped to check on casualties in the area,⁴⁸⁴ and Inspector Smith contacted GMP Control to direct closing off the surrounding roads.⁴⁸⁵

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.⁴⁸⁶ 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.⁴⁸⁷

13.382 Following a brief discussion with firearms officers,⁴⁸⁸ Inspector Smith and Sergeant McGowan ran towards the City Room.⁴⁸⁹ On the raised walkway, Inspector Smith spoke to a BTP officer in order to gain further situational awareness.⁴⁹⁰ By 22:47:51, he had entered the City Room.⁴⁹¹ 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.⁴⁹² This meant that it was his responsibility to implement the tactical plan on the ground.⁴⁹³ The development of the tactical plan was the responsibility of the Tactical/Silver Commander.⁴⁹⁴ 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

⁴⁸¹ [102/198/1-25](#)

⁴⁸² [103/49/20-52/5](#)

⁴⁸³ [INQ035612/89](#)

⁴⁸⁴ [INQ035612/95](#)

⁴⁸⁵ [102/188/14-189/15](#)

⁴⁸⁶ [INQ035612/99](#)

⁴⁸⁷ [102/190/11-21](#)

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](#)

Hill at 00:00 on 23rd May 2017.⁴⁹⁵ At no stage did 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.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.⁵⁰¹ Once he had arrived in the City Room, his plan had two stages.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 lives had been saved, steps needed to be taken to preserve the area as a crime scene.⁵⁰³

13.388 This was the correct plan. It gives rise to two questions.

⁴⁹⁵ [103/51/16-52/5](#)

⁴⁹⁶ [103/49/20-52/5](#)

⁴⁹⁷ [103/49/20-52/5](#)

⁴⁹⁸ [104/65/16-66/18](#)

⁴⁹⁹ [103/49/20-52/5](#)

⁵⁰⁰ [INQ007279/11-12](#)

⁵⁰¹ [102/167/2-24](#)

⁵⁰² [102/194/6-23](#)

⁵⁰³ [102/194/6-23](#)

- 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”*.⁵⁰⁴ For example, he had never received training in the application of a tourniquet.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.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 22nd 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.⁵⁰⁹ In fact, no one mentioned zoning until after 23:30, following the arrival of CI Dexter.⁵¹⁰

⁵⁰⁴ [102/144/25-146/8](#)

⁵⁰⁵ [102/144/25-146/8](#)

⁵⁰⁶ [78/16/22-18/2](#), [139/37/6-39/16](#)

⁵⁰⁷ [76/78/10-79/12](#), [103/2/11-3/17](#), [INQ018644T/9](#)

⁵⁰⁸ [102/170/19-172/13](#)

⁵⁰⁹ [102/170/19-172/13](#)

⁵¹⁰ [102/170/19-172/13](#)

- 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.⁵¹¹ 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.⁵¹² 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 Room.⁵¹³ The first meeting between Inspector Smith and CI Dexter that night can be seen on CCTV at 23:25:56.⁵¹⁴ This was just before CI Dexter switched on his Dictaphone.⁵¹⁵
- 13.396** 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.⁵¹⁶ I am satisfied, however, that CI Dexter informed Inspector Smith of the declaration of Operation Plato in the unrecorded 23:25 conversation.
- 13.397** 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 NWS 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.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.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.

⁵¹¹ [102/143/10-144/18](#)

⁵¹² [103/100/22-101/19](#)

⁵¹³ [102/172/4-22](#)

⁵¹⁴ [INQ035612/315](#)

⁵¹⁵ [106/166/12-16](#)

⁵¹⁶ [INQ040657/14](#), [INQ040657/58](#)

⁵¹⁷ [102/173/3-174/25](#), [102/195/6-197/23](#), [103/5/7-12](#)

⁵¹⁸ [102/195/6-196/10](#)

- 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.
- 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.⁵¹⁹ 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."*⁵²⁰ 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.⁵²¹ 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.⁵²²
- 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."*⁵²³
- 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."*⁵²⁴
- 13.404** Advanced Paramedic Patrick Ennis was the first NWAS resource at the scene.⁵²⁵ 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:

⁵¹⁹ [103/2/11-3/17](#)

⁵²⁰ [103/2/11-3/17](#)

⁵²¹ [103/3/11-4/14](#)

⁵²² [103/8/8-22](#)

⁵²³ [INQ018644T/9](#)

⁵²⁴ [INQ018644T/10](#)

⁵²⁵ [109/106/1-9](#)

"[PC Barker] Every NWAS. They want every NWAS there."

"[Patrick Ennis] Where?"

"[PC Barker] At the booking office which is just ... [upstairs]."⁵²⁶

- 13.405** Patrick Ennis made his way to the City Room, entering at 22:53.⁵²⁷ Almost straight away, he was approached by Inspector Smith, and the two men spoke.⁵²⁸ By the time they gave evidence, neither could recall what was discussed.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.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."*⁵³¹
- 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.⁵³² 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.⁵³³

⁵²⁶ [76/78/10-79/12](#)

⁵²⁷ [INQ035612/141-143](#)

⁵²⁸ [INQ035612/143](#)

⁵²⁹ [103/18/22-19/5](#)

⁵³⁰ [109/123/21-124/7](#)

⁵³¹ [103/22/19-24/1](#)

⁵³² [INQ035612/123](#) [Note: the text narrative erroneously refers to seven officers: there are eight listed]

⁵³³ [78/3/18-4/7](#)

- 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.⁵³⁴ 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.⁵³⁵ By that stage, Sergeant Hare had switched on his body-worn video camera.⁵³⁶ 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 22:55.⁵³⁷ 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.⁵³⁸
- 13.411** Sergeant Hare had been told by GMP Control that Inspector Smith was in charge in the City Room.⁵³⁹ 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."⁵⁴⁰ He then instructed his officers to work in pairs. One of the team asked about the arrival of ambulances, and Sergeant Hare replied: "They're coming mate. They're co-ordinating."⁵⁴¹ 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.⁵⁴²
- 13.412** 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.⁵⁴³ As I have made clear, Inspector Smith was in exactly the same position: he had never received anything but basic training.⁵⁴⁴
- 13.413** 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.⁵⁴⁵ As time passed and it became apparent to him that paramedics were not entering the City Room, he became concerned.⁵⁴⁶

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](#)

⁵⁴¹ [78/52/17-53/14](#)

⁵⁴² [78/53/7-54/16](#)

⁵⁴³ [78/53/23-55/3](#)

⁵⁴⁴ [102/144/25-145/24](#)

⁵⁴⁵ [78/53/23-55/3](#)

⁵⁴⁶ [78/53/23-55/3](#)

At 23:00, a second Tactical Aid Unit team led by Sergeant John Goodwin entered the City Room.⁵⁴⁷ Sergeant Hare spoke to Sergeant Goodwin, saying: *"We need the fucking medics John."*⁵⁴⁸ He was referring to paramedics.⁵⁴⁹

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."*⁵⁵⁰ 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."*⁵⁵¹

13.415 A highly unsatisfactory situation had developed. If NWS 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 NWS deployment, Sergeant Hare, his team and indeed others in the City Room did what they could to provide support and treatment for casualties. 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 F2⁵⁶¹ and Sergeant Peter Anwyl⁵⁶² assisted Georgina Callander.

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](#)

⁵⁵² [78/53/23-55/11](#), [78/65/8-68/13](#)

⁵⁵³ [152/13/2-3](#)

⁵⁵⁴ [155/11/10-21](#)

⁵⁵⁵ [155/11/22-16/16](#)

⁵⁵⁶ [155/19/20-24/22](#)

⁵⁵⁷ [155/21/15-17](#)

⁵⁵⁸ [155/29/4-5](#)

⁵⁵⁹ [155/13/21-14/25](#)

⁵⁶⁰ [155/13/22-15/25](#)

⁵⁶¹ [155/11/15-14/9](#)

⁵⁶² [155/19/10-25/8](#)

- 13.420** PC Whittell,⁵⁶³ Sergeant Anwyl⁵⁶⁴ and PC Thomas Ho-McKenna⁵⁶⁵ gave CPR to Jane Tweddle. GMP officers PC Whittell⁵⁶⁶ 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.⁵⁶⁹ When the improvised stretcher on which John Atkinson was being carried failed, PC Leon McLaughlin went to seek help from NWS together with Special Constable Michael Dalton.⁵⁷⁰ GMP Sergeant Darren Prince was involved in John Atkinson's evacuation.⁵⁷¹
- 13.422** Sergeant Hare⁵⁷² sought to assist Kelly Brewster with a defibrillator. However, he found that, when he unpacked it, there were no defibrillator pads.⁵⁷³ PC Michael Williams assisted with evacuating Kelly Brewster from the City Room.⁵⁷⁴
- 13.423** PC Sivori⁵⁷⁵ and Sergeant Anwyl⁵⁷⁶ assisted Megan Hurley. Sergeant Hare assisted Megan Hurley, her father and brother.⁵⁷⁷ PC Whittell gave CPR to Megan Hurley and, with others, used a defibrillator in an attempt to resuscitate her.⁵⁷⁸ Officer F2 provided CPR to Megan Hurley.⁵⁷⁹ Officer F2 covered Megan Hurley when the attempts at CPR were unsuccessful.⁵⁸⁰ PC Gareth Dennison checked Megan Hurley for signs of life.⁵⁸¹
- 13.424** PC Sivori checked on Nell Jones. He believed that she had died when he saw her.⁵⁸² PC McLaughlin also checked Nell Jones for a pulse.⁵⁸³
- 13.425** Special Constable Dalton was involved in finding a makeshift stretcher for Saffie-Rose Roussos.⁵⁸⁴ PC McLaughlin helped carry Saffie-Rose Roussos from the City Room to Trinity Way.⁵⁸⁵

⁵⁶³ [151/30/5-34/4](#)

⁵⁶⁴ [151/33/10-34/4](#)

⁵⁶⁵ [151/30/5-34/4](#)

⁵⁶⁶ [151/30/6-34/4](#)

⁵⁶⁷ [151/33/10-34/4](#)

⁵⁶⁸ [151/34/13-19](#)

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](#)

⁵⁷⁹ [153/9/7-18/7](#)

⁵⁸⁰ [153/17/16-18/7](#)

⁵⁸¹ [153/23/17-22](#)

⁵⁸² [152/27/14-19](#)

⁵⁸³ [152/27/1-3](#)

⁵⁸⁴ [174/30/3-19](#)

⁵⁸⁵ [174/30/8-33/7](#)

13.426 Sergeant Hare⁵⁸⁶ assisted Sorrell Leczkowski. PC McLaughlin gave CPR to Sorrell Leczkowski.⁵⁸⁷ Sergeant Anwyl and PC Hill also gave CPR to Sorrell Leczkowski.⁵⁸⁸ PC Hill was assisted by PC Michael Ball.⁵⁸⁹ PC Whittell used a defibrillator in an attempt to resuscitate Sorrell Leczkowski.⁵⁹⁰

13.427 PC McLaughlin checked on Wendy Fawell.⁵⁹¹

Evacuation of the casualties

13.428 Just before 23:00, NWS Consultant Paramedic Daniel Smith arrived at Manchester Victoria Railway Station.⁵⁹² Shortly afterwards, he designated himself the NWS Operational Commander.⁵⁹³ Patrick Ennis left the City Room⁵⁹⁴ and went to the station concourse, where he spoke to Daniel Smith and others from NWS.⁵⁹⁵ He then returned to the City Room at 23:05.⁵⁹⁶ 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.⁵⁹⁷ In evidence, Inspector Smith explained that, absent expert assistance and equipment: *"[M]y view was ... we need to get them out as quickly as possible and we'll use whatever we can to do that."*⁵⁹⁸ 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.⁵⁹⁹

13.430 At 23:12, having returned to the City Room, Patrick Ennis spoke to Inspector Smith.⁶⁰⁰ From that discussion, Inspector Smith learned that the Casualty Clearing Station was being set up on the station concourse.⁶⁰¹ 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.⁶⁰²

⁵⁸⁶ [153/76/14-77/17](#)

⁵⁸⁷ [153/74/9-75/2](#)

⁵⁸⁸ [153/76/18-77/17](#), [153/75/1-76/17](#)

⁵⁸⁹ [153/76/10-13](#)

⁵⁹⁰ [153/76/23-77/17](#)

⁵⁹¹ [152/19/13-20/18](#)

⁵⁹² [INQ035612/169](#)

⁵⁹³ [110/102/14-103/16](#)

⁵⁹⁴ [109/152/2-24](#)

⁵⁹⁵ [INQ035612/183](#)

⁵⁹⁶ [INQ035612/203](#)

⁵⁹⁷ [103/34/22-39/3](#)

⁵⁹⁸ [103/36/17-23](#)

⁵⁹⁹ [103/34/22-39/3](#)

⁶⁰⁰ [INQ035612/243](#)

⁶⁰¹ [103/30/10-32/1](#)

⁶⁰² [INQ041266](#)

- 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.⁶⁰³ On the evidence I heard, GMFRS possessed significant expertise in the extrication of casualties and considerable capacity in that regard.⁶⁰⁴ 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.
- 13.433** By 23:42, the last casualty had been evacuated from the City Room.⁶⁰⁵ Inspector Smith remained at the scene for many hours thereafter, eventually leaving after 04:00.⁶⁰⁶ 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

- 13.434** 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.
- 13.435** 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

⁶⁰³ [78/12/11-23](#), [103/38/5-39/3](#)

⁶⁰⁴ [119/78/23-79/11](#), [119/104/17-109/2](#)

⁶⁰⁵ [103/84/11-85/5](#)

⁶⁰⁶ [103/55/6-18](#)

⁶⁰⁷ [INQ007279/10](#)

- 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.⁶¹² CI Dexter took the role of Ground Assigned Tactical Firearms Commander on his arrival at the scene at 23:23.⁶¹³ 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 23rd May 2017, by Temporary Superintendent Hill.⁶¹⁴
- 13.439** There will usually be several Operational/Bronze Commanders.⁶¹⁵ Their role will be to organise separate resources to carry out the tactical plan.⁶¹⁶ On the night of the Attack, PC Richardson held operational command for the firearms officers at the Arena,⁶¹⁷ and Inspector Smith held operational command for the unarmed officers in the City Room.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.
- 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

⁶⁰⁸ [INQ007279/11-12](#)

⁶⁰⁹ [105/2/11-19](#)

⁶¹⁰ [INQ007279/11](#), [INQ034751/48](#)

⁶¹¹ [INQ007279/11](#)

⁶¹² [97/3/5-13](#), [97/109/21-24](#)

⁶¹³ [106/100/8-11](#)

⁶¹⁴ [104/60/21-61/1](#)

⁶¹⁵ [INQ007279/11](#)

⁶¹⁶ [INQ007279/21-22](#)

⁶¹⁷ [101/10/12-12/10](#)

⁶¹⁸ [102/141/14-18](#)

⁶¹⁹ [INQ034751/3](#)

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.⁶²³ 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.⁶²⁴ 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.⁶²⁵

⁶²⁰ [INQ034751/10](#)

⁶²¹ [148/95/21-24](#)

⁶²² [INQ034751/38](#), [INQ034751/39](#)

⁶²³ [104/1/11-25](#)

⁶²⁴ [104/2/9-16](#)

⁶²⁵ [104/2/1-21](#), [104/19/3-20/2](#)

- 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.⁶²⁶
- 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.
- 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 Superintendent Nawaz had experienced previously.⁶³⁰
- 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.⁶³¹ 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.⁶³² 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.

⁶²⁶ [104/3/24-4/18](#), [104/19/3-14](#)

⁶²⁷ [104/16/11-25](#)

⁶²⁸ [104/18/5-19/2](#)

⁶²⁹ [104/38/20-40/1](#)

⁶³⁰ [104/19/3-20/2](#)

⁶³¹ [97/4/11-7/10](#), [98/2/2-8](#)

⁶³² [INQ034751/39-40](#), [104/57/24-58/13](#)

13.452 Temporary Superintendent Nawaz himself recognised in evidence that his training and experience did not equip him to deal with a terrorist incident.⁶³³

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] [Is the upshot that Temporary Superintendent Nawaz] was not competent to perform the role that he was initially put into?

[ACC Ford] 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.

[Counsel to the Inquiry] 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 22nd to 23rd 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 22nd 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.⁶³⁵ Temporary Superintendent Nawaz then took steps to locate and

⁶³³ [104/98/1-99/19](#)

⁶³⁴ [105/21/20-22/13](#)

⁶³⁵ [INQ018839T/5-6](#)

print out a contingency plan for the Arena.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.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."⁶³⁸

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.⁶³⁹ 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.

⁶³⁶ [INQ007219, 104/29/15-30/12](#)

⁶³⁷ [INQ018855T/2-4](#)

⁶³⁸ [INQ018855T/2-4](#)

⁶³⁹ [104/60/21-61/1](#)

- 13.460** At 22:52, Temporary Superintendent Nawaz telephoned ACC Ford.⁶⁴⁰ 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.⁶⁴¹
- 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.
- 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

⁶⁴⁰ [104/39/5-45/14](#)

⁶⁴¹ [104/39/5-45/14](#)

⁶⁴² [104/45/25-49/10](#)

⁶⁴³ [INQ018840T](#)

⁶⁴⁴ [104/50/1-51/17](#)

⁶⁴⁵ [INQ018840T](#)

⁶⁴⁶ [104/52/15-54/8](#)

⁶⁴⁷ [INQ018616T/4](#)

⁶⁴⁸ [104/115/17-116/14](#)

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 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 Attack. He provided the list to the Inquiry Legal Team following the completion of his evidence.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: "*review the FWIN [Force Wide Incident Number]*" and "*locate Arena plan*".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: "*BTP to be made aware and attend*"; "*ARVs [Armed Response Vehicles] to scene*"; and "*unarmed Bronze Commander to the scene*".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. "*GMFRS to be notified and attend*" and "*Collocate, coordinate and communicate with partners*" are examples of these.⁶⁵⁷

⁶⁴⁹ [102/191/10-192/1](#)

⁶⁵⁰ [104/115/17-117/12](#)

⁶⁵¹ [104/10/2-15](#)

⁶⁵² [104/73/10-11](#)

⁶⁵³ [103/72/20-75/13](#)

⁶⁵⁴ [INQ041317](#)

⁶⁵⁵ [INQ041317](#)

⁶⁵⁶ [INQ041317](#)

⁶⁵⁷ [INQ041317](#)

- 13.470 If this document represents Temporary Superintendent Nawaz's coterminous 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 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 seconds⁶⁵⁹ and at 23:12 for just short of two minutes.⁶⁶⁰ As a result of those conversations, ACC Ford developed "a growing unease".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."⁶⁶²

- 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

⁶⁵⁸ [104/6/3-7/3](#), [104/79/16-82/16](#), [INQ034751/39-40](#)

⁶⁵⁹ [105/80/25-81/6](#)

⁶⁶⁰ [105/80/25-81/6](#)

⁶⁶¹ [105/84/3-17](#)

⁶⁶² [105/84/18-85/5](#)

⁶⁶³ [105/85/6-20](#)

- 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 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.⁶⁶⁸ 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.⁶⁶⁹ 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.⁶⁷⁰
- 13.479** On the night of the Attack, ACC Ford was rostered as duty Gold and duty Strategic Firearms Commander. She was a highly trained and experienced senior officer.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.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

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](#)

⁶⁶⁸ [105/84/3-86/5](#)

⁶⁶⁹ [INQ029177/9](#) at paragraph 40

⁶⁷⁰ [105/32/8-33/14](#)

⁶⁷¹ [105/32/8-33/14](#)

⁶⁷² [105/2/20-3/13](#), [105/24/21-27/25](#)

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.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 7th and 12th May 2017, only days before the Attack, she attended a specialist firearms commander course.⁶⁷⁴ The aim of that course was to prepare senior firearms commanders for the additional demands of the policing response to the most demanding operations, including counter-terrorism operations.⁶⁷⁵

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.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.⁶⁷⁷

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 28th May 2021.⁶⁷⁸ 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:

*"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."*⁶⁷⁹

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.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.⁶⁸¹ She expressed a serious concern in evidence that not all of those involved in the emergency response were as

⁶⁷³ [105/166/15-168/1](#)

⁶⁷⁴ [105/14/19-15/5](#), [105/25/25-27/25](#)

⁶⁷⁵ [105/27/8-28/12](#)

⁶⁷⁶ [105/29/8-30/11](#)

⁶⁷⁷ [105/221/20-226/24](#)

⁶⁷⁸ [INQ041475](#)

⁶⁷⁹ [INQ041475/7](#)

⁶⁸⁰ [191/85/21-88/12](#)

⁶⁸¹ [105/29/20-31/8](#)

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.⁶⁸² This was plainly a surprising and disturbing revelation for ACC Ford.

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.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.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.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 28th 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

⁶⁸² [105/19/5-22/13](#), [105/116/7-117/11](#)

⁶⁸³ [105/9/7-10/25](#)

⁶⁸⁴ [105/13/19-14/10](#)

⁶⁸⁵ [105/5/17-7/6](#)

⁶⁸⁶ [100/111/2-18](#)

⁶⁸⁷ [105/5/17-7/6](#), [106/1/17-4/12](#)

⁶⁸⁸ [105/4/11-5/25](#)

*courses, including the nationally accredited courses held by the College of Policing and for example, table tops, testing and exercising, and national exercises within Counter Terrorism policing.*⁶⁸⁹

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.⁶⁹⁰ 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 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.⁶⁹⁴

⁶⁸⁹ [INQ041475/2](#)

⁶⁹⁰ [105/34/1-39/16](#), [105/71/22-73/20](#)

⁶⁹¹ [105/32/13-22](#)

⁶⁹² [105/32/13-22](#), [105/39/17-42/8](#)

⁶⁹³ [105/39/17-42/8](#)

⁶⁹⁴ [105/42/9-45/24](#)

- 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 2015.⁶⁹⁵ 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 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.⁶⁹⁶ CI Dexter did so notwithstanding that his principal focus was on the armed assets in his role as Ground Assigned Tactical Firearms Commander.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.
- 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.⁶⁹⁸ Those steps would have been unnecessary if the system I recommend above had been in place. She then called the Chief Constable, Ian Hopkins,⁶⁹⁹ and the Head of the North West Counter Terrorist Unit, Chief Superintendent Russell Jackson, to let them know what was happening.⁷⁰⁰ Next, she called her staff officer⁷⁰¹ and Chief Superintendent John O'Hare,⁷⁰² a highly experienced firearms commander.

⁶⁹⁵ [105/175/5-176/21](#)

⁶⁹⁶ [97/3/5-13](#), [106/100/8-11](#)

⁶⁹⁷ [106/100/8-11](#)

⁶⁹⁸ [105/56/24-57/16](#)

⁶⁹⁹ [105/74/14-75/11](#)

⁷⁰⁰ [105/75/12-76/6](#)

⁷⁰¹ [105/76/7-77/11](#)

⁷⁰² [105/77/12-79/4](#)

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.⁷⁰³ 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 NWS, NWFC or GMFRS. If so, she may have discovered that the issue of Operation Plato zoning had not been addressed.⁷⁰⁴ 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.⁷⁰⁵ One of the recommendations that emerged was for the creation of a dedicated hotline by which senior staff within the command structure could contact the FDO.⁷⁰⁶ Unsurprisingly given her experience on the night, ACC Ford wholeheartedly supports that recommendation.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.⁷⁰⁸ In those calls, ACC Ford gained no additional information from the Night Silver.⁷⁰⁹

⁷⁰³ [105/79/12-80/3](#)

⁷⁰⁴ [99/45/2-46/6](#), [148/111/5-17](#)

⁷⁰⁵ [INQ000790/1](#)

⁷⁰⁶ [INQ000790/2](#)

⁷⁰⁷ [105/215/7-14](#)

⁷⁰⁸ [105/80/8-82/18](#)

⁷⁰⁹ [105/80/8-82/18](#)

As I explained earlier, she therefore began to develop a concern about the competence of Temporary Superintendent Nawaz.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.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.⁷¹²

Force Command Module

13.504 ACC Ford arrived at GMP HQ at about 23:15 and entered the Force Command Module at about 23:20.⁷¹³ 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.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:

*"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 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

⁷¹⁰ [105/83/18-85/20](#)

⁷¹¹ [105/82/19-837](#)

⁷¹² [106/152/2-13](#)

⁷¹³ [105/86/13-16](#)

⁷¹⁴ [105/166/15-168/1](#)

⁷¹⁵ [105/167/16-168/1](#)

⁷¹⁶ [105/91/2-21](#)

⁷¹⁷ [INQ025409/10-11](#)

18 minutes⁷¹⁸ and had spent time in the City Room.⁷¹⁹ He had good situational awareness. The call between ACC Ford and CI Dexter lasted for just over four minutes.⁷²⁰ 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.⁷²¹ 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*⁷²²

13.508 In evidence, ACC Ford accepted that this was somewhat general, but maintained that she considered the strategy was adequate.⁷²³ The Policing Experts were not critical of ACC Ford's strategy.⁷²⁴ 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*

⁷¹⁸ [INQ035612/302](#)

⁷¹⁹ [INQ035612/310](#), [INQ035612/332](#)

⁷²⁰ [INQ025409/10-11](#)

⁷²¹ [INQ025409/10-11](#)

⁷²² [INQ029053/6](#), [105/180/25-181/5](#)

⁷²³ [105/181/13-182/23](#)

⁷²⁴ [148/109/3-6](#)

management” of the Attack.⁷²⁵ 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.⁷²⁶ 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.⁷²⁷ 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.*⁷²⁸

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.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

⁷²⁵ [105/179/2-18](#)

⁷²⁶ [105/179/13-180/13](#)

⁷²⁷ [148/109/3-6, INQ035309/249](#)

⁷²⁸ [105/180/15-24](#)

⁷²⁹ [105/133/21-134/17](#)

so.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.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.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.⁷³³ As ACC Ford correctly acknowledged, she had an obligation to review the declaration.⁷³⁴ That necessarily involved a review of zoning. Annemarie Rooney, the NWS 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.⁷³⁵
- 13.515** ACC Ford proceeded on the basis that others knew that Operation Plato had been declared and were addressing that issue.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.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 in numbers were needed in the City Room.⁷³⁸ ACC Ford was unaware of this, and no one seems to have drawn it to her attention.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: "*We've got no fire.*"⁷⁴⁰ She accepted in evidence that this was significant information but explained that she had not registered it given everything that was going on.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.⁷⁴²

⁷³⁰ [105/133/21-134/17](#)

⁷³¹ [105/133/21-134/17](#)

⁷³² [105/40/17-41/12](#)

⁷³³ [105/46/24-47/16](#)

⁷³⁴ [105/69/4-70/7](#)

⁷³⁵ [105/69/4-70/7](#), [105/100/21-102/15](#)

⁷³⁶ [105/100/21-102/15](#)

⁷³⁷ [INQ025409/36](#), [INQ025409/37](#), [105/195/11-196/2](#)

⁷³⁸ [76/78/10-79/12](#), [103/2/11-3/17](#), [INQ018644T/9](#)

⁷³⁹ [105/172/24-173/19](#)

⁷⁴⁰ [INQ025409/11](#)

⁷⁴¹ [105/161/2-166/9](#)

⁷⁴² [105/161/13-166/9](#)

- 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.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.⁷⁴⁴ It was understandable that she considered that others in the command structure 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.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 3rd November 2016.⁷⁴⁶ 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.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.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

⁷⁴³ [119/104/17-108/10](#)

⁷⁴⁴ [105/161/13-166/9](#)

⁷⁴⁵ [105/149/16-152/15](#)

⁷⁴⁶ [105/143/24-152/15](#)

⁷⁴⁷ [100/112/6-23](#), [105/183/15-188/17](#)

⁷⁴⁸ [100/131/18-132/6](#), [105/183/15-188/17](#)

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](#)

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.

13.520 Fifth, by the time ACC Ford arrived at GMP HQ, no common RVP had been established, nor had an FCP been identified.⁷⁵³ These steps are vital to joint working. ACC Ford failed to establish that these steps had not been taken.⁷⁵⁴ 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 co-ordination 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 12.⁷⁵⁵ 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."*⁷⁵⁶

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.⁷⁵⁷ 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.⁷⁵⁸

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".⁷⁵⁹ 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.⁷⁶⁰ That was, however, no substitute for a Strategic Co-ordinating Group. An early meeting of the Strategic Co-ordinating Group should have

⁷⁵³ [105/218/15-220/2](#)

⁷⁵⁴ [105/218/15-220/2](#)

⁷⁵⁵ [105/206/4-211/8](#)

⁷⁵⁶ [105/206/15-24](#)

⁷⁵⁷ [105/206/4-211/8](#)

⁷⁵⁸ [105/206/4-211/8](#)

⁷⁵⁹ [105/206/4-207/19](#), [INQ040516/29](#)

⁷⁶⁰ [105/206/4-207/19](#)

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."⁷⁶²

⁷⁶¹ [105/103/2-104/2](#)

⁷⁶² [106/18/10-19](#)

- 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.⁷⁶³ It was, as she put it, *"my responsibility to make sure that the response is as good as it can be"*.⁷⁶⁴ 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.
- 13.527** 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.⁷⁶⁵ 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.
- 13.528** 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.

⁷⁶³ [105/139/7-12](#)

⁷⁶⁴ [106/49/21-50/7](#)

⁷⁶⁵ [105/32/6-14](#)

⁷⁶⁶ [106/100/8-11](#)

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.*
- 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

13.532 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."*⁷⁶⁹

13.533 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.

13.534 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.⁷⁷⁰ Because JOPs 3 made an on-scene commander responsible for

⁷⁶⁷ [INQ016688/1](#)

⁷⁶⁸ [INQ016688/16](#), [INQ016688/17](#) (emphasis added)

⁷⁶⁹ [INQ008372/4](#) (emphasis added)

⁷⁷⁰ [105/94/23-95/7](#), [105/112/1-113/12](#), [106/82/9-20](#), [INQ008372/5](#)

decision-making on the deployment of police assets at the scene, without distinguishing 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.⁷⁷¹ 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.⁷⁷²

- 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.⁷⁷³ 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,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.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 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

⁷⁷¹ [INQ008372/5](#)

⁷⁷² [105/109/21-115/5](#)

⁷⁷³ [106/133/5-135/2](#), [107/77/21-79/8](#), [107/125/23-127/22](#)

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

⁷⁷⁵ [106/133/5-135/2](#), [107/125/23-127/22](#)

⁷⁷⁶ [106/132/14-134/12](#)

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 22nd 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 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.”*⁷⁷⁹

- 13.539** In my view, CI 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.

⁷⁷⁷ [106/133/1-24](#)

⁷⁷⁸ [106/143/11-13](#)

⁷⁷⁹ [107/87/3-14](#)

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.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.⁷⁸¹ By May 2017, CI Dexter was one of GMP's most experienced firearms commanders.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.⁷⁸³ 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.⁷⁸⁴ In that call, PC Winyard explained that there had been an explosion at the Arena and that Operation Plato had been declared.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 22:41.⁷⁸⁶ This explains what would otherwise be an odd feature of the evidence.

⁷⁸⁰ [106/100/12-126/2](#)

⁷⁸¹ [106/110/8-15](#)

⁷⁸² [106/110/22-111/23](#)

⁷⁸³ [106/112/15-113/19](#)

⁷⁸⁴ [106/126/18-127/11](#)

⁷⁸⁵ [106/129/6-10](#)

⁷⁸⁶ [INQ024445T/1](#)

- 13.546** CI Dexter was not on duty on 22nd May 2017 and was at home asleep when PC Winyard telephoned.⁷⁸⁷ CI Dexter explained that the Specialist Operations Branch, of which he was a senior member, is at the sharp end of policing.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 22nd May 2017.⁷⁸⁹
- 13.547** CI Dexter responded to PC Winyard's call by deploying to the Arena.⁷⁹⁰ He took steps to inform the command structure of what he was doing.⁷⁹¹ 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.⁷⁹² 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.⁷⁹³ Even though I am satisfied it did not cause problems on 22nd May 2017, such an approach is capable of causing difficulties during the response to an emergency. CI Dexter acknowledged that this was so.⁷⁹⁴ 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.⁷⁹⁵ At 22:51, he made contact with the FDO by radio asking whether a Ground Assigned Tactical Firearms Commander had

⁷⁸⁷ [106/126/10-17](#)

⁷⁸⁸ [106/128/18-23](#)

⁷⁸⁹ [106/126/21-130/14](#), [107/113/22-115/25](#)

⁷⁹⁰ [106/129/11-130/8](#)

⁷⁹¹ [106/152/2-13](#)

⁷⁹² [108/2/3-6](#)

⁷⁹³ [147/29/22-31/6](#)

⁷⁹⁴ [106/154/1-24](#)

⁷⁹⁵ [106/129/11-16](#)

been assigned.⁷⁹⁶ 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"*.⁷⁹⁷ 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.⁷⁹⁸ 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.⁸⁰² At some stage that night, a Counter Terrorism Police Operations Room⁸⁰³ 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.⁸⁰⁴ 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.

⁷⁹⁶ [106/145/18-146/8](#)

⁷⁹⁷ [106/146/16](#)

⁷⁹⁸ [106/146/9-147/17](#)

⁷⁹⁹ [106/146/9-147/17](#)

⁸⁰⁰ [106/149/10-14](#)

⁸⁰¹ [106/149/15-151/18](#)

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](#)

- 13.553** While travelling in his car, CI Dexter was involved in further radio communication relevant to the Attack.⁸⁰⁵ He also took steps to liaise with military assets.⁸⁰⁶ At 23:13, he telephoned ACC Ford, the Strategic/Gold Commander and the Strategic Firearms Commander.⁸⁰⁷ He was unable to get through and left her a voicemail message.⁸⁰⁸ She called him back at 23:41.⁸⁰⁹
- 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.⁸¹⁰ 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.⁸¹¹ On reaching Station Approach, he wanted to find the Operational Firearms Commander and therefore headed straight inside the railway station.⁸¹² He went to the City Room, entering at 23:25.⁸¹³ He then spoke to Inspector Smith.⁸¹⁴ On his first visit to the City Room, CI Dexter remained for five minutes, leaving at 23:30.⁸¹⁵
- 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.⁸¹⁶ This demonstrates that he was, as he told me, concerned about a multi-site attack.

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](#)

⁸¹⁰ [106/152/14-25](#)

⁸¹¹ [INQ035612/302](#)

⁸¹² [106/157/20-158/23](#)

⁸¹³ [INQ035612/310](#)

⁸¹⁴ [INQ035612/315](#), [INQ035612/317](#)

⁸¹⁵ [INQ035612/335](#)

⁸¹⁶ [106/162/13-164/6](#)

- 13.558** CI Dexter owned a Dictaphone because of a previous role as a crisis negotiator.⁸¹⁷ He had sensibly brought it to the scene. At 23:27, while still in the City Room, CI Dexter activated this device.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”.⁸¹⁹
- 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

⁸¹⁷ [106/166/12-167/1](#)

⁸¹⁸ [106/166/12-167/8](#)

⁸¹⁹ [106/167/21-168/1](#)

⁸²⁰ [106/168/18/169/1](#)

⁸²¹ [INQ040657/1-2](#)

⁸²² [INQ040657/3-4](#)

- 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.⁸²³ His recollection was that he considered the City Room to be warm in terms of Operation Plato zoning.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.⁸²⁵ There existed what PC Richardson described as a “*spiky bubble*”.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 public present.⁸²⁷ 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.⁸²⁸ 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.⁸²⁹ 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 emergency services.⁸³⁰ As I have explained already, the failure of GMP to declare a Major Incident was a significant omission.

⁸²³ [106/175/6-13](#)

⁸²⁴ [106/175/14-176/11](#)

⁸²⁵ [102/105/10-106/6](#)

⁸²⁶ [101/126/4-12](#)

⁸²⁷ [106/177/24-178/8](#)

⁸²⁸ [106/180/16-25](#)

⁸²⁹ [106/181/6-23](#)

⁸³⁰ [106/181/24-184/23](#)

- 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.⁸³¹ 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 NWS 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 replied: *"Yes."*⁸³⁷ In evidence, CI Dexter explained that in this short conversation he was referring to the area of the Casualty Clearing Station.⁸³⁸ It follows that by this stage, at 23:32, CI 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

⁸³¹ [106/181/19-23](#)

⁸³² [INQ035612/336](#)

⁸³³ [INQ035612/337](#)

⁸³⁴ [107/2/14-23](#)

⁸³⁵ [INQ040657/4](#)

⁸³⁶ [INQ040657/5](#)

⁸³⁷ [INQ040657/5](#) [the transcript wrongly attributes the speech of PC Richardson to PC Moore]

⁸³⁸ [107/6/9-20](#)

Policing Experts⁸³⁹ and also of CI Thomas of CTPHQ.⁸⁴⁰ CI 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, CI 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.⁸⁴¹ He explained that he did not consider his assessment would affect deployments within the City Room and that the issue of Operation Plato zoning was therefore not "*massively relevant or critical at the time*".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.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,⁸⁴⁴ and Saffie-Rose Roussos, who by-passed the Casualty Clearing Station, had arrived at hospital nine minutes earlier.⁸⁴⁵ Of the remaining ten, all had arrived in the Casualty Clearing Station by 23:42.⁸⁴⁶ Of those ten, two were already being 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.

⁸³⁹ [147/105/6-23](#)

⁸⁴⁰ [141/70/23-71/21](#)

⁸⁴¹ [106/176/15-177/5](#)

⁸⁴² [107/8/12-9/5](#)

⁸⁴³ [107/8/18-9/15](#)

⁸⁴⁴ [INQ041266](#)

⁸⁴⁵ [174/92/3-9](#)

⁸⁴⁶ [INQ041266](#)

⁸⁴⁷ [INQ041266](#), [106/89/5-19](#)

⁸⁴⁸ [119/78/23-79/11](#), [119/104/17-109/2](#)

- 13.576** There were, of course, NWS 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 NWS Operational Commander, Daniel Smith, of his Operation Plato zoning decision at or shortly after 23:32, would Daniel Smith have committed additional NWS resources forward? Second, if Daniel Smith had committed additional NWS 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 NWS 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 NWS 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 NWS 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 NWS 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 NWS 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 22:50.⁸⁴⁹ Indeed, the first evacuation of any of the 38 did not commence until 23:02,⁸⁵⁰ and that person did not arrive in the Casualty Clearing Station until 23:07.⁸⁵¹
- 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 23:24.⁸⁵² 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 22:58.⁸⁵³ She transferred into an ambulance at 23:06⁸⁵⁴ before travelling on to hospital.⁸⁵⁵ 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,

⁸⁴⁹ [INQ041266](#), [110/172/9-18](#)

⁸⁵⁰ [INQ035612/187](#), [110/172/9-18](#)

⁸⁵¹ [110/172/9-18](#), [INQ041266](#)

⁸⁵² [158/54/9-16](#)

⁸⁵³ [174/39/2-11](#)

⁸⁵⁴ [174/65/6-16](#)

⁸⁵⁵ [174/92/6-9](#)

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*".⁸⁶² CI 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.⁸⁶³

13.588 My impression was that, in making these deployments, CI Dexter was seeking to assist the FDO because he knew of the pressure that he was under. However, CI 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.

⁸⁵⁶ [107/10/22-11/11](#)

⁸⁵⁷ [107/11/1-12/25](#), [107/27/22-28/5](#)

⁸⁵⁸ [107/11/1-12/25](#)

⁸⁵⁹ [107/2/24-4/10](#), [107/11/1-14/4](#)

⁸⁶⁰ [107/61/9-62/21](#)

⁸⁶¹ [107/13/4-15/24](#)

⁸⁶² [INQ024325/37](#)

⁸⁶³ [107/13/4-15/24](#), [107/32/8-17](#)

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, CI 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.⁸⁶⁴ 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.⁸⁶⁵ He then gave further instructions in relation to the broader search.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.⁸⁶⁷
- 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.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.
- 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 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.⁸⁶⁹ In their discussion, CI Dexter provided her with an update. It was in this conversation that he said: "*We've got no fire.*"⁸⁷⁰ CI Dexter confirmed, in evidence, that he was referring to the fact that GMFRS was not at the scene.⁸⁷¹ In the Dictaphone recording, after CI Dexter said this, there is a short

⁸⁶⁴ [106/169/6-173/2](#)

⁸⁶⁵ [INQ040657/8-9](#)

⁸⁶⁶ [106/172/7-176/5](#)

⁸⁶⁷ [INQ040657/9](#)

⁸⁶⁸ [106/133/5-134/123](#)

⁸⁶⁹ [INQ040657/10-11](#)

⁸⁷⁰ [INQ040657/11](#)

⁸⁷¹ [107/22/4-24](#)

pause, following which CI Dexter said: “[Y]ou might as well.”⁸⁷² In evidence, his understanding of this was that, in the pause, ACC Ford indicated that she would put right the absence of GMFRS.⁸⁷³ ACC Ford explained, conversely, that she simply had not registered the reference to fire and so did not accept this interpretation.⁸⁷⁴

- 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 with Police Dog Mojo.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.⁸⁷⁹ CI Dexter then left Station Approach⁸⁸⁰ to return to the City Room, arriving there at 23:47.⁸⁸¹ He remained in that location until 00:15.⁸⁸²
- 13.596** Once in the City Room, CI Dexter liaised with Inspector Smith and others.⁸⁸³ They ascertained that no living casualty remained in the City Room.⁸⁸⁴ He ensured that the City Room remained secure and that the cordon was in place around Manchester Victoria Railway Station.⁸⁸⁵ He again became involved in the deployment of firearms officers to Manchester Piccadilly Railway Station.⁸⁸⁶

⁸⁷² [107/23/7-13](#)

⁸⁷³ [107/22/25-23/25](#)

⁸⁷⁴ [105/228/12-229/24](#)

⁸⁷⁵ [107/24/9-25/19](#)

⁸⁷⁶ [INQ041266](#), [110/172/9-18](#)

⁸⁷⁷ [107/26/5-16](#)

⁸⁷⁸ [INQ040657/12](#), [107/26/7-26/24](#)

⁸⁷⁹ [INQ040657/12](#), [107/26/7-24](#)

⁸⁸⁰ [INQ035612/388](#)

⁸⁸¹ [INQ035612/392](#), [107/29/2-16](#)

⁸⁸² [INQ035612/432](#), [107/29/2-16](#)

⁸⁸³ [107/29/2-23](#)

⁸⁸⁴ [107/29/2-23](#)

⁸⁸⁵ [INQ040657/13](#)

⁸⁸⁶ [INQ040657/12-17](#)

13.597 At 23:52, Inspector Sexton made a telephone call to CI Dexter.⁸⁸⁷ The conversation is captured on the Dictaphone recording of each,⁸⁸⁸ and it is therefore possible to understand the whole of it. 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."*⁸⁸⁹ It was agreed that CI Dexter would *"take command at Victoria and the MEN"*⁸⁹⁰ and Inspector Sexton would speak to Temporary CI Buckle about command at Manchester Piccadilly Railway Station.⁸⁹¹ 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.⁸⁹² 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.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 system⁸⁹⁴ and to the FDO in relation to the deployment of sensitive assets.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.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

⁸⁸⁷ [INQ040657/18](#)

⁸⁸⁸ [INQ024325/37](#), [INQ040657/18](#)

⁸⁸⁹ [INQ024325/37](#)

⁸⁹⁰ [INQ040657/18](#)

⁸⁹¹ [INQ040657/18](#)

⁸⁹² [INQ040657/18-20](#)

⁸⁹³ [INQ040657/24-33](#)

⁸⁹⁴ [INQ040657/26](#)

⁸⁹⁵ [INQ040657/26-27](#)

⁸⁹⁶ [INQ040657/27-29](#)

command the unarmed assets on what he described as *“the outer perimeter”*.⁸⁹⁷ This conversation, along with others that night, indicates that CI Dexter regarded himself as responsible for the armed assets and wanted support in relation to the unarmed assets.

13.601 CI 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.⁸⁹⁸

13.602 At 00:15, CI Dexter left the City Room.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:

*“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 ...”*⁹⁰⁰

13.603 In his evidence, CI Dexter explained that he had developed an understanding that the FCP was on Station Approach.⁹⁰¹ In a sense, that is what Station Approach was to become because that 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

⁸⁹⁷ [INQ040657/29-30](#)

⁸⁹⁸ [INQ040657/29-30](#)

⁸⁹⁹ [107/29/7-16](#)

⁹⁰⁰ [INQ040657/32](#)

⁹⁰¹ [106/160/9-22](#)

⁹⁰² [INQ040657/33](#)

⁹⁰³ [INQ035612/435](#), [INQ040657/33](#)

- 13.606** Outside, CI Dexter was asked by Stephen Hynes if he was in charge, and he answered: *"I am from the firearms point of view."*⁹⁰⁴ 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.⁹⁰⁵ 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."*⁹⁰⁶ Stephen Hynes pressed him and CI Dexter then said: *"I would declare this cold for now."*⁹⁰⁷
- 13.608** In evidence, CI Dexter acknowledged that this represented, on his part, *"a rather vague or non-technical approach to zoning"*.⁹⁰⁸ 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.⁹⁰⁹
- 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, CI Dexter spoke to PC Lee Moore and again to ACC Ford.⁹¹⁰ In his discussions with them, CI Dexter's references to Operation Plato zoning were also vague.⁹¹¹

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.⁹¹² In evidence, CI Dexter described how this report hit him hard. He explained the fear it generated that a Paris-style attack was under way.⁹¹³ Coincidentally, a CTSFO team from outside Greater Manchester contacted him at 00:25, and CI Dexter was therefore able to deploy them to Oldham.⁹¹⁴ The report was later discovered to be false.

⁹⁰⁴ [INQ040657/33](#)

⁹⁰⁵ [INQ040657/33](#)

⁹⁰⁶ [INQ040657/33](#)

⁹⁰⁷ [INQ040657/33-34](#)

⁹⁰⁸ [107/56/8-18](#)

⁹⁰⁹ [107/56/8-60/5](#)

⁹¹⁰ [INQ040657/38](#)

⁹¹¹ [INQ040657/38](#), [107/58/22-61/2](#)

⁹¹² [INQ040657/39](#)

⁹¹³ [107/61/13-62/21](#)

⁹¹⁴ [INQ040657/40](#), [107/62/8-64/1](#)

- 13.612** In the ten minutes that followed this report, CI Dexter was heavily involved in managing the events at Oldham. Then, at 00:37, he was spoken to again by Stephen Hynes.⁹¹⁵ Stephen Hynes continued to be concerned about the issue of safety. CI Dexter explained that the Casualty Clearing Station was “*getting near to cold*”.⁹¹⁶ 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.⁹¹⁷ 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.⁹¹⁸ He then briefed a group of firearms officers on the Arena concourse⁹¹⁹ before returning to the City Room⁹²⁰ and then going again to Station Approach, where he spoke to Superintendent Thompson, Temporary 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

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](#)

⁹²¹ [INQ040657/62-67](#)

⁹²² [INQ040657/67-71](#)

⁹²³ [INQ040657/67-71](#)

⁹²⁴ [INQ040657/68-69](#)

⁹²⁵ [INQ040657/69-70](#)

⁹²⁶ [107/93/12-97/18](#)

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 03:30.⁹²⁷ Before leaving, he updated NWS 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.⁹²⁸

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.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.

⁹²⁷ [107/74/18-75/8](#)

⁹²⁸ [107/75/2-22](#)

⁹²⁹ [107/123/16-124/4](#)

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 22nd 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

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](#)

if demand in one part of the country requires CTSFO resources from another police service.⁹³⁵ Inspector David Murtagh from 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 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

⁹³⁵ [INQ029536/2](#) at paragraph 11

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](#)

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](#)

be deployed.⁹⁴⁸ 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.⁹⁴⁹

- 13.629** 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.⁹⁵⁰
- 13.630** Assistant Commissioner Basu noted: *"If we all relied on one individual doing all of those actions that would be too slow."*⁹⁵¹ 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.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.⁹⁵³

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.⁹⁵⁴ He was told that it had been. He shared this information with CI Thomas.⁹⁵⁵ Assistant Commissioner Basu was informed 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

⁹⁴⁸ [59/63/2-20](#)

⁹⁴⁹ [60/95/4-11](#)

⁹⁵⁰ [59/62/18-63/20](#)

⁹⁵¹ [59/63/8-9](#)

⁹⁵² [60/94/2-8](#), [60/93/7-13](#)

⁹⁵³ [59/59/5-60/18](#)

⁹⁵⁴ [INQ029536/2](#) at paragraph 16

⁹⁵⁵ [60/96/5-7](#)

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.⁹⁵⁶

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.⁹⁵⁷ 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.⁹⁵⁸

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.⁹⁵⁹ 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.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.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 23rd 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 being treated as terrorism and that CTPHQ had assumed national strategic command.⁹⁶² This declaration can only be made by the Senior National Co-ordinator.⁹⁶³

⁹⁵⁶ [59/66/2-67/21](#)

⁹⁵⁷ [60/96/8-12](#)

⁹⁵⁸ [60/96/18-97/3](#)

⁹⁵⁹ [INQ040526/25](#), [105/141/18-24](#), [107/45/9-46/11](#), [INQ040657/29](#), [107/39/21-40/12](#)

⁹⁶⁰ [INQ029536/3](#) at paragraphs 21 and 23

⁹⁶¹ [INQ029536/4](#) at paragraphs 25-26

⁹⁶² [59/70/25-71/20](#)

⁹⁶³ [59/29/15-24](#)

- 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 23rd May 2017. He said that it was clear that armed support from the CTSFO network would be required over the coming days.⁹⁶⁴ He spoke to the National Police Co-ordination Centre to ensure that there was adequate Armed Response Vehicle support available to GMP.⁹⁶⁵
- 13.640** CI Thomas remained at the temporary operations room at the hotel until the late afternoon on 23rd 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.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"*⁹⁶⁷ that a number of people who would have been involved in a response to a terrorist incident were all located in one place.⁹⁶⁸ 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.

⁹⁶⁴ [60/98/3-13](#)

⁹⁶⁵ [60/98/25-99/5](#)

⁹⁶⁶ [60/100/11-101/2](#)

⁹⁶⁷ [INQ029536/5](#) at paragraph 42

⁹⁶⁸ [INQ029536/5](#) at paragraph 42

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 (NIOs) 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."*¹ 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"*.² He went on to say: *"[T]here's people everywhere, blood everywhere."*³ The call ended, after just over two and a half minutes, with the caller saying he needed to find his daughter.⁴

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.⁵

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.⁶ 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?"*⁷ NWAS Control replied: *"[W]e're 10 minutes away – we've got quite a lot of ambulances coming."*⁸ 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*

¹ [INQ015293T](#)

² [INQ015293T](#)

³ [INQ015293T](#)

⁴ [INQ015293T](#)

⁵ [INQ040952](#)

⁶ [INQ015140T/1-2](#)

⁷ [INQ015140T/2](#)

⁸ [INQ015140T/2](#)

out for crews to clear if they can.”⁹ As the call was concluding, GMP Control stated: “[W]e’ve got an officer on scene ... they’re just updating literally every few minutes.”¹⁰

- 14.16** This call covered the period 22:38 to 22:44.¹¹ 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).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?”¹³ NWAS Control 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.”¹⁴
- 14.20** On 22nd 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.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.

⁹ [INQ015140T/3](#)

¹⁰ [INQ015140T/3](#)

¹¹ [INQ015140T/1](#)

¹² [INQ001218](#)

¹³ [INQ015106T, 76/34/18-35/17](#)

¹⁴ [INQ015106T](#)

¹⁵ [INQ015361T](#)

- 14.21 At 22:38, Patrick Ennis contacted NWS Control again. He said: *"I'm just on my way ... I'm just going to follow the police."*¹⁶ He also requested: *"[J]ust see if anybody in Manchester has spoken to ... Silver."*¹⁷ "Silver" was a reference to the on-call NWS Tactical Commander.
- 14.22 As Patrick Ennis was confirming that he was on his way to the Arena, NWS Control called Annemarie Rooney. Annemarie Rooney was the on-call NWS 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 NWS Control would contact the on-call Operational Commanders: Derek Poland and Matthew Calderbank.²¹ Nicola Pratt can be heard asking for someone in NWS Control to contact both of these men.²² It was identified that the on-call NWS 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 report at 22:32 that *"a bomb"*²⁶ had detonated, it would have been better if the need for HART had been identified before 22:39 by NWS. 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. NWS 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, NWS Control called the GM HART crew.²⁷

¹⁶ [INQ015338T](#)

¹⁷ [INQ015338T](#)

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](#)

²⁶ [INQ015293T](#)

²⁷ [INQ040616/2-3](#)

- 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.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.³⁰

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"*.³¹ 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."*³²
- 14.32 BTP Control informed NWAS Control: *"[I]t has been declared a major incident by [BTP] ... we are working on getting more officers to the scene obviously."*³³ BTP Control told NWAS Control: *"[F]ire have been made aware etc."*³⁴

²⁸ [INQ015336T](#), [INQ015337T](#)

²⁹ [110/80/10-83/5](#)

³⁰ [115/14/16-18/12](#)

³¹ [INQ015145T](#)

³² [INQ015145T](#)

³³ [INQ015145T](#)

³⁴ [INQ015145T](#)

- 14.33** The call continued, with NWAS Control saying: *"[W]e [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 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.⁴⁴ I will return to Ambulance A344 at paragraphs 14.189 to 14.191.

³⁵ [INQ015145T](#)

³⁶ [INQ015145T](#)

³⁷ [INQ015145T](#)

³⁸ [INQ015056T](#)

³⁹ [175/106/4-7](#)

⁴⁰ [INQ015094T](#)

⁴¹ [INQ015037T](#)

⁴² [175/111/20-112/14](#)

⁴³ [175/111/20-112/14](#)

⁴⁴ [175/113/3-114/23](#)

Major Incident declaration (22:46)

- 14.39** At 22:45, a call within NWS 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?”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.”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, NWS 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. NWS records indicate that, by 23:00, six hospitals had been informed of the Major Incident declaration. More hospitals were notified in the minutes following 23:00.⁴⁷ NWS 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 NWS 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 23rd May 2017.⁴⁸ GMFRS and NWFC should also have declared a Major Incident.

Notification of Tactical Advisors/NILOs (22:49)

- 14.43** At 22:49, NWS Control contacted Jonathan Butler. Jonathan Butler was one of two on-call Tactical Advisors/NILOs.⁴⁹ In accordance with the guidance provided by the National Ambulance Resilience Unit (NARU), NWS operated a system in which the roles of Tactical Advisor and NILO were combined.⁵⁰
- 14.44** In the telephone call, NWS Control gave Jonathan Butler a brief situation report. He said he would contact the other on-call Tactical Advisor/NILO, Stephen Taylor.⁵¹ I shall return to the role the NWS Tactical Advisors/NILOs played on the night of the Attack below, at paragraphs 14.523 to 14.574.

⁴⁵ [INQ015335T](#)

⁴⁶ [INQ015335T](#)

⁴⁷ [INQ041691/1-5](#)

⁴⁸ [INQ022399/11](#)

⁴⁹ [INQ015355T](#)

⁵⁰ [116/31/5-21](#)

⁵¹ [INQ015355T](#)

Rendezvous Point

- 14.45 At an early stage of NWS's response, it was decided that Manchester Central Fire Station would be used by NWS as an RVP. NWS Control informed BTP Control of this at 22:43.⁵² 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 NWS Control to inform BTP Control where NWS 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 NWS 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 NWS Control and Patrick Ennis (22:46)

- 14.48 At 22:46, NWS 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."*⁵³ He said he could see six to eight casualties whom he described as walking wounded.⁵⁴ 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"*.⁵⁵ 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 NWS 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 NWS Control: *"[W]e need NWS to be at ... Hunts Bank, by Victoria Station will be ... the best access for the moment, we can*

⁵² [INQ015145T](#)

⁵³ [INQ015047T](#)

⁵⁴ [INQ015047T](#)

⁵⁵ [INQ015047T](#) [Note: Victoria Station is incorrectly transcribed as "Gurriers Station" in the transcript]

⁵⁶ [INQ035612/128](#)

⁵⁷ [INQ035612/130](#)

*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 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.
- 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]."*⁶⁴ 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.

⁵⁸ [INQ035612/132](#), [INQ032872T](#)

⁵⁹ [110/81/12-14](#)

⁶⁰ [INQ015056T](#)

⁶¹ [INQ015056T](#)

⁶² [INQ015056T](#)

⁶³ [INQ015056T](#)

⁶⁴ [INQ041728/29](#)

- 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. 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.⁶⁵ These were ambulances that could immediately have been dispatched to Hunts Bank in accordance with Patrick Ennis's request. 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 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.

⁶⁵ [INQ040368/1-2](#)

⁶⁶ [INQ040368/1](#)

⁶⁷ [INQ015139T/1](#)

⁶⁸ [INQ015139T/1](#), [INQ015139T/2](#)

14.63 NWAS Control did start to mobilise individual resources to Hunts Bank shortly after the call with GMP Control concluded.⁶⁹ 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.⁷⁰

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.”⁷¹

Contact between NWAS Control and Patrick Ennis (22:54)

14.65 Patrick Ennis entered the City Room at 22:53.⁷² 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.”⁷³ NWAS Control replied: “[E]veryone is now making their way to Hunts Bank.”⁷⁴

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”.⁷⁵

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.”⁷⁶

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

⁶⁹ [INQ015061T](#), [INQ032874T](#), [INQ015079T](#)

⁷⁰ [INQ015093T](#)

⁷¹ [INQ028932/36-38](#)

⁷² [INQ035612/141-143](#), [109/119/16-120/8](#)

⁷³ [INQ015070T](#)

⁷⁴ [INQ015070T](#)

⁷⁵ [INQ015041T](#)

⁷⁶ [INQ015052T](#)

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."*⁷⁷

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."*⁷⁸

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."*⁷⁹

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."*⁸⁰ This should have resulted in the immediate departure of the five ambulances that, by then, were at Manchester Central Fire Station. It did not.

⁷⁷ [INQ015381T](#)

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 NWS Control and Joanne Hedges (23:03)

- 14.75 At 23:03, Senior Paramedic Joanne Hedges contacted NWS 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, NWS 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 NWS 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 NWS 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 mobilising instruction by NWS 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 NWS Control. This was reasonable advice for 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."*⁸⁹

⁸¹ [INQ040368/1](#)

⁸² [INQ023919T](#)

⁸³ [INQ023919T](#)

⁸⁴ [INQ023919T](#)

⁸⁵ [80/28/25-29/7](#)

⁸⁶ [80/18/11-20](#)

⁸⁷ [81/84/15-88/6](#)

⁸⁸ [INQ015353T](#)

⁸⁹ [INQ015353T](#)

- 14.80** Annemarie Rooney also said: “[W]e need to find out who’s the AITC.”⁹⁰ AITC stands for ‘Ambulance Intervention Team Commander’. The Ambulance Intervention Team was NWS’s specialist response team for Operation Plato. It comprised HART operatives and other employees drawn from NWS’s wider operational staff.⁹¹
- 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?”⁹² He asked if the police had “declared it ... a marauding terrorist incident”.⁹³ She replied: “I don’t know, I will speak to the Force Duty Officer now.”⁹⁴
- 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 officer.”⁹⁵ 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?”⁹⁶ Annemarie Rooney replied: “Right.”⁹⁷
- 14.83** 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?”⁹⁸ Annemarie Rooney replied: “[Y]es.” The two discussed who that might be. The call ended with NWS Control saying: “I’ll find one.”⁹⁹
- 14.84** 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, NWS’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 I consider the Tactical Advisors/NILOs at paragraphs 14.523 to 14.574.
- 14.85** I am satisfied that NWS 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 NWS Control had at that time.

⁹⁰ [INQ015353T](#)

⁹¹ [INQ026738/34](#)

⁹² [INQ015339T](#)

⁹³ [INQ015339T](#)

⁹⁴ [INQ015339T](#)

⁹⁵ [INQ015381T](#)

⁹⁶ [INQ015381T](#)

⁹⁷ [INQ015381T](#)

⁹⁸ [INQ015381T](#)

⁹⁹ [INQ015381T](#)

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 22:50.¹⁰⁰ He headed straight for the City Room. He entered the City Room for the first time at 22:53.¹⁰¹ He then left the City Room at 22:59 to return to the station concourse.¹⁰²
- 14.87** At 22:58, the first ambulance arrived on Station Approach.¹⁰³ One minute later, Daniel Smith approached the War Memorial entrance with Dr Michael Daley. They entered the Victoria Exchange Complex seconds later.¹⁰⁴ Following almost immediately behind Daniel Smith and Dr Daley were two paramedics and a student paramedic: Martyn Nealon, Callum Gill and Leigh-Sa Smith.¹⁰⁵ These five NWS staff were joined by on-call Operational Commander, Derek Poland.¹⁰⁶
- 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.¹⁰⁷ The GM HART crew and other non-ambulance resources were on their way to Hunts Bank.¹⁰⁸

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

¹⁰⁰ [109/100/4-102/6](#)

¹⁰¹ [109/119/16-121/11](#), [INQ035612/143](#)

¹⁰² [109/152/3-24](#)

¹⁰³ [INQ035612/162](#)

¹⁰⁴ [110/92/21-95/15](#), [INQ035612/169](#), [INQ035612/172](#)

¹⁰⁵ [INQ035612/176-178](#)

¹⁰⁶ [112/21/6-25](#)

¹⁰⁷ [INQ040368/3](#)

¹⁰⁸ [INQ040616](#), [INQ040368](#)

¹⁰⁹ [76/6/13-11/23](#)

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.

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.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 2nd June 2010.¹¹²

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 NWS 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 22nd May 2017.¹¹³ 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 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.¹¹⁴

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

¹¹⁰ [76/9/14-10/6](#)

¹¹¹ [76/16/19-30/25](#)

¹¹² [76/11/17-16/8](#)

¹¹³ [76/25/3-26/19](#), [76/142/2-12](#)

¹¹⁴ [76/28/1-14](#)

partners in order to see how JESIP worked, or did not work, and in order to see and understand the capabilities of each service.¹¹⁵ 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’.

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.

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).¹¹⁸ Each call was shown as involving “*bomb or explosion*”, so to prioritise them in the second lowest category would seem to be wrong.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.*”¹²⁰ Patrick Ennis was clear that this had not delayed

¹¹⁵ [76/29/5-31/12](#)

¹¹⁶ [76/32/14-17](#)

¹¹⁷ [76/37/21-39/15](#)

¹¹⁸ [76/34/18-36/21](#)

¹¹⁹ [76/39/16-40/16](#)

¹²⁰ [76/41/2-4](#)

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.¹²¹

14.103 My understanding is that AMPDS is applied generally around the country, so this issue is not restricted to NWS. 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.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 NWS Control to say he had seen a message on his pager. He asked: “[W]hat’s going on in the city?”¹²³ NWS Control said that they would get back to him.¹²⁴ Patrick Ennis explained that he was already in the car at this time.¹²⁵ It follows that within five minutes of the explosion, Patrick Ennis was already on his way to the Arena. He responded swiftly.

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 NWS 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.¹²⁶ I introduced the Trauma Cell in Part 12. In this call, Patrick Ennis made clear that Major Incident command needed to be established.¹²⁷ Patrick Ennis was taking appropriate steps to set up the NWS 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 22:45:46.¹²⁸

¹²¹ [76/54/9-56/14](#)

¹²² [INQ015106T](#)

¹²³ [76/45/18-47/12](#), [INQ015106T](#)

¹²⁴ [INQ015106T](#)

¹²⁵ [76/44/8-18](#)

¹²⁶ [76/47/13-50/14](#), [INQ015338T](#)

¹²⁷ [INQ015338T](#)

¹²⁸ [76/62/14-63/4](#), [76/72/8-22](#)

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 NWS 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
- 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

¹²⁹ [76/63/6-69/25](#)

¹³⁰ [109/176/8-177/23](#)

¹³¹ [INQ012913/23](#)

¹³² [76/69/5-72/1](#)

¹³³ [192/48/25-49/9](#)

¹³⁴ [76/71/3-72/1](#)

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 NWS 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 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

- 14.113** 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.¹³⁶ At 22:46, while still outside but having spoken to police officers and members of the public, Patrick Ennis made contact with NWS 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 ..."*¹³⁷

- 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 NWS Control to the likelihood that this was what they were dealing with.¹³⁸ '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 ... NWS

¹³⁵ [109/175/2-179/25](#), [109/181/14-183/11](#)

¹³⁶ [76/61/2-15](#)

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](#)

resources should be identified and held awaiting further information. EOC [the Emergency Operations Centre within NWS 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.”¹³⁹

- 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 NWS 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 NWS 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.¹⁴⁰ Just before he entered the station, at 22:50:02, he was approached by PC Barker.¹⁴¹ The officer’s body-worn video¹⁴² 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 NWS. They want every NWS there.”

“[Patrick Ennis] Where?”

“[PC Barker] At the booking office which is just ... [upstairs].”¹⁴³

- 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.¹⁴⁴ He then made his way straight to the City Room, entering at 22:53.¹⁴⁵ He was asked in evidence what role he was performing when he did so. Patrick Ennis said:

¹³⁹ [INQ012913/11](#)

¹⁴⁰ [INQ035612/128](#)

¹⁴¹ [76/77/25-79/22](#), [INQ035612/130](#)

¹⁴² [76/78/10-79/12](#)

¹⁴³ [76/78/22-79/3](#)

¹⁴⁴ [INQ035612/132](#)

¹⁴⁵ [109/119/16-120/8](#)

*"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."*¹⁴⁶

- 14.118** Patrick Ennis confirmed in evidence that he recognised he was, so far as NWS 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.¹⁴⁷ 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.¹⁴⁸
- 14.119** Patrick Ennis agreed that, even though he was the first NWS 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 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.

¹⁴⁶ [76/86/6-17](#)

¹⁴⁷ [76/86/18-89/11](#), [76/132/3-6](#), [109/105/11-119/12](#)

¹⁴⁸ [INQ012913/22](#)

¹⁴⁹ [109/108/24-110/6](#)

First visit to the City Room

- 14.122** Patrick Ennis entered the City Room at 22:53.¹⁵⁰ Although he was an experienced paramedic, he had not received HART training¹⁵¹ and had none of the personal protective equipment (PPE) that such operatives have.¹⁵² 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.¹⁵³ 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?"*¹⁵⁴ Fewer than 90 seconds later, at 22:50:03, Inspector Smith passed a further, similar message to GMP Control, stating: *"I need every NWS facility that we've got in here, please. Directly in here."*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 NWS staff they need to get in here as soon as."*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.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

¹⁵⁰ [109/119/16-120/8](#), [INQ035612/136](#), [INQ035612/143](#)

¹⁵¹ [76/27/9-25](#)

¹⁵² [76/26/8-27/8](#), [110/44/22-45/2](#)

¹⁵³ [INQ035612/113](#)

¹⁵⁴ [103/1/20-3/17](#)

¹⁵⁵ [INQ018644T/9](#)

¹⁵⁶ [103/16/14-24](#)

¹⁵⁷ [109/122/2-124/7](#)

¹⁵⁸ [109/124/11-16](#)

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.

[Emergency Operations Centre] [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.

E 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.¹⁶⁰ 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.¹⁶¹ 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:

<i>"[Patrick Ennis]</i>	<i>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."</i>
<i>"[PC Dawson]</i>	<i>What do you need from us now? What's best that we can do for you now?"</i>
<i>"[Patrick Ennis]</i>	<i>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."¹⁶²</i>

14.130 This conversation is instructive.¹⁶³ 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.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.¹⁶⁵

¹⁶⁰ [109/125/21-128/6](#), [109/215/19-218/11](#)

¹⁶¹ [109/126/17-128/6](#)

¹⁶² [109/135/13-136/6](#)

¹⁶³ [109/135/5-149/12](#)

¹⁶⁴ [INQ041266](#)

¹⁶⁵ [109/200/10-21](#)

Discussion with Daniel Smith

- 14.131** Patrick Ennis left the City Room shortly before 22:59:46.¹⁶⁶ 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.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 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.¹⁶⁸ 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.¹⁶⁹
- 14.134** Daniel Smith and Dr Daley entered the railway station at 22:59:53.¹⁷⁰ A little behind them was NWS Operations Manager Derek Poland,¹⁷¹ 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.¹⁷² At 23:01:01, Patrick Ennis started his descent down the staircase leading to the concourse.¹⁷³ By 23:01:24, he had joined the others.¹⁷⁴ There was a conversation, but by 23:02:51, Daniel Smith had walked away and left the concourse via the War Memorial entrance.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.¹⁷⁶ So did Daniel Smith.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

¹⁶⁶ [INQ035612/170](#)

¹⁶⁷ [109/124/17-125/11](#)

¹⁶⁸ [110/63/16-21](#), [INQ035612/169](#)

¹⁶⁹ [111/1/16-2/22](#)

¹⁷⁰ [INQ035612/172](#)

¹⁷¹ [INQ035612/173](#)

¹⁷² [INQ035612/179](#)

¹⁷³ [INQ035612/182](#)

¹⁷⁴ [INQ035612/183](#)

¹⁷⁵ [INQ035612/189](#)

¹⁷⁶ [109/152/11-169/13](#)

¹⁷⁷ [110/126/15-135/25](#)

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 NWS Operational Commander.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 NWS Control informing them that he had been told that all communications were to be passed through Daniel Smith's channel.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.¹⁸⁰ That this instruction was given accords with the recollection of Daniel Smith.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 NWS 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.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.'*"¹⁸³
- 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 conversation 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 NWS 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:

¹⁷⁸ [109/156/13-157/8](#), [110/95/5-11](#), [110/102/14-24](#)

¹⁷⁹ [INQ015078T](#)

¹⁸⁰ [109/186/14-187/15](#)

¹⁸¹ [110/126/15-129/16](#)

¹⁸² [109/163/20-164/4](#)

¹⁸³ [110/153/11-23](#)

- "[Chairman] [W]ere 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."¹⁸⁴*

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.¹⁸⁵ Even if Patrick Ennis had been told, it would have meant nothing to him because he had never heard of Operation Plato.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.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 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:

¹⁸⁴ [110/12/25-13/10](#)

¹⁸⁵ [109/128/10-21](#)

¹⁸⁶ [109/128/10-24](#)

¹⁸⁷ [76/29/5-31/12](#)

"[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*

- 14.145** Daniel Smith was the NWS Operational Commander. It was his job to decide which assets of NWS should be deployed forward into the City Room.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 the emergency service partners of NWS 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.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 NWS 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.¹⁹¹

¹⁸⁸ [110/14/10-15/4](#) (emphasis added)

¹⁸⁹ [110/105/10-16](#), [110/132/6-133/1](#), [110/141/9-143/4](#)

¹⁹⁰ [102/172/16-173/19](#)

¹⁹¹ [110/130/11-131/9](#)

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 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.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 23:05:30¹⁹³ and remained there until 00:39:23.¹⁹⁴ He spent almost 94 minutes in that location on this occasion. He provided no treatment to any casualty during that period.¹⁹⁵ Instead, he understood that it was his job to perform the role of Primary Triage Officer, even though he was never designated as such by the Operational Commander.¹⁹⁶

- 14.151 The description of the Primary Triage Officer given in the NWS 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 NWS 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

¹⁹² [110/235/18-238/1](#)

¹⁹³ [INQ035612/203](#)

¹⁹⁴ [INQ035612/476](#)

¹⁹⁵ [109/184/11-21](#)

¹⁹⁶ [109/171/9-174/23](#), [INQ013132/22](#)

¹⁹⁷ [INQ012913/23](#) (emphasis added)

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

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."*²⁰¹

14.155 At 23:15:10, two members of HART, Lea Vaughan and Christopher Hargreaves, entered the City Room.²⁰² Patrick Ennis provided them with a briefing and then left them to get on with their work.²⁰³ 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 NWS response observed, in their closing statement, that while it was possible to find examples

¹⁹⁸ [INQ012913/37](#) at paragraph 8.1

¹⁹⁹ [109/171/9-173/25](#), [109/183/12-184/21](#)

²⁰⁰ [78/62/1-13](#)

²⁰¹ [109/199/21-200/9](#)

²⁰² [INQ035612/258](#)

²⁰³ [109/200/14-201/6](#)

²⁰⁴ [109/210/20-212/23](#)

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
- 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.

²⁰⁵ [INQ042543/17](#)

²⁰⁶ [174/28/21-29/2](#)

²⁰⁷ [153/75/6-8](#)

²⁰⁸ [152/12/21-13/13](#)

²⁰⁹ [152/12/21-13/13](#)

²¹⁰ [153/16/23-18/3](#)

²¹¹ [155/11/22-12/23](#)

²¹² [155/22/12-13](#)

²¹³ [156/50/13-15](#)

- 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 informed another police officer that Georgina Callander was *“critically unwell”*.²¹⁶ Patrick Ennis said she needed to be removed by any means possible.²¹⁷
- 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.²¹⁸
- 14.169** At 23:16, Patrick Ennis assessed Georgina Callander a second time.²¹⁹
- 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.²²⁰ 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.²²¹ 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.

²¹⁴ [153/77/6-8](#)

²¹⁵ [155/13/11-20](#)

²¹⁶ [155/13/11-20](#)

²¹⁷ [155/13/11-20](#)

²¹⁸ [154/14/3-18](#)

²¹⁹ [155/16/7-10](#)

²²⁰ [151/9/25-10/10](#)

²²¹ [152/6/18-24](#)

²²² [150/109/16-110/4](#)

²²³ [152/20/19-25](#)

²²⁴ [154/22/1-4](#)

²²⁵ [151/17/18-24](#)

- 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.
- 14.177** At 00:32, Patrick Ennis assessed Michelle Kiss.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.²²⁸

Covering people

- 14.179** The NWS Major Incident Response Plan advises NWS 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.²²⁹
- 14.180** On 22nd 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.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 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.

²²⁶ [151/34/5-12](#)

²²⁷ [151/25/4-8](#)

²²⁸ [152/6/25-7/2](#)

²²⁹ [INQ012913/37](#)

²³⁰ [110/28/1-24](#)

²³¹ [150/107/18-108/24](#), [150/119/1-4](#), [151/9/12-13](#), [151/12-13](#), [151/24/21-25](#), [151/33/24-25](#), [152/6/4-9](#), [152/13/2-3](#), [152/19/25-20/5](#), [152/27/4](#), [153/65/24-66/4](#), [154/99/18-24](#), [156/11/19-20](#), [156/48/16-18](#)

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.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.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 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

²³³ [138/11/8-13/12](#)

²³⁴ [138/13/21-14/8](#)

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 NWS. He was Lead Paramedic for Greater Manchester and a Consultant Paramedic.²³⁸ 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 23:00.²³⁹ 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.²⁴⁰ This was good practice. He was the only emergency services commander at the scene who did this.²⁴¹ If all commanders had done so, it would have made it easier for them to identify each other.
- 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 NWS 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 NWS 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 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

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](#)

²⁴² [INQ015056T](#)

²⁴³ [110/91/11-92/20](#)

²⁴⁴ [INQ035612/178-179](#), [INQ035612/182](#)

²⁴⁵ [110/96/13-97/21](#)

- 14.197** At the time of this deployment, there were six members of NWS 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 in the conversation lasted for no more than 90 seconds.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.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

²⁴⁶ [INQ035612/183](#), [110/126/15-127/12](#)

²⁴⁷ [110/102/14-103/16](#), [110/127/8-154/12](#)

²⁴⁸ [110/14/19-15/4](#), [110/147/4-19](#), [110/153/11-154/2](#)

- 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 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 NWS 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."²⁵⁰

²⁴⁹ [110/129/17-136/18](#)

²⁵⁰ [110/147/4-18](#), [110/150/1-13](#)

- 14.207 Later in his evidence, Daniel Smith stated: “[T]he zoning would be from the JOPs [Joint Operating Principles].”²⁵¹ 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.²⁵²
- 14.208 Daniel Smith was supported in his position by NWS. In its closing statement, NWS submitted that I should find that Daniel Smith “properly concluded that it [the City Room] was a warm zone”.²⁵³ In that closing statement, NWS also invited me to note that: “[T]here was no discretion for non-specialist paramedics to enter a warm zone.”²⁵⁴
- 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.²⁵⁵ 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.²⁵⁶ 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 NWS Major Incident Response Plan.

²⁵¹ [110/151/15-19](#)

²⁵² [110/137/17-138/2](#), [110/153/11-154/12](#)

²⁵³ [INQ042544/38](#)

²⁵⁴ [INQ042544/38](#)

²⁵⁵ [110/137/1-146/5](#)

²⁵⁶ [110/144/22-146/12](#)

²⁵⁷ [110/147/4-148/17](#), [110/163/25-164/19](#)

- 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 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 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.

²⁵⁸ [110/147/4-25](#), [110/215/4-6](#), [110/221/1-15](#)

²⁵⁹ [110/130/11-131/9](#), [110/132/6-133/1](#)

²⁶⁰ [110/123/21-24](#)

²⁶¹ [115/64/7-23](#)

14.218 If Daniel Smith had not deployed Martyn Nealon and Callum Gill at 23:01 to treat a patient on 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 NWS assets into different zones. He was also one of the two NWS 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

14.223 What had happened was that a senior figure within the NWS hierarchy attended the scene because of an informal arrangement with another senior figure. Once there, he assumed the position of Operational Commander

²⁶² [112/23/2-25/24, INQ035612/189](#)

²⁶³ [112/1/12-3/22](#)

²⁶⁴ [112/16/2-4](#)

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](#)

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 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.²⁷⁷ Daniel Smith did not realise this.²⁷⁸

²⁷⁰ [112/26/4-14](#)

²⁷¹ [INQ005854/1](#)

²⁷² [112/1/12-3/20](#)

²⁷³ [112/26/4-31/20](#)

²⁷⁴ [110/11/13-12/5](#), [112/120/18-121/17](#), [INQ013422/12](#), [144/184/23-185/11](#)

²⁷⁵ [INQ035612/194](#)

²⁷⁶ [INQ035612/420](#)

²⁷⁷ [110/172/9-174/24](#), [110/237/12-25](#)

²⁷⁸ [110/173/10-174/6](#)

- 14.229** Daniel Smith made other significant errors in the discharge of his role as Operational Commander.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.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, 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,²⁸¹ 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.²⁸²
- 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.²⁸³ 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.²⁸⁴ 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.²⁸⁵ 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.²⁸⁶ 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

²⁷⁹ [110/103/17-126/3](#)

²⁸⁰ [77/30/20-31/11](#), [110/208/1-209/23](#)

²⁸¹ [INQ012913/16](#)

²⁸² [110/105/23-106/18](#)

²⁸³ [110/107/6-13](#)

²⁸⁴ [110/105/17-111/10](#)

²⁸⁵ [110/119/5-126/3](#)

²⁸⁶ [INQ012913/24](#)

a mistake in not appointing one.²⁸⁷ He did not appoint an Equipment Officer or Forward Doctor either.²⁸⁸ 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.²⁸⁹ 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."²⁹⁰ What Daniel Smith said of this was: "Currently we've got a large number of emergency services on scene."²⁹¹ 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.²⁹² He was unaware of their absence until Stephen Hynes arrived at the scene and pointed it out to him.²⁹³

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

²⁸⁷ [110/122/11-20](#)

²⁸⁸ [110/125/22-126/3](#)

²⁸⁹ [INQ034313](#)

²⁹⁰ [INQ014270/1](#)

²⁹¹ [INQ034313](#)

²⁹² [110/172/19-173/5](#)

²⁹³ [110/183/13-25](#)

²⁹⁴ [INQ041266](#)

²⁹⁵ [110/100/16-102/13](#)

²⁹⁶ [110/10/1-22](#)

- 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.²⁹⁷ 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 23:07.²⁹⁸
- 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.²⁹⁹
- 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.³⁰⁰ 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

²⁹⁷ [110/127/8-129/2](#)

²⁹⁸ [INQ041266](#)

²⁹⁹ [110/172/15-174/24](#)

³⁰⁰ [110/95/16-97/21](#)

*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.*³⁰¹

- 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.³⁰³

³⁰¹ [110/173/6-174/6](#)

³⁰² [158/36/15-40/4](#)

³⁰³ [158/41/16-44/6](#)

- 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.³⁰⁴
- 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.³⁰⁵
- 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 23:23:54.³⁰⁶
- 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 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."*³⁰⁷ 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."*³⁰⁸ To this, PC McLaughlin responded: *"[Y]es, no problem, is there any blankets anywhere?"*³⁰⁹
- 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."*³¹⁰
- 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.

³⁰⁴ [158/44/14-50/13](#)

³⁰⁵ [158/50/8-21](#)

³⁰⁶ [158/52/8-54/13](#)

³⁰⁷ [159/54/18-55/23](#)

³⁰⁸ [158/48/13-19](#)

³⁰⁹ [158/47/20-48/22](#)

³¹⁰ [159/91/16-92/23](#)

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.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.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.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.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.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.

³¹¹ [155/11/24-12/9](#)

³¹² [155/11/22-13/16](#), [155/67/21-68/2](#)

³¹³ [155/13/21-14/22](#)

³¹⁴ [155/16/1-6](#)

³¹⁵ [155/16/24-18/24](#)

³¹⁶ [155/19/22-20/15](#)

³¹⁷ [155/21/22-28/23](#)

³¹⁸ [155/29/10](#)

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 NWS 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.³²⁰ He had been replaced as Operational Commander. Daniel Smith's perception was that this had happened because the senior management of NWS was unhappy with his command.³²¹

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."*³²² 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 NWS and the emergency services more generally to learn the lessons of what went wrong.

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

³¹⁹ [INQ035612/412](#)

³²⁰ [INQ035612/420](#)

³²¹ [110/184/4-184/15](#)

³²² [113/105/1-106/10](#)

³²³ [INQ006618/1](#)

³²⁴ [INQ006618/2, 76/155/23-156/7](#)

³²⁵ [76/204/15-206/11](#)

³²⁶ [77/83/17-84/3](#)

- 14.273** The role of HART Team Leader in NWS 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 NWS.³²⁷ Simon Beswick had never had any training in the use of the Team Leader action card produced by NARU.³²⁸
- 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 NWS 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 NWS. Simon Beswick's evidence was that it would have been helpful to have had a prompt to remind him of his key tasks.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.³³¹
- 14.279** When giving evidence, Simon Beswick stated that he did not think he was adequately qualified to act as HART Team Leader.³³² I agree. Responsibility for this unacceptable state of affairs lies with NWS. Simon Beswick made a number of mistakes during the response to the Attack. In my view, NWS 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.

³²⁷ [140/10/20-12/10](#)

³²⁸ [76/180/22-25](#)

³²⁹ [76/174/24-175/11](#)

³³⁰ [77/14/20-22](#)

³³¹ [77/83/20-84/14](#), [79/77/22-78/19](#), [INQ004979/1](#), [INQ006559/1](#)

³³² [76/176/20-178/8](#)

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 NWS 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.
- 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 22nd 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, NWS Control contacted Christopher Hargreaves and informed him of *"a large-scale incident in the city centre"*.³³⁷ NWS Control asked if the GM HART crew could be redirected to that incident.³³⁸ One minute later, Simon Beswick contacted NWS 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 NWS Control to say that he and his team were able to attend the incident in Manchester City Centre.³⁴¹

³³³ [77/110/11-112/6](#)

³³⁴ [77/78/5-17](#), [79/20/19-21/1](#)

³³⁵ [77/79/17-22](#)

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](#)

- 14.285** Nicholas Priest and Stephen English travelled to the fire near Stockport in a Public Support Unit 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.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"*.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.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 22:58.³⁴⁵ At the point of allocation, he was only 16 minutes away from the Victoria Exchange Complex.³⁴⁶ When he was allocated, he diverted from the course he was on in order to go to the Arena.³⁴⁷ 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)

- 14.289** 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."*³⁴⁸
- 14.290** Once on Trinity Way, they encountered Martyn Nealon.³⁴⁹ 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

³⁴² [76/205/7-206/7](#), [77/5/22-6/24](#)

³⁴³ [INQ015071T](#), [INQ034282](#), [INQ015041T](#), [77/18/10-18](#)

³⁴⁴ [79/81/3-83/5](#)

³⁴⁵ [79/85/9-16](#)

³⁴⁶ [INQ040616/4-5](#)

³⁴⁷ [79/83/6-84/6](#)

³⁴⁸ [INQ034282/1](#), [77/157/21-158/24](#)

³⁴⁹ [77/22/18-23/5](#)

Operational Commander.³⁵⁰ At 23:03, Simon Beswick radioed NWS Control. He informed NWS Control that Daniel Smith was *“already inside the Arena actioning clinical aid”*.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.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.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

³⁵⁰ [77/22/18-23/23](#)

³⁵¹ [INQ034282/2](#)

³⁵² [INQ040616/4](#)

³⁵³ [77/25/4-126/8](#)

³⁵⁴ [77/26/24-28/20](#)

³⁵⁵ [INQ040616/5](#), [77/29/10-20](#)

³⁵⁶ [110/175/15-177/9](#)

³⁵⁷ [77/30/5-16](#)

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.³⁶¹

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.³⁶² While he and other HART operatives had relevant skills for supporting a Major Incident response outside the hazard area,³⁶³ 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.³⁶⁴

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 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.’”*³⁶⁵ Later in his evidence, Daniel Smith stated he could not recall being told that any further HART operatives were ready to deploy.³⁶⁶ His evidence was that he *“thought the operational plan was working and if any more resources were needed, then they would have been requested”*.³⁶⁷

³⁵⁸ [79/39/14-41/15](#)

³⁵⁹ [79/33/12-18](#)

³⁶⁰ [77/171/9-172/23](#)

³⁶¹ [79/33/19-34/9](#)

³⁶² [77/30/2-24](#)

³⁶³ [77/34/7-13](#)

³⁶⁴ [INQ040616/5](#)

³⁶⁵ [110/185/16-187/10](#)

³⁶⁶ [110/206/1-13](#)

³⁶⁷ [110/209/12-23](#)

- 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.³⁶⁸
- 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.
- 14.304** 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

- 14.305** 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
- 14.306** 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
- 14.307** I recognise that Simon Beswick and his team were confronted with an extremely stressful situation, and it was important that the immediate 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.

³⁶⁸ [77/44/4-22](#)

³⁶⁹ [77/61/8-64/14](#)

³⁷⁰ [77/61/8-17](#)

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*”.³⁷¹ 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 23:13.³⁷² At 23:15, they entered the City Room.³⁷³ They immediately spoke to Patrick Ennis.³⁷⁴

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.³⁷⁵

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*”.³⁷⁶ 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.*”³⁷⁷

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.³⁷⁸

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.*”³⁷⁹ 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.*”³⁸⁰

³⁷¹ [77/62/22-63/2](#)

³⁷² [INQ035612/252](#)

³⁷³ [INQ035612/257-258](#)

³⁷⁴ [INQ035612/259](#)

³⁷⁵ [112/162/17-164/17](#)

³⁷⁶ [79/51/11-18](#), [113/7/24-8/4](#)

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](#)

- 14.315 During the questioning, it was suggested to Christopher Hargreaves that the treatment which 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."*³⁸¹
- 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."*³⁸² 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.³⁸³ 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.³⁸⁴ 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."*³⁸⁵
- 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"*.³⁸⁶ I agree.

³⁸¹ [112/169/5-12](#)

³⁸² [77/51/1-9](#)

³⁸³ [77/52/9-13](#)

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.³⁸⁷ 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.³⁸⁸
- 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 NWS 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.³⁸⁹
- 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.³⁹⁰ 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.³⁹¹ 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.
- 14.325** HART operatives train as a team and operate most effectively as a team.³⁹² Daniel Smith's decision had the effect of splitting the team up for an important period in the emergency response.

³⁸⁷ [77/51/22-25](#)

³⁸⁸ [79/51/1-3](#)

³⁸⁹ [77/53/1-54/5](#)

³⁹⁰ [77/54/16-55/14](#)

³⁹¹ [77/33/18-23](#), [77/42/15-24](#)

³⁹² [77/170/10-14](#), [79/31/18-22](#)

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.³⁹³ Georgina Callander was moved out of the City Room on a makeshift stretcher by others at 23:26.³⁹⁴ 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.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.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.³⁹⁷

14.331 At 23:45, Lea Vaughan attached a label to Eilidh MacLeod identifying that she was dead.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.³⁹⁹

³⁹³ [155/16/24-17/2](#)

³⁹⁴ [155/22/6-13](#)

³⁹⁵ [154/99/25-100/15](#)

³⁹⁶ [152/27/20-22](#)

³⁹⁷ [156/11/21-12/11](#)

³⁹⁸ [153/66/19-24](#)

³⁹⁹ [156/50/22-51/8](#)

14.333 At 23:46, Lea Vaughan attached a label to Sorrell Leczkowski identifying that she was dead.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.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 NWS 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."*⁴⁰² 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"*.⁴⁰³ 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."*⁴⁰⁴

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.⁴⁰⁵ He stated:

*"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."*⁴⁰⁶

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.

⁴⁰⁰ [153/77/25-78/5](#)

⁴⁰¹ [152/13/14-17](#)

⁴⁰² [INQ012913/41](#)

⁴⁰³ [INQ012913/42](#)

⁴⁰⁴ [INQ012913/42](#)

⁴⁰⁵ [110/159/18-160/15](#)

⁴⁰⁶ [110/208/4-13](#)

- 14.340 Simon Beswick's evidence was: *"I was tasked by Mr [Daniel] Smith to establish a CCP and support him in his response."*⁴⁰⁷ Setting up a Casualty Collection Point was something in which Simon Beswick had received training.⁴⁰⁸ 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.⁴⁰⁹
- 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."*⁴¹⁰ He went on to say that this area *"did progress to a casualty clearing station"*.⁴¹¹
- 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.⁴¹² 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."*⁴¹³ 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.⁴¹⁴
- 14.343 Both Nicholas Priest and Stephen English stated that they were asked to set up a Casualty Collection Point.⁴¹⁵ In a presentation she gave on 16th 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 "HART CCP/ CCS".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, *"but the casualty collection point appeared to be on the pavement outside Victoria, where some of the HART team were operating"*.⁴¹⁷

⁴⁰⁷ [77/30/20-24](#)

⁴⁰⁸ [77/33/18-23](#)

⁴⁰⁹ [77/35/19-36/16](#)

⁴¹⁰ [77/35/19-36/16](#)

⁴¹¹ [77/36/20-37/3](#)

⁴¹² [79/97/6-98/10](#)

⁴¹³ [79/100/3-8](#)

⁴¹⁴ [79/100/25-101/16](#)

⁴¹⁵ [INQ006559/3](#), [INQ004979/3](#)

⁴¹⁶ [INQ022850/3](#), [INQ022850/5](#), [INQ022850/6](#)

⁴¹⁷ [81/36/19-37/8](#)

- 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.
- 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.⁴²⁰ As a result, Simon Beswick accepted the area of Station Approach as an appropriate location for a Casualty Collection Point.⁴²¹ 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.⁴²² 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 operatives were working further from any potential hazard than the non-specialist paramedics.

⁴¹⁸ [INQ035612/268](#)

⁴¹⁹ [INQ012913/41](#) at paragraph 9.2

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](#)

- 14.350** During the critical period of the response, at around 23:30, Simon Beswick briefly entered the Victoria Exchange Complex.⁴²³ 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*".⁴²⁴ 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.⁴²⁵ 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 22nd 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 Merseyside, approximately 30 miles from the Arena.⁴³⁰ 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.⁴³¹

⁴²³ [INQ040647/25-28](#)

⁴²⁴ [77/40/5-42/3](#)

⁴²⁵ [77/39/11-18](#)

⁴²⁶ [77/59/9-60/6](#)

⁴²⁷ [INQ035612/374](#)

⁴²⁸ [INQ035612/373](#)

⁴²⁹ [77/59/17-60/6](#)

⁴³⁰ [81/115/18-118/9](#)

⁴³¹ [81/115/15-118/6](#)

- 14.356** Ronald Schanck's evidence was that he would have expected to have been notified by NWS Control of the incident earlier than he was.⁴³² In my view, Ronald Schanck was correct to have this expectation. There was an unacceptable delay by NWS Control to notify the C&M HART crew. In the NWS closing statement to the Inquiry, NWS accepted this.⁴³³
- 14.357** I have already criticised NWS 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 notification to be given to his team within ten minutes of the explosion.⁴³⁴ Again, I agree with his evidence.
- 14.358** If NWS 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.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.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 NWS's behalf that sending the C&M HART crew straight to the scene at 22:40 would not have been reasonable.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."*⁴³⁸
- 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

⁴³² [81/118/10-119/5](#)

⁴³³ [INQ042544/26](#) at paragraph 58

⁴³⁴ [81/119/23-120/4](#)

⁴³⁵ [81/120/9-16](#)

⁴³⁶ [INQ016411/1-2](#)

⁴³⁷ [INQ042544/26](#) at paragraphs 58–59

⁴³⁸ [144/29/1-11](#), [INQ042544/26-27](#) at paragraph 59

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 22nd 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 NWS HART crews so that they could be ready to provide support to NWS 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: *"[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."*⁴⁴³
- 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.⁴⁴⁴
- 14.367** At 23:50, Ronald Schanck contacted the NWS 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."*⁴⁴⁵

⁴³⁹ [144/28/11-29/11](#)

⁴⁴⁰ [81/119/6-17](#)

⁴⁴¹ [INQ040368/9](#), [81/123/20-124/10](#)

⁴⁴² [81/124/23-128/16](#)

⁴⁴³ [81/125/2-22](#)

⁴⁴⁴ [INQ034307/1](#), [81/128/2-16](#)

⁴⁴⁵ [INQ033208T](#)

- 14.368** At 23:54, the NWS Merseyside Control Room spoke to Ronald Schanck. He repeated that he wanted to know if NWS 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 NWS Control Room in Greater Manchester. The NWS 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."*⁴⁴⁶
- 14.369** At 00:13, the C&M HART crew were deployed from the RVP to Hunts Bank. They arrived on Hunts Bank at 00:19.⁴⁴⁷
- 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 NWS Control sought to contact the Manchester-based part of NWS 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 NWS 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 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 NWS Control that he was eager to move forward and support his colleagues.

⁴⁴⁶ [INQ033217T](#)

⁴⁴⁷ [INQ040368/9](#)

⁴⁴⁸ [101/101/2-115/16](#)

⁴⁴⁹ [INQ041266](#)

⁴⁵⁰ [81/128/2-16](#)

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, NWS 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.⁴⁵³ By this point, Saffie-Rose Roussos had been evacuated from the City Room to Trinity Way.⁴⁵⁴

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.⁴⁵⁵ 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.⁴⁵⁶

14.378 From 23:15, Patrick Ennis received support from two members of the GM HART crew, Lea Vaughan and Christopher Hargreaves.⁴⁵⁷ By this point, one P1 casualty had been carried into the Casualty Clearing Station on a makeshift stretcher. Two more P2 casualties had been 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

⁴⁵¹ [81/129/22-130/25](#)

⁴⁵² [INQ042544/26](#) at paragraph 58

⁴⁵³ [INQ041266](#)

⁴⁵⁴ [174/38/22-39/8](#)

⁴⁵⁵ [110/19/10-20/15](#)

⁴⁵⁶ [INQ041266](#)

⁴⁵⁷ [INQ035612/259](#)

⁴⁵⁸ [INQ041266](#)

⁴⁵⁹ [INQ041266](#)

- 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.
- 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 NWS 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 NWS 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** NWS provided data for its fleet of vehicles. At 22:32, there were 319 vehicles in operation across the region covered by NWS.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, NWS 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 NWS 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

⁴⁶⁰ [109/178/11-181/15](#)

⁴⁶¹ [INQ040950/1](#)

⁴⁶² [INQ040950/1](#)

⁴⁶³ [144/180/4-9](#)

⁴⁶⁴ [INQ015140T/3](#), [INQ042544/67-68](#) at paragraph 141

⁴⁶⁵ [INQ040368/1](#), [INQ040368/2](#)

⁴⁶⁶ [INQ015047T/1](#)

⁴⁶⁷ [INQ015047T](#)

- 14.387** At 22:54, Patrick Ennis sent a METHANE message from the City Room to NWS Control. In it, he said: *"[W]e've got at least 40 casualties approximately 10 or 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 NWS Control, informed Annemarie Rooney that Patrick Ennis had reported *"only ... six casualties, but that the police are saying there are up to 60"*.⁴⁶⁹ 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"*.⁴⁷⁰
- 14.389** At 22:57, the Chief Executive Officer of NWS, Derek Cartwright, telephoned NWS Control. He asked: *"So we've no sign, we don't have any casualties yet?"*⁴⁷¹ 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."*⁴⁷² NWS Control went on to inform Derek Cartwright that the casualty numbers came from the police.⁴⁷³ This provides a snapshot of NWS 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 NWS 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."*⁴⁷⁴ NWS Control replied that it was understood that *"you need 20 vehicles"*.⁴⁷⁵ 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 NWS Control would get back to him.⁴⁷⁶
- 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.⁴⁷⁷
- 14.392** The position by the time Derek Poland gave his instruction at 23:06 was that NWS Control had allocated 14 ambulances to respond to the Attack.⁴⁷⁸
- 14.393** Following Derek Poland's instruction, NWS Control continued to allocate resources to the response. By 23:23, a further 13 ambulances had been allocated, bringing the total to 27.⁴⁷⁹

⁴⁶⁸ [INQ015070T/1](#)

⁴⁶⁹ [INQ015381T/1](#)

⁴⁷⁰ [INQ015381T/2](#)

⁴⁷¹ [INQ015382T/1](#)

⁴⁷² [INQ015382T/1](#)

⁴⁷³ [INQ015382T/2](#)

⁴⁷⁴ [INQ015073T](#)

⁴⁷⁵ [INQ015073T](#)

⁴⁷⁶ [INQ015073T](#)

⁴⁷⁷ [112/63/16-65/1](#)

⁴⁷⁸ [INQ040368](#)

⁴⁷⁹ [INQ040368](#)

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."*⁴⁸⁰ At the time he sent this message, there were 16 casualties in the Casualty Clearing Station.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.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.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.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, 4 0, 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."*⁴⁸⁵

14.397 By this time, there were 29 patients in the Casualty Clearing Station.⁴⁸⁶ 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."*⁴⁸⁷ 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."*⁴⁸⁸

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

⁴⁸⁰ [INQ034313/1](#)

⁴⁸¹ [INQ041266](#)

⁴⁸² [INQ041266](#)

⁴⁸³ [110/123/21-24](#)

⁴⁸⁴ [INQ040368/1-14](#)

⁴⁸⁵ [INQ034302/1](#)

⁴⁸⁶ [INQ041266](#)

⁴⁸⁷ [INQ034326/1](#)

⁴⁸⁸ [INQ034326/1](#)

*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 NWS 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 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 NWS in relation to the ambulances that were allocated to respond. I am grateful to NWS 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, NWS 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 NWS 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 NWS. I did not receive sufficient evidence on this issue to make any finding.

NWS 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.⁴⁹⁵

⁴⁸⁹ [INQ034316/1](#)

⁴⁹⁰ [INQ040368/13](#)

⁴⁹¹ [INQ040368](#)

⁴⁹² [INQ040368/2-4](#)

⁴⁹³ [INQ040368/1-14](#)

⁴⁹⁴ [INQ040368/1-14](#)

⁴⁹⁵ [INQ040368/1](#), [INQ040368/2-4](#)

- 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.⁴⁹⁶
- 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 17.⁴⁹⁷ 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 23:40.⁴⁹⁸ 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.⁴⁹⁹
- 14.411** At midnight, there were 36 patients in the Casualty Clearing Station. There were 20 ambulances at the Victoria Exchange Complex.⁵⁰⁰

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.

⁴⁹⁶ [174/50/7-24](#)

⁴⁹⁷ [INQ041992/1](#)

⁴⁹⁸ [155/34/11-35/25](#)

⁴⁹⁹ [INQ041266](#), [INQ041992/1](#)

⁵⁰⁰ [INQ041266](#)

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 NWS 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 NWS 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 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 NWS Control until 23:34.⁵⁰⁴

14.417 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."⁵⁰⁵

14.418 His reference to the "casualty plan" was to 23:39, when Annemarie Rooney provided the numbers for each hospital's capacity.⁵⁰⁶ 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

⁵⁰¹ [114/187/13-188/3](#)

⁵⁰² [114/182/22-185/3](#)

⁵⁰³ [114/185/4-186/16](#)

⁵⁰⁴ [INQ034302/1-2](#)

⁵⁰⁵ [114/84/11-85/18](#)

⁵⁰⁶ [INQ034333/1-2](#)

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 NWS 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 NWS 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 quickly.⁵⁰⁹ 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 23:02.⁵¹⁰ 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.⁵¹¹

⁵⁰⁷ [INQ040368/1](#), [INQ040368/2-9](#), [81/33/7-34/4](#), [INQ035612/268](#)

⁵⁰⁸ [114/85/5-18](#)

⁵⁰⁹ [114/99/1-100/1](#), [114/182/22-183/20](#)

⁵¹⁰ [112/42/15-43/1](#)

⁵¹¹ [112/42/15-43/10](#)

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."*⁵¹² 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."*⁵¹³

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.⁵¹⁴

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.

⁵¹² [110/155/3-16](#)

⁵¹³ [110/155/3-156/3](#)

⁵¹⁴ [110/156/9-25](#)

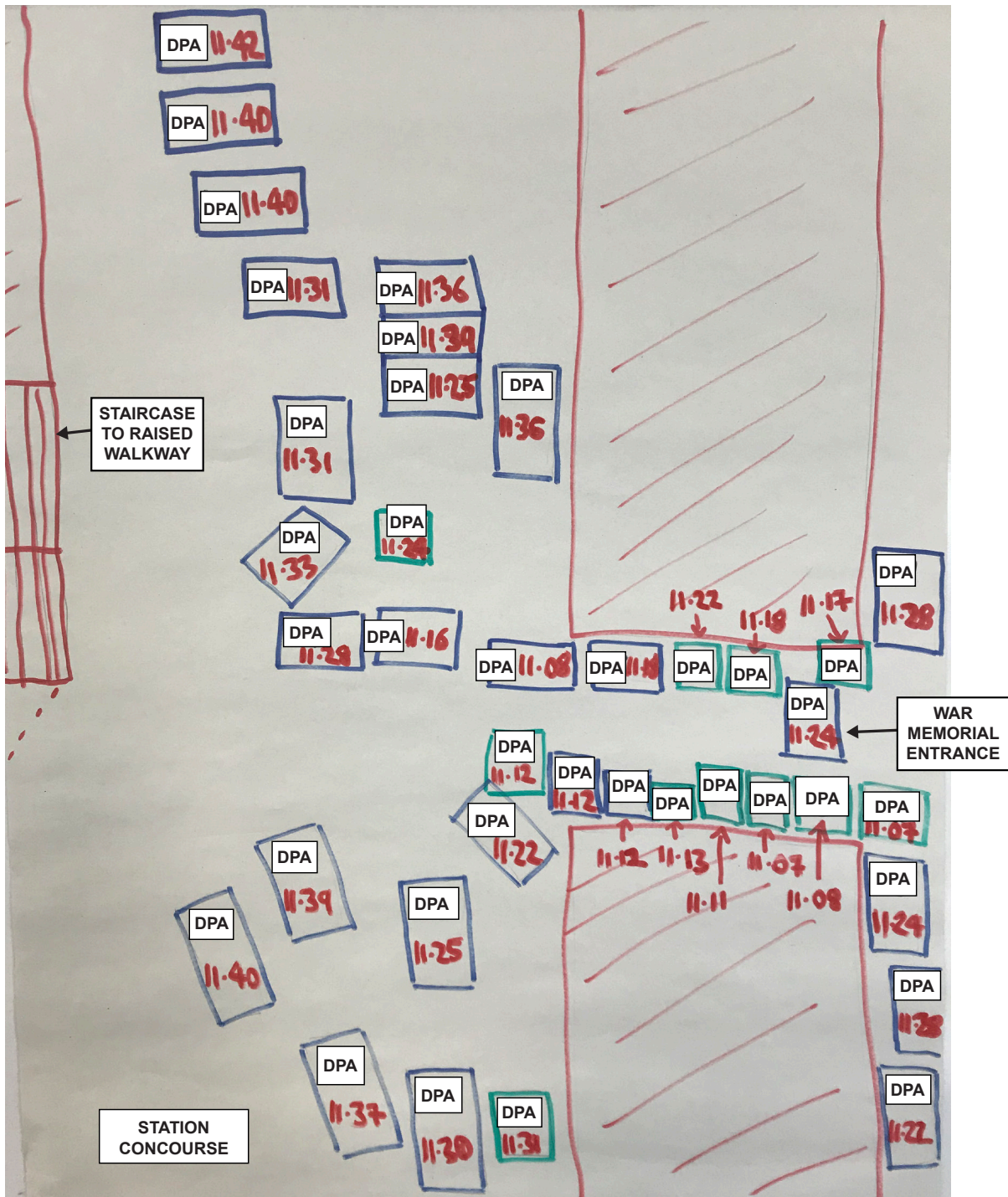


Figure 38: Drawing of the Casualty Clearing Station showing casualties' locations and arrival times⁵¹⁵

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.⁵¹⁶ 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.⁵¹⁷

⁵¹⁵ INQ041266

⁵¹⁶ 112/83/2-86/2

⁵¹⁷ 112/85/8-86/10

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.”⁵¹⁸ Daniel Smith began the process of allocating functional roles before this message.⁵¹⁹
- 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 23:06.⁵²⁰ She arrived on Hunts Bank at 23:10. She was given an initial briefing by Daniel Smith.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.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.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.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.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 23:09.⁵²⁶
- 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 it’s safe inside.”⁵²⁷ She stated that he asked for volunteers and that she put her hand “straight up”.⁵²⁸

⁵¹⁸ [INQ034324/1](#)

⁵¹⁹ [110/119/5-122/12](#)

⁵²⁰ [80/32/5-12](#)

⁵²¹ [80/34/14-35/15](#)

⁵²² [80/35/20-39/6](#)

⁵²³ [80/40/19-42/1](#)

⁵²⁴ [80/44/23-45/17](#)

⁵²⁵ [80/44/23-45/25](#)

⁵²⁶ [81/28/4-23](#)

⁵²⁷ [INQ022542/5](#)

⁵²⁸ [81/30/20](#)

- 14.436** Helen Mottram was told that she was to undertake the role of *"Triage Officer"*.⁵²⁹ 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 23:17.⁵³⁰ She regarded herself as working in the Casualty Clearing Station, but the layout of the arrangements was not explained to her.⁵³¹
- 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.⁵³² He was told by NWAS Control that there were reports of shootings at the Arena. He was not asked to mobilise to the Arena.⁵³³
- 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 the next five minutes.⁵³⁴ At 22:58, he contacted NWAS Control. He was asked to respond to the Attack. He was told to go to Hunts Bank.⁵³⁵ He arrived on Hunts Bank in an Emergency Rapid Response Vehicle at 23:11.⁵³⁶
- 14.439** James Birchenough spoke to Daniel Smith on arrival. Daniel Smith asked James Birchenough to undertake the role of Casualty Clearing Officer.⁵³⁷ 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.⁵³⁸
- 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.⁵³⁹
- 14.441** The Ambulance Loading Officer on the night of the Attack was Matthew Calderbank.⁵⁴⁰ Matthew Calderbank was one of the two on-call Operational Commanders contacted by NWAS Control on the night of 22nd May 2017. He was notified of the Attack at 22:42.⁵⁴¹ He arrived on Hunts Bank at 23:28.⁵⁴²

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](#)

⁵³⁴ [114/14/19-15/19](#)

⁵³⁵ [INQ015024T](#)

⁵³⁶ [114/23/14-23](#)

⁵³⁷ [114/32/3-11](#)

⁵³⁸ [114/30/20-33/12](#)

⁵³⁹ [114/37/15-25](#)

⁵⁴⁰ [114/160/9-11](#)

⁵⁴¹ [INQ015337T](#), [114/140/5-18](#)

⁵⁴² [114/152/12-153/12](#)

- 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.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.⁵⁴⁴ The loading point was chosen to be Station Approach, opposite the War Memorial entrance.⁵⁴⁵
- 14.443** As I have said, the role of Parking Officer was allocated to Derek Poland.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

⁵⁴³ [114/159/7-160/11](#)

⁵⁴⁴ [114/168/10-169/1](#)

⁵⁴⁵ [114/171/11-25](#)

⁵⁴⁶ [112/13/22-23](#)

⁵⁴⁷ [INQ013422/12](#)

⁵⁴⁸ [155/29/10-11](#)

⁵⁴⁹ [155/29/10-34/2](#)

⁵⁵⁰ [155/34/12-13](#)

⁵⁵¹ [155/35/19-20](#)

⁵⁵² [155/34/11-35/25](#)

⁵⁵³ [INQ041266](#)

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 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 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.

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](#)

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](#)

14.452 Annemarie Rooney was notified of the Attack by NWS 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 NWS'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 NWS'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, NWS Strategic Commander.⁵⁶⁹ Second, she spoke to Stephen Taylor, one of the on-call Tactical Advisors/NiLOs.⁵⁷⁰ 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.⁵⁷¹ Third, at 22:56, she had a further call with NWS 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."*⁵⁷²

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 NWS 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.

⁵⁶⁶ [115/114/12-20](#), [INQ015353T](#)

⁵⁶⁷ [INQ041856/18-19](#), [115/114/12-115/23](#)

⁵⁶⁸ [115/116/6-117/1](#), [INQ041728/20-21](#) at paragraph 50

⁵⁶⁹ [115/115/24-116/3](#), [INQ041728/32](#)

⁵⁷⁰ [115/118/13-18](#)

⁵⁷¹ [115/118/13-23](#)

⁵⁷² [115/118/5-119/2](#), [INQ015381T](#)

National Capability Mass Casualty Equipment Vehicle

- 14.458** During the call with NWS 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."*⁵⁷³
- 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."*⁵⁷⁴ The plan anticipated that once a mass casualty incident was confirmed, the National Capability Mass Casualty Equipment Vehicle would be deployed.⁵⁷⁵
- 14.460** The National Capability Mass Casualty Equipment Vehicle was not deployed to the Victoria Exchange Complex on 22nd May 2017.⁵⁷⁶ In her second witness statement, Annemarie Rooney stated that deployment of the National Capability Mass Casualty Equipment Vehicle was within the action cards for NWS Control. She stated deployment of that vehicle *"did not cross my mind"*.⁵⁷⁷ She stated that at no stage did anyone tell her that there was a shortage of equipment at the scene.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.⁵⁷⁹ The Ambulance Service Experts invited me to consider recommending the inclusion of stretchers on National Capability Mass Casualty Equipment Vehicles.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 NWS 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.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.

⁵⁷³ [INQ015381T](#)

⁵⁷⁴ [INQ008123/7](#)

⁵⁷⁵ [INQ008123/19](#)

⁵⁷⁶ [144/147/2-19](#), [140/23/11-24/1](#)

⁵⁷⁷ [INQ041728/14](#)

⁵⁷⁸ [INQ041728/14](#)

⁵⁷⁹ [144/151/16-152/1](#), [INQ042544/11](#) at paragraph 24

⁵⁸⁰ [144/151/16-152/1](#)

⁵⁸¹ [144/149/1-151/15](#)

- 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 National Capability Mass Casualty Equipment Vehicle would be on scene within 60 minutes of mobilisation.⁵⁸² 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.⁵⁸³
- 14.464** It was accepted on NWS's behalf that insufficient consideration was given to the deployment of the National Capability Mass Casualty Equipment Vehicle.⁵⁸⁴ I agree. While Annemarie Rooney as Tactical Commander bears particular responsibility for the failure to deploy the vehicle, I consider that NWS 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 NWS Control had the relevant information earlier than this. However, none of those involved in the response from NWS thought to suggest that this vehicle was mobilised. This demonstrates a failure to embed the use of this vehicle at an organisational level.⁵⁸⁵

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.

⁵⁸² [INQ041856/15](#)

⁵⁸³ [INQ041856/14-15](#), [INQ041856/18-19](#)

⁵⁸⁴ [INQ042544/11](#), [INQ042544/44](#), [INQ042544/71](#)

⁵⁸⁵ [INQ042544/11](#)

⁵⁸⁶ [115/122/6-124/5](#)

⁵⁸⁷ [INQ041728/33-34](#) at paragraph 89

⁵⁸⁸ [INQ015145T](#), [INQ015047T](#), [INQ015353T](#), [INQ015360T](#)

⁵⁸⁹ [115/123/24-124/9](#)

- 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.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.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.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.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.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.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.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.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.⁵⁹⁸ JESIP expects that risk will be jointly assessed.⁵⁹⁹ 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.

⁵⁹⁰ [110/147/4-19](#)

⁵⁹¹ [INQ041728/33-34](#) at paragraphs 33–34

⁵⁹² [INQ041728/33-34](#) at paragraph 89

⁵⁹³ [INQ015381T/2](#)

⁵⁹⁴ [INQ041728/33-34](#) at paragraph 89

⁵⁹⁵ [INQ041728/33-34](#) at paragraph 89, [115/122/6-124/9](#)

⁵⁹⁶ [104/57/4-11](#), [115/133/24-134/20](#)

⁵⁹⁷ [104/18/5-22](#)

⁵⁹⁸ [104/66/19-68/17](#)

⁵⁹⁹ [INQ004542/5](#)

- 14.472** GMP had assessed at 22:50 that the City Room was “safe enough” for all of its personnel to operate in.⁶⁰⁰ That assessment extended to BTP officers, members of the public and a non-specialist paramedic, Patrick Ennis.⁶⁰¹ By contrast, shortly after 23:00, NWS assessed that only the specialist members of HART could be deployed to the City Room.⁶⁰² 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.⁶⁰³ An FCP is key to ensuring the co-location of commanders at the scene.⁶⁰⁴ Both Tactical Commanders finished their conversation without any realisation that their respective Operational Commanders had 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 there.”⁶⁰⁸ 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.”⁶⁰⁹
- 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 NWS Control or a Tactical Advisor/NILO

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](#)

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](#)

⁶⁰⁸ [INQ041728/13](#) at paragraph 20

⁶⁰⁹ [INQ041728/13](#) at paragraph 24

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 NWS tactical plan.*"⁶¹⁰ "John Butler" was a reference to Tactical Advisor/NILO Jonathan Butler, who had travelled to GMP HQ.⁶¹¹ I will return to his role on the night at paragraph 14.523.

14.478 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."*⁶¹²

14.479 "CSCATTT" stands for Command and Control; Safety; Communications; Assessment; Triage; Treatment; Transport.⁶¹³

14.480 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.⁶¹⁴ It included, for example, the need to appoint a Safety Officer.

14.481 NWS'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 provides a framework for the Operational Commander to operate within.*"⁶¹⁵

14.482 Annemarie Rooney's communications with Daniel Smith do not reveal any occasion when she set out what her tactical plan was.⁶¹⁶ 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.

⁶¹⁰ [INQ014791/10](#)

⁶¹¹ [116/43/14-44/12](#), [116/47/1-18](#)

⁶¹² [INQ041728/12](#) at paragraph 18

⁶¹³ [116/32/24-33/13](#)

⁶¹⁴ [115/139/8-140/18](#), [INQ025533/2](#)

⁶¹⁵ [INQ012913/15](#)

⁶¹⁶ [110/111/17-114/3](#), [INQ041728/12-13](#), [INQ041728/19-20](#), [INQ041728/44](#)

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.⁶¹⁷
- 14.484** 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.
- 14.485** The action card for Annemarie Rooney's role would have assisted her in this.⁶¹⁸ 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.
- 14.486** First, action prompt 3 expected Annemarie Rooney to *"[o]btain a full briefing from the Operational Commander"*.⁶¹⁹ 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.⁶²⁰ There was no discussion about major decisions that Daniel Smith was making:⁶²¹ 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"*.⁶²² 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"*.⁶²³ Action prompt 22 expected Annemarie Rooney to *"[l]iaise with Operational Commander to ensure functional roles are being undertaken"*.⁶²⁴ As I set

⁶¹⁷ [115/125/1-126/10](#)

⁶¹⁸ [INQ013422/24-25](#)

⁶¹⁹ [INQ013422/24-25](#)

⁶²⁰ [110/114/4-18](#)

⁶²¹ [INQ041728/20](#) at paragraph 48, [115/130/16-24](#)

⁶²² [INQ013422/24-25](#)

⁶²³ [INQ013422/24-25](#)

⁶²⁴ [INQ013422/24-25](#)

out at paragraph 14.233, Daniel Smith did not appoint a Safety Officer or an Equipment Officer.⁶²⁵ It was Annemarie Rooney's responsibility to ensure that all functional roles, including a Safety Officer and an Equipment Officer, were appointed.

- 14.488** Third, action prompt 13 expected Annemarie Rooney to "*[c]onsider the sectorisation of the incident, if required and ensure they match Police / Fire sectors. Allocate Sector Commanders via the Operational Commander.*"⁶²⁶ 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]*".⁶²⁷
- 14.489** This is not the approach expected by the action card.⁶²⁸ 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 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.

⁶²⁵ [110/121/18-122/20](#), [110/125/22-23](#)

⁶²⁶ [INQ013422/24-25](#)

⁶²⁷ [INQ041728/20](#) at paragraph 48

⁶²⁸ [INQ013422/24-25](#), [INQ013422/6-7](#)

⁶²⁹ [INQ013422/24-25](#)

⁶³⁰ [INQ013422/24-25](#)

⁶³¹ [115/118/13-25](#), [INQ041728/24-25](#), [116/176/10-178/20](#), [INQ041728/39](#)

'GM Framework for Patient Dispersal in a Mass Casualty Event'

14.493 On 29th March 2017, NWS tested a draft plan titled 'GM Framework for Patient Dispersal in a Mass Casualty Event' (the draft NWS 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 NWS 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."*⁶³⁴

14.495 This email was to prove prescient. The draft NWS GM Patient Dispersal Plan had not been signed off by 22nd May 2017, but it was used that night to inform command decisions.⁶³⁵

14.496 At 23:32, Annemarie Rooney contacted NWS Control. In that call, she said: *"I need to know ... about hospitals, ... we are going to be activating the Greater Manchester Mass Casualty Plan."*⁶³⁶ 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"*.⁶³⁷ The call concluded with NWS Control informing Annemarie Rooney that a check would be made that the hospitals were aware.⁶³⁸

14.497 At 23:34, Annemarie Rooney spoke to Daniel Smith. In the course of the conversation, the following exchange took place:

⁶³² [INQ008124](#)

⁶³³ [INQ025532/2](#)

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."⁶³⁹

"[Annemarie Rooney] [three minutes later] I've got details for you on the GM casualty capability chart in the mass casualty event."⁶⁴⁰

14.498 At 23:39, Annemarie Rooney read out to Daniel Smith the information contained in the draft NWS GM Patient Dispersal Plan.⁶⁴¹

14.499 Based on the above exchange, it appears that at 23:32 Annemarie Rooney spoke to NWS Control about activating the Greater Manchester Resilience Forum Mass Casualty Plan.⁶⁴² Two minutes later, Daniel Smith raised with her the need for the chart contained within the draft NWS GM Patient Dispersal Plan.⁶⁴³

14.500 The casualty capability chart in the draft NWS 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.⁶⁴⁴

14.501 In her second witness statement, Annemarie Rooney stated: "[T]he 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."⁶⁴⁵

⁶³⁹ [INQ034302](#)

⁶⁴⁰ [INQ034333](#)

⁶⁴¹ [INQ034333](#)

⁶⁴² [INQ025178T](#)

⁶⁴³ [INQ034302](#)

⁶⁴⁴ [115/126/11-14](#), [INQ041728/39](#) at paragraph 103

⁶⁴⁵ [INQ041728/17-18](#) at paragraph 40

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.⁶⁴⁶

- 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."*⁶⁴⁷
- 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 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.⁶⁴⁹
- 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.⁶⁵¹

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.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 12.⁶⁵³ NWFC responded to this broadcast. NWS did not.⁶⁵⁴ This was because it was not until 00:05 that Annemarie Rooney was provided with the short dial code

⁶⁴⁶ [INQ041728/17-18](#) at paragraph 40

⁶⁴⁷ [INQ041856/17-18](#)

⁶⁴⁸ [145/41/24-43/25](#)

⁶⁴⁹ [INQ034302](#)

⁶⁵⁰ [144/188/1-190/4](#), [145/38/12-41/17](#)

⁶⁵¹ [INQ041691/1-5](#)

⁶⁵² [INQ014791/7](#), [INQ041728/10-13](#) at paragraph 12(b)

⁶⁵³ [INQ030816T](#)

⁶⁵⁴ [INQ030816T](#), [100/4/3-8/4](#), [109/9/14-11/13](#), [125/39/16-41/2](#)

for this channel. Once she had it, she passed it on to NWS Control at 00:08.⁶⁵⁵ This talk group was not used again that night by any of the emergency services' control rooms.⁶⁵⁶

14.507 This is just one of a number of examples of time being spent during the emergency response on 22nd 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.⁶⁵⁷ A multi-agency control room talk group should have been an embedded part of all control rooms' practice before 22nd May 2017.⁶⁵⁸ Responsibility for failing to ensure this lies with GMP, NWS and GMFRS.

Role after midnight

14.509 Shortly before midnight, Stephen Hynes relieved Daniel Smith of his role as Operational Commander.⁶⁵⁹ At 00:02, Annemarie Rooney contacted Derek Poland to ask for confirmation of whether Stephen Hynes was now Operational Commander.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.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.⁶⁶²

14.511 Six minutes after Annemarie Rooney had asked Derek Poland if Stephen Hynes had taken over 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 NWS. He was senior to Annemarie Rooney.⁶⁶⁴ The Ambulance Service Experts commented:

⁶⁵⁵ [INQ041728/10-13](#) at paragraph 12(b), [INQ023725T](#)

⁶⁵⁶ [INQ030816T](#), [100/4/3-8/4](#), [125/39/16-41/2](#), [INQ041623/5-6](#) at paragraphs 7d and 7h

⁶⁵⁷ [INQ012913/32-33](#) at paragraph 6.4

⁶⁵⁸ [INQ008372/10-11](#) at paragraph 4.4, [63/93/10-20](#), [109/12/20-13/7](#)

⁶⁵⁹ [110/78/23-79/12](#), [110/182/6-183/12](#), [INQ035612/412](#), [INQ035612/420](#)

⁶⁶⁰ [INQ023657T](#), [115/133/3-11](#)

⁶⁶¹ [INQ013422/24-26](#), [INQ041728/22-24](#) at paragraphs 55, 61-62

⁶⁶² [113/104/17-25](#)

⁶⁶³ [113/110/9-111/11](#), [115/133/3-11](#)

⁶⁶⁴ [113/122/11-20](#)

*"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:

*"[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."*⁶⁶⁸

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 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.

⁶⁶⁵ [INQ041856/13](#)

⁶⁶⁶ [INQ041728/20/23](#) at paragraphs 49 and 61

⁶⁶⁷ [INQ041728/18](#) at paragraph 49

⁶⁶⁸ [INQ041728/21-22](#) at paragraph 55

⁶⁶⁹ [113/111/2-11](#)

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 NWSA'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 NWSA 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.
- 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 00:50.⁶⁷⁶ 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.⁶⁷⁷ 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.

⁶⁷⁰ [115/133/25-135/11](#)

⁶⁷¹ [INQ014791/11](#)

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](#)

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 2017.⁶⁷⁸ As the name suggests, there are two parts to this role. The Tactical Advisor role involves providing tactical advice to NWS commanders. This advice is not limited to the Tactical Commander. Operational Commanders can use the Tactical Advisor, as can the control room.⁶⁷⁹ The NILO role faces outward from NWS. 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.⁶⁸⁰ NWS operated an action card created by NARU for the Tactical Advisor/NILO role.⁶⁸¹
- 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.”*⁶⁸²
- 14.526** At 22:49, NWS Control contacted Jonathan Butler. The purpose of the call was *“to get you [Jonathan Butler] going”* to the incident.⁶⁸³ Jonathan Butler informed NWS Control that he would speak to Stephen Taylor, the other NWS on-call Tactical Advisor/NILO.⁶⁸⁴
- 14.527** After the call with NWS 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.⁶⁸⁵ At the time he mobilised, Jonathan Butler considered that the fact he was an Ambulance Intervention Team Commander may have been relevant to NWS Control’s direction that he attend the scene.⁶⁸⁶
- 14.528** At 22:56, NWS Control spoke to Jonathan Butler a second time. In that call, he was informed that NWS had declared a Major Incident. He was also told that the RVP was *“Hunts Bank”*.⁶⁸⁷ NWS Control told him that Annemarie Rooney was the Tactical Commander. Jonathan Butler concluded the call by saying: *“I’m on me way ... Steve [Taylor] will be able to assist you on the phone if you need anything.”*⁶⁸⁸

⁶⁷⁸ [116/37/10-12](#), [116/82/25-83/7](#)

⁶⁷⁹ [116/29/14-30/16](#), [116/34/1-9](#)

⁶⁸⁰ [116/30/17-31/4](#)

⁶⁸¹ [116/31/5-12](#)

⁶⁸² [INQ013422/27](#)

⁶⁸³ [INQ015355T](#)

⁶⁸⁴ [INQ015355T](#)

⁶⁸⁵ [116/38/8-39/15](#)

⁶⁸⁶ [116/38/8-39/15](#)

⁶⁸⁷ [INQ015507T](#)

⁶⁸⁸ [INQ015507T](#)

14.529 In that call, Jonathan Butler raised the issue of an NWS Airwave talk group. In evidence, he stated: “Steve [Taylor] was going to be dealing with [the multi-agency talk group].”⁶⁸⁹

Diversion to GMP HQ (23:47)

14.530 Jonathan Butler lived approximately 45 minutes’ drive from Manchester City Centre.⁶⁹⁰ He left his home shortly after 23:00.⁶⁹¹ At approximately 23:47, Stephen Taylor contacted Jonathan Butler. Stephen Taylor informed Jonathan Butler that Annemarie Rooney wanted him to attend GMP HQ.⁶⁹² 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.⁶⁹³ As a result, he changed course and drove to GMP HQ.⁶⁹⁴

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.⁶⁹⁵

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.”⁶⁹⁶ 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.⁶⁹⁷ Once in the GMP Silver Control Room, he “overheard somebody mention Plato”.⁶⁹⁸ He spoke to Temporary Superintendent Hill, who told him that Operation Plato had been declared very shortly after the Attack had occurred.⁶⁹⁹

14.534 Jonathan Butler said that Annemarie Rooney was “extremely busy going from one phone call to a second phone call”.⁷⁰⁰ 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”.⁷⁰¹

⁶⁸⁹ [116/42/4-21](#)

⁶⁹⁰ [116/39/24-40/6](#)

⁶⁹¹ [116/40/7-22](#)

⁶⁹² [116/46/14-47/6](#)

⁶⁹³ [116/45/1-21](#)

⁶⁹⁴ [116/39/24-40/22](#), [116/44/2-45/21](#)

⁶⁹⁵ [INQ034311](#)

⁶⁹⁶ [116/36/11-21](#)

⁶⁹⁷ [116/52/2-12](#)

⁶⁹⁸ [116/48/1-13](#)

⁶⁹⁹ [116/47/7-48/13](#)

⁷⁰⁰ [116/52/13-25](#)

⁷⁰¹ [116/52/2-25](#)

- 14.535** 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.”*⁷⁰² Stephen Hynes replaced Daniel Smith as Operational Commander at 23:57.⁷⁰³
- 14.536** Jonathan Butler went on to explain during his evidence that he wrote this because Stephen Hynes took a lot of decisions at the scene.⁷⁰⁴ 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 NWS should take a more pragmatic approach to scene management”*.⁷⁰⁵ By this he meant that the NWS 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.⁷⁰⁶
- 14.537** I recommend that NWS, 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]”*.⁷⁰⁷ This is unfortunate. Jonathan Butler struck me as being a highly capable member of the NWS response. It was clear to me that he was able to add a substantial amount to the quality of the NWS 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.
- 14.540** I will consider the wisdom of the decision to divert Jonathan Butler once I have dealt with the second Tactical Advisor/NILO.

⁷⁰² [116/53/1-24](#)

⁷⁰³ [INQ035612/420](#)

⁷⁰⁴ [116/53/1-24](#)

⁷⁰⁵ [116/53/1-24](#)

⁷⁰⁶ [116/53/1-55/21](#)

⁷⁰⁷ [116/58/9-59/7](#)

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 22:49.⁷⁰⁸ 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.⁷⁰⁹ Because of his Ambulance Intervention Team Commander qualification, Jonathan Butler had an additional set of competencies relevant to the response.⁷¹⁰ 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 NWS review its approach to Tactical Advisors/NILOs in light of this issue. NWS 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 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 NWS 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 NWS Control. It was a further consequence of Inspector Sexton's failure to notify NWS of his declaration.⁷¹⁵
- 14.545** Stephen Taylor was informed by NWS Control that a Major Incident had been declared. He informed NWS Control that he had tried to get through to GMP on a number of occasions and had been unsuccessful.⁷¹⁶
- 14.546** At 23:22, Stephen Taylor called NWS Control. He enquired whether NWS Control had "*done a hailing group call to GMP*".⁷¹⁷ He explained he was "*struggling to get hold of them*".⁷¹⁸

⁷⁰⁸ [116/38/4-11](#), [116/125/24-126/7](#)

⁷⁰⁹ [116/154/7-156/13](#)

⁷¹⁰ [116/2/21-4/25](#)

⁷¹¹ [115/118/13-24](#)

⁷¹² [INQ015347T](#)

⁷¹³ [116/130/16-132/4](#), [INQ015347T](#)

⁷¹⁴ [INQ024325/1](#), [97/163/21-164/2](#), [98/7/19-8/18](#)

⁷¹⁵ [97/114/1-9](#)

⁷¹⁶ [INQ015347T](#)

⁷¹⁷ [INQ015055T](#)

⁷¹⁸ [INQ015055T](#)

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 NWS Strategic Commander, Neil Barnes, should go. Daniel Smith told him, *"I haven't a clue,"* and directed Stephen Taylor to contact the Tactical Commander.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.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.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 NWS Strategic Commander to go to GMP HQ, as well as the NWS Tactical Commander. David Myerscough confirmed that the NWS 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.

⁷¹⁹ [INQ032953T](#)

⁷²⁰ [INQ034313/1](#)

⁷²¹ [116/158/5-18](#)

⁷²² [119/199/3-200/23](#), [120/36/5-9](#), [120/49/18-20](#), [121/51/15-17](#), [128/2/12-23](#)

⁷²³ [116/136/25-140/1](#), [INQ018835/2-4](#)

⁷²⁴ [INQ018835T/3-5](#)

⁷²⁵ [INQ018835T/3](#)

⁷²⁶ [INQ018835T/3](#)

⁷²⁷ [INQ018835T/4](#)

- 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.⁷²⁸ 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 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."*⁷³³ 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.

⁷²⁸ [INQ001186/1-2](#)

⁷²⁹ [INQ041728/10-13](#) at paragraph 12(b), [INQ023725T](#)

⁷³⁰ [116/163/7-164/16](#)

⁷³¹ [116/150/21-152/23](#)

⁷³² [116/166/14-167/14](#)

⁷³³ [116/168/6-169/18](#)

- 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."*⁷³⁴ 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.⁷³⁵
- 14.558** The other side of Stephen Taylor's role was to provide advice. He spoke to Daniel Smith, the NWS Operational Commander, during the critical period of the response. He did not offer him any advice. He provided limited advice to NWS Control during his two calls set out above at paragraphs 14.544 to 14.546.⁷³⁶
- 14.559** Stephen Taylor stated in evidence that he did speak to Annemarie Rooney, the NWS Tactical Commander, but he was not *"100% sure"* when.⁷³⁷ He stated that he thought it was before Annemarie Rooney's conversation with Daniel Smith at 23:39.⁷³⁸ Stephen Taylor stated that in his call with Annemarie Rooney, he discussed the activation of the *"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.⁷³⁹ His witness statement, which was based upon his notes, records that he *"recall[s] discussing the Mass Casualty Distribution Plan with Annemarie [Rooney]"* in a call at 22:47.⁷⁴⁰
- 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.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.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"*.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

⁷³⁴ [INQ001221](#)

⁷³⁵ [116/168/1-5](#)

⁷³⁶ [116/158/5-160/22](#)

⁷³⁷ [116/177/16-25](#)

⁷³⁸ [116/176/10-178/19](#)

⁷³⁹ [116/176/10-178/19](#)

⁷⁴⁰ [INQ029153/1](#), [INQ029154/3](#), [INQ029152/4](#) at paragraph 16

⁷⁴¹ [115/118/13-24](#)

⁷⁴² [115/118/13-24](#)

⁷⁴³ [115/126/6-14](#)

the plan that was being discussed with Daniel Smith was the draft NWS 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 NWS 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."*⁷⁴⁴
- 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.
- 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.⁷⁴⁵ 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.⁷⁴⁶
- 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.⁷⁴⁷ 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 calls.⁷⁴⁸ He stated that some notes were written up *"a few hours into the evening"*.⁷⁴⁹ Although he was concerned about the accuracy, he did not make any record to indicate this concern.⁷⁵⁰

⁷⁴⁴ [INQ041728/25](#) at paragraph 68

⁷⁴⁵ [INQ029154/1](#)

⁷⁴⁶ [116/122/21-23/6](#)

⁷⁴⁷ [116/146/17-147/21](#)

⁷⁴⁸ [116/123/12-24](#)

⁷⁴⁹ [116/147/7-8](#)

⁷⁵⁰ [116/146/17-147/21](#)

- 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.⁷⁵¹ 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.⁷⁵²
- 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), Inspector Dale Sexton".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."⁷⁵⁴ At 22:52, he recorded: "[F]rom FDO at this stage no secondary devices or active shooting."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.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.⁷⁵⁷ Further, there was no discussion during Stephen Taylor's call with GMP about secondary devices or active shooters.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."⁷⁵⁹ 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.⁷⁶⁰

⁷⁵¹ [116/153/8-154/6](#)

⁷⁵² [115/79/5-81/13](#)

⁷⁵³ [INQ029154/3](#)

⁷⁵⁴ [INQ029154/4](#)

⁷⁵⁵ [INQ029154/4](#)

⁷⁵⁶ [116/134/4-137/24](#)

⁷⁵⁷ [115/116/4-117/1](#)

⁷⁵⁸ [INQ018835T/2-4](#)

⁷⁵⁹ [INQ029152/7-8](#)

⁷⁶⁰ [INQ029152/7-8](#) at paragraph 33

14.574 Jonathan Butler suggested that increasing the Tactical Advisors/NiLOs within Nwas may lead to overall improvement.⁷⁶¹ Stephen Taylor said that a third Tactical Advisor/NiLO on call “*would have been ideal*”.⁷⁶² 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.⁷⁶³ 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.”⁷⁶⁴

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.”⁷⁶⁵

14.578 He stated that an Ambulance Intervention Team Commander would locate herself or himself at the FCP at the scene.⁷⁶⁶

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.*”⁷⁶⁷ Annemarie Rooney then said: “*Identify your AIT on duty.*”⁷⁶⁸

⁷⁶¹ [116/106/22-107/25](#)

⁷⁶² [116/171/12-172/1](#)

⁷⁶³ [116/2/21-3/1](#)

⁷⁶⁴ [116/3/3-4/20](#)

⁷⁶⁵ [116/5/18-6/1](#)

⁷⁶⁶ [116/5/3-6/5](#)

⁷⁶⁷ [INQ015353T/1](#)

⁷⁶⁸ [INQ015353T/1](#)

- 14.580** In her call with NWS 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.⁷⁶⁹ The call concluded with NWS Control informing Annemarie Rooney: “I’ll find one, I’ll get one.”⁷⁷⁰
- 14.581** At 23:10, the Greater Manchester Emergency Operations Centre within NWS Control contacted the Regional Health Control Desk within NWS Control.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.⁷⁷² It is not clear to me whether this happened or not.
- 14.582** It is unsatisfactory that, over 30 minutes after the Attack, NWS Control had still not identified an Ambulance Intervention Team Commander who could be mobilised in that capacity. NWS’s plan was that the Ambulance Intervention Team Commander would lead the specialist team responding to a Marauding Terrorist Firearms Attack.⁷⁷³ If there had been marauding gunmen, there would have been an even more urgent need than there was on 22nd 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 that Annemarie Rooney wanted him to go to GMP HQ rather than the scene.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.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.

⁷⁶⁹ [INQ015381T](#)

⁷⁷⁰ [INQ015381T/3](#)

⁷⁷¹ [INQ015367T](#)

⁷⁷² [INQ015367T](#)

⁷⁷³ [INQ026738/13](#) at paragraphs 86–87, [INQ026738/34](#) at paragraph 248

⁷⁷⁴ [INQ034311](#), [116/39/24-40/22](#), [116/44/2-45/21](#)

⁷⁷⁵ [115/133/24-134/20](#)

- 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 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.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 NWS qualified Ambulance Intervention Team Commander had arrived: Stephen Hynes.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.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 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 22nd May 2017 into 23rd May 2017, Neil Barnes was the NWS on-call Strategic Commander for Greater Manchester.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.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.⁷⁸¹

⁷⁷⁶ [116/2/21-3/17](#)

⁷⁷⁷ [113/81/16-21](#)

⁷⁷⁸ [INQ035612/405](#), [INQ035612/420](#)

⁷⁷⁹ [115/11/11-17/24](#)

⁷⁸⁰ [115/11/11-17/24](#)

⁷⁸¹ [115/11/11-17/24](#)

- 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 NWS Strategic Commander would be required. Doing nothing until he received a METHANE message from his Tactical Commander was unacceptably passive. NWS's Major Incident Response Plan stated: *"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
- 14.595** Following his call with Annemarie Rooney, Neil Barnes switched on his television to see if he could learn anything more.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.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.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 NWS Control to obtain an update. Relying entirely on the media for information while he waited for Annemarie Rooney to call him back was inadequate.⁷⁸⁸
- 14.597** Had Neil Barnes telephoned NWS Control a few minutes after he had spoken to Annemarie Rooney, he would have discovered that, at 22:46, NWS declared a Major Incident.⁷⁸⁹ It is likely he would have been provided with information

⁷⁸² [115/18/13-19/25](#)

⁷⁸³ [INQ012913/15](#)

⁷⁸⁴ [115/11/11-17/24](#)

⁷⁸⁵ [115/22/1-27/6](#)

⁷⁸⁶ [115/22/1-27/6](#)

⁷⁸⁷ [115/22/1-27/6](#)

⁷⁸⁸ [115/22/1-27/6](#)

⁷⁸⁹ [INQ015335T](#)

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 NWS Control.

Call from NWS Chief Executive Officer (23:00)

14.598 At approximately 23:00, Neil Barnes received a telephone call from Derek Cartwright, the NWS Chief Executive Officer. Derek Cartwright suggested that Neil Barnes should mobilise to GMP HQ. Following the call, Neil Barnes decided to remain at home.⁷⁹⁰

14.599 Neil Barnes' reasoning for this decision was that, although Derek Cartwright was the most senior person within NWS, he was not *"part of the command structure"*⁷⁹¹ 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 NWS Control]."*⁷⁹²

14.600 I recognise that Derek Cartwright was not formally part of the command structure on the night of 22nd May 2017. However, as Chief Executive Officer he was the most senior person in NWS. 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, NWS 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 NWS Control (23:20)

14.602 At approximately 23:20, NWS Control called Neil Barnes.⁷⁹³ In the course of this call, Neil Barnes was informed that NWS Control was receiving offers of staff to come on duty. Neil Barnes stated: *"Right, well we don't know the 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, NWS 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

⁷⁹⁰ [115/37/6-38/9](#)

⁷⁹¹ [115/38/15-16](#)

⁷⁹² [115/38/10-39/2](#)

⁷⁹³ [INQ034628T](#)

⁷⁹⁴ [INQ034628T/1](#)

⁷⁹⁵ [INQ034628T/1](#)

- 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.”⁷⁹⁹
- 14.607** Third, Neil Barnes failed to enquire whether Operation Plato had been declared.⁸⁰⁰ 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.⁸⁰¹ 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”⁸⁰² 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

⁷⁹⁶ [INQ034628T/2](#)

⁷⁹⁷ [INQ034628T/2](#)

⁷⁹⁸ [INQ034628T/2](#)

⁷⁹⁹ [INQ012913/14](#)

⁸⁰⁰ [INQ034628T](#)

⁸⁰¹ [INQ034628T](#)

⁸⁰² [INQ034628T/2](#)

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.⁸⁰³

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 NWS 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 NWS 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.

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

⁸⁰³ [INQ034628T](#)

⁸⁰⁴ [115/35/1-36/3](#)

⁸⁰⁵ [115/37/6-12](#)

⁸⁰⁶ [INQ034628T](#)

⁸⁰⁷ [115/40/18-42/23](#)

⁸⁰⁸ [115/41/19-42/23](#)

⁸⁰⁹ [115/51/17-53/4](#)

- 14.617 In the course of his journey, Neil Barnes had further conversations with NWS Control. At 23:52, he called NWS 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 NWS 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 NWS 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 NWS 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 00:35 he was relying on a generic strategic plan.⁸¹⁶
- 14.620 The Major Incident Response Plan states the following of the role of Strategic Commander:

*"NWS major incident action card 22 outlines the Strategic Commander's key responsibilities. The action card **must** be used during the management of the incident.*

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."⁸¹⁷

⁸¹⁰ [INQ025232T/1](#)

⁸¹¹ [INQ025213T](#)

⁸¹² [115/42/24-43/25](#)

⁸¹³ [115/47/21-49/22](#)

⁸¹⁴ [115/55/1-56/4](#)

⁸¹⁵ [INQ014784/4](#)

⁸¹⁶ [115/68/1-19](#), [INQ025534/2](#)

⁸¹⁷ [INQ012913/14](#)

- 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.⁸¹⁸ First, action card 22 directed: “[O]n notification of the incident start an incident log.”⁸¹⁹ 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”.⁸²⁰ 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 NWS risk assessment was conducted by the NWS 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”.⁸²¹ Although Neil Barnes did attend 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.⁸²² 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.”⁸²³ 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.⁸²⁴
- 14.626** Fifth, action card 22 expected Neil Barnes to “[e]nsure inter service liaison at the appropriate strategic level”.⁸²⁵ 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.

⁸¹⁸ [INQ013422/44-45](#)

⁸¹⁹ [INQ013422/44](#)

⁸²⁰ [INQ013422/44](#)

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.⁸²⁶ 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.⁸²⁷

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".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]."⁸²⁹

14.631 For the reasons I have given above, I agree with the opinion of the Ambulance Service Experts.

⁸²⁶ [115/11/20-12/4](#)

⁸²⁷ [115/74/6-76/3](#)

⁸²⁸ [115/49/15-22](#)

⁸²⁹ [INQ041856/19-20](#)

Casualty Clearing Station after midnight

- 14.632** 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."*⁸³⁰
- 14.633** 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."*⁸³¹
- 14.634** 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 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.⁸³² At 23:57, Stephen Hynes is captured on CCTV wearing the Operational Commander's tabard.⁸³³ At the point he took over as Operational Commander, Stephen Hynes was not aware of GMP's Operation Plato declaration.⁸³⁴
- 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.⁸³⁵
- 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.

⁸³⁰ [INQ040615/5](#)

⁸³¹ [INQ040615/6](#)

⁸³² [113/101/8-103/23](#)

⁸³³ [INQ035612/420](#)

⁸³⁴ [113/130/23-25](#)

⁸³⁵ [113/132/10-133/8](#)

⁸³⁶ [113/110/13-111/1](#)

⁸³⁷ [113/112/5-113/11](#)

- 14.639** At 00:16, Stephen Hynes spoke to CI Dexter.⁸³⁸ Stephen Hynes asked: *"[I]s 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 the same terminology within NWS for Major Incidents as was used for Operation Plato.
- 14.641** Following this conversation, Stephen Hynes spoke to NWS Control. NWS Control then called NWFC and communicated the request for GMFRS officers at the scene.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.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"*.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.⁸⁴⁴
- 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

⁸³⁸ [INQ035612/436](#)

⁸³⁹ [INQ040657/33-34](#)

⁸⁴⁰ [113/130/20-136/12](#)

⁸⁴¹ [INQ001149](#)

⁸⁴² [INQ040657/53](#)

⁸⁴³ [113/148/4-149/18](#), [113/161/17-162/21](#)

⁸⁴⁴ [113/130/20-136/12](#), [113/147/18-155/5](#)

⁸⁴⁵ [113/147/18-155/5](#)

⁸⁴⁶ [120/82/9-83/17](#)

- 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 Rooney.⁸⁴⁹ The participants were Stephen Hynes for NWS, CI Dexter for GMP and Station Manager Berry for GMFRS.⁸⁵⁰ 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.⁸⁵¹ I set out, in detail, what was said in the section relating to GMFRS's response to the Attack in Part 15.
- 14.648** 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.⁸⁵² 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 NWS's response.

Resources allocated

- 14.649** By midnight, 41 ambulances had been allocated to the response. Within the following 30 minutes, another seven ambulances were allocated by NWS 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

⁸⁴⁷ [113/153/9-25](#)

⁸⁴⁸ [INQ035612/522](#)

⁸⁴⁹ [113/155/6-9](#)

⁸⁵⁰ [INQ035612/522](#)

⁸⁵¹ [INQ040657/67-70](#)

⁸⁵² [113/157/14-16](#)

⁸⁵³ [INQ040368/1-17](#)

⁸⁵⁴ [INQ040368/1-17](#)

⁸⁵⁵ [81/127/2-132/20](#), [114/193/15-22](#), [114/225/10-22](#)

- 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
- 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 NWS response. This evidence only serves to highlight the importance of GMFRS's arriving two hours earlier.

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.

⁸⁵⁶ [INQ041992/1](#)

⁸⁵⁷ [INQ041992/1](#), [INQ041266](#)

⁸⁵⁸ [INQ041992/1](#)

⁸⁵⁹ [INQ041992/1](#)

⁸⁶⁰ [INQ035612/470](#)

⁸⁶¹ [INQ035612/495](#)

⁸⁶² [INQ035612/499](#), [INQ035612/504](#), [INQ035612/507](#)

Time (by)	Total casualties transported from Casualty Clearing Station	Total casualties remaining in Casualty Clearing Station	P1s remaining in Casualty Clearing Station	P2s remaining in Casualty Clearing Station
00:01	2	36	18	18
00:31	9	29	11	18
01:01	14	24	6	18
01:31	17	21	4	17
02:01	24	14	1	13
02:31	32	6	0	6
02:51	38	0	0	0

Table 4: Casualty Clearing Station after 00:00 on 23rd May 2017⁸⁶³

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.⁸⁶⁴

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.⁸⁶⁵ 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.⁸⁶⁶

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. As such, I reach no conclusions in relation to the adequacy of care of any individual who survived the Attack.

⁸⁶³ [INQ041266/1](#)

⁸⁶⁴ [INQ041266/1](#)

⁸⁶⁵ [INQ041266/1](#)

⁸⁶⁶ [114/84/11-85/18](#)

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."⁸⁶⁷

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.

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)."⁸⁶⁸

14.670 It was accepted on NWS's behalf "that some patients were not always given information as to the process".⁸⁶⁹

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.⁸⁷⁰

⁸⁶⁷ [INQ041856/17](#)

⁸⁶⁸ [INQ041856/17](#)

⁸⁶⁹ [INQ042544/51](#) at paragraph 108

⁸⁷⁰ [89/40/20-47/25](#), [138/16/5-19/8](#), [INQ041856/17](#)

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:

"Given proximity to designated hospitals, patient distribution although effective could have been faster in some cases ...

The dispatch of casualties from the CCS [Casualty Clearing Station] to hospital was effective and followed the patient dispersal plan.

...

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."⁸⁷¹

14.674 In its closing statement, NWAS accepted this evidence.⁸⁷²

14.675 At 02:00, there were 28 ambulances at the scene.⁸⁷³ 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.⁸⁷⁴ 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,

⁸⁷¹ [INQ041856/17-18](#)

⁸⁷² [INQ042544/52-53](#) at paragraph 112

⁸⁷³ [INQ041992/1](#)

⁸⁷⁴ [INQ041266/1](#)

I encourage NWS to reflect carefully on the experiences of those people.⁸⁷⁵ In any event, in my view, steps should be taken by NWS 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.⁸⁷⁶ 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.⁸⁷⁷
- 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.⁸⁷⁸
- 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.⁸⁷⁹
- 14.680** In its closing statement, NWS 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."*⁸⁸⁰
- 14.681** The Ambulance Service Experts identified that treatment of P3 casualties could have been improved.⁸⁸¹ 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"*.⁸⁸² 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

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](#)

⁸⁷⁸ [110/160/1-11](#)

⁸⁷⁹ [114/65/15-19](#)

⁸⁸⁰ [INQ042544/51-52](#) at paragraph 109

⁸⁸¹ [INQ041856/17](#)

⁸⁸² [144/167/1-6](#)

⁸⁸³ [114/63/19-64/1](#)

⁸⁸⁴ [INQ034333/2](#)

⁸⁸⁵ [110/182/6-184/3](#)

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.

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.

⁸⁸⁶ [INQ040366](#)

⁸⁸⁷ [114/194/4-195/2](#)

⁸⁸⁸ [113/163/15-164/10](#)

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

¹ [136/14/12-20](#)

- 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. 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"*.⁶ Over the course of the next six minutes, GMP Control provided David Ellis with more information about the Attack.⁷
- 15.11 He was told it was in the *"foyer area of the Manchester Arena"*.⁸ He was told that *"a bomb has exploded"*⁹ and that there were reports of 30 to 40 casualties.¹⁰ At 22:38, he was informed of the *"RVP [Rendezvous Point] car park area outside the Cathedral"*.¹¹ 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."*¹² He was provided with the BTP and NWS log numbers.¹³
- 15.12 As David Ellis was receiving this information, he was entering it into the NWFC system.¹⁴ To do so, he had to create an entry for the incident (the Arena log).¹⁵ He started typing *"explosion"*. He then selected the *"Explosion"* incident type,

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](#)

⁶ [INQ001231/2](#)

⁷ [INQ001231/2-6](#)

⁸ [INQ001231/3](#)

⁹ [INQ001231/3](#)

¹⁰ [INQ001231/4](#)

¹¹ [INQ001231/5](#)

¹² [INQ001231/5](#)

¹³ [INQ001231/3-6](#)

¹⁴ [122/178/10-13](#)

¹⁵ [INQ008376/3](#)

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.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.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.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.¹⁹ This was at approximately 22:39.²⁰
- 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.²¹ Although it did not occur to David Ellis to do this, for the reasons I gave in Part 12, it would have been reasonable for him to select the “*Operation Plato Standby phase*” incident type.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.

¹⁶ [122/182/23-183/5](#)

¹⁷ [122/187/22-188/12](#)

¹⁸ [122/185/20-186/8](#)

¹⁹ [122/185/3-186/2](#)

²⁰ [INQ001231/5](#)

²¹ [129/168/4-15](#)

²² [122/183/6-9](#)

- 15.18 David Ellis continued his call with GMP Control.²³ At 22:40, David Ellis was told: *"[W]e have an absolute load of officers going down."*²⁴ A minute later, he was told: *"[W]e've got an off duty PCSO [Police Community Support Officer] who is on scene."*²⁵ At 22:43, he was informed that *"ambulance state they have [up] to 5 vehicle on route as well" and "officers are now landing on scene"*.²⁶
- 15.19 At 22:44, David Ellis raised the fact that NWFC had received reports of a *"possible shooting"*.²⁷ This information came from NWS 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"*.²⁸ David Ellis said *"so police, are you confirming this"*.²⁹ The response from GMP Control was, *"Yeah police officer has just said injured party with gunshot wound to the leg."*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 ****"*.³¹
- 15.20 In an update three minutes later, GMP Control stated, *"[T]hese are not gunshot ... not gunshot wounds ... look like shrapnel wounds."*³² David Ellis made the following corresponding entry in the log at 22:48: *"*** FROM POLICE – NOT GUNSHOT WOUNDS LOOK LIKS [sic] SHRAPNEL WOUNDS ****"*.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."*³⁴ 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."*³⁵
- 15.22 Five minutes later, at 22:54, GMP Control informed David Ellis: *"The paramedic bronze has just arrived on scene as well."*³⁶ This was a reference to Patrick Ennis, an NWS Advanced Paramedic whom Inspector Michael Smith, the GMP Operational/Bronze Commander, had mistakenly thought was the NWS Operational Commander.³⁷ 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."*³⁸ GMP Control followed this up

²³ [122/187/8-21](#)

²⁴ [INQ001231/7](#)

²⁵ [INQ001231/7](#)

²⁶ [INQ001231/8](#)

²⁷ [INQ001231/8](#)

²⁸ [INQ001231/9](#)

²⁹ [INQ001231/9](#)

³⁰ [INQ001231/9](#)

³¹ [INQ008376/5](#)

³² [INQ001231/10](#)

³³ [INQ08376/6](#)

³⁴ [INQ001231/12](#)

³⁵ [INQ001231/12](#)

³⁶ [INQ001231/14](#)

³⁷ [INQ007214/18](#), [102/156/17-22](#)

³⁸ [INQ001231/15](#)

with: *"He's here now all NWS to attend booking office asap."*³⁹ GMP Control confirmed that NWS 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"*.⁴⁰

- 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."*⁴¹ He went on to say that NWFC would be contacting its senior officers and *"we will be RVP and contacting your guys"*.⁴² GMP Control replied: *"Ok that's not a problem."*⁴³
- 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?"*⁴⁴ 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, NWS 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."*⁴⁵ 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.⁴⁶
- 15.26** The call was ended. From about 23:40, the Silver Control Room began to be operational.⁴⁷ 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 NWS were monitoring the proposed multi-agency control room channel.⁴⁸ This was the extent of the contact before 00:36 from the Silver Control Room.

³⁹ [INQ001231/15](#)

⁴⁰ [INQ001231/16](#)

⁴¹ [INQ001231/16](#)

⁴² [INQ001231/16](#)

⁴³ [INQ001231/16](#)

⁴⁴ [INQ001231/17](#)

⁴⁵ [INQ001231/17](#)

⁴⁶ [99/198/16-203/5](#)

⁴⁷ [99/203/9-23](#)

⁴⁸ [125/39/16-41/2](#)

- 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 50061.⁴⁹ 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 NWS 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*".⁵⁰ One minute later, he added: "*AMB HAVE 5 VEHICLES ON ROUTE – POL HAVE ADVISED OFFICER LANDING ON SCENE*".⁵¹ 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 NWS 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 NWS Control. Joanne Haslam was informed by NWS Control that a "*bomb had gone off*" at the "*MEN Arena*".⁵⁶ In the course of the call, Joanne Haslam made entries on the Arena log.⁵⁷ Joanne Haslam's user handle was 50032.⁵⁸

⁴⁹ [122/178/24-179/6](#)

⁵⁰ [INQ008376/4](#)

⁵¹ [INQ008376/5](#)

⁵² [INQ008376/5](#)

⁵³ [INQ008376/8](#)

⁵⁴ [INQ008376/9](#)

⁵⁵ [123/61/25-62/6](#), [123/62/23-63/10](#)

⁵⁶ [INQ001218/1](#)

⁵⁷ [INQ008376/5-6](#)

⁵⁸ [123/55/21-56/1](#)

- 15.33** Joanne Haslam also relayed to NWS Control the information that GMP Control had given to David Ellis. This included telling NWS that GMP had declared an RVP.⁵⁹ In doing this, Joanne Haslam was doing what was expected of her by JESIP.
- 15.34** At one point in the call, NWS Control suggested that there might have been an “active shooter”.⁶⁰ Joanne Haslam carefully and calmly explored this information with NWS Control, establishing that this had not been confirmed by the police. Joanne Haslam also relayed to NWS Control the information from GMP Control that the previously reported gunshot wounds were shrapnel injuries.⁶¹
- 15.35** At 22:49, Joanne Haslam concluded the call. While that call was taking place, NWS declared a Major Incident,⁶² Patrick Ennis reported to NWS Control that the best access was Hunts Bank,⁶³ and NWS 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 NWS Control. It should have been.
- 15.36** Joanne Haslam did not ask whether NWS had received a METHANE message. Patrick Ennis provided a METHANE message five minutes after this call ended, so there was not yet one for NWS to share.⁶⁴ 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 NWS 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*”.⁶⁵ 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 NWS Control whether NWS had declared a Major Incident, I am not critical of her for not doing so.
- 15.38** Joanne Haslam did not inform NWS 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.*”⁶⁶ Less than two minutes after this, the GMFRS duty NILO had issued the instruction to mobilise fire appliances to Philips Park Fire Station.

⁵⁹ [INQ001218/6-7](#)

⁶⁰ [INQ001218/5](#)

⁶¹ [INQ001218/5-7](#)

⁶² [INQ015335T](#)

⁶³ [INQ032872T](#)

⁶⁴ [INQ015070T](#), [109/215/19-218/10](#)

⁶⁵ [123/61/5-24](#)

⁶⁶ [INQ001218/3](#)

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).⁶⁷

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.⁶⁸ At 22:40:48, the NWFC incident log number was entered into the GMP incident log.⁶⁹ Following this, Rochelle Fallon asked: *“Do you have any additional information on it [the incident]?”*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”*.⁷¹
- 15.42 GMP Control informed Rochelle Fallon that the RVP *“is car park area outside cathedral”*.⁷² Rochelle Fallon confirmed that NWFC already had that fact recorded.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.

⁶⁷ [INQ004284/2](#)

⁶⁸ [INQ004279/1](#)

⁶⁹ [INQ007214/12](#)

⁷⁰ [INQ001136/1](#)

⁷¹ [102/182/1-8](#), [INQ018514T/7](#)

⁷² [INQ001136/1](#)

⁷³ [102/182/22-183/2](#)

15.45 Towards the end of the call, GMP Control informed Rochelle Fallon: “[W]e’ve got the RVP. We’ve got all our supervision there and all the ... all our officers going as well.”⁷⁴ 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.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.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, “It sounded like a big blast and looking at the people, I would suggest it’s a dirty bomb of some description.”⁷⁷

Call from BTP Control (22:44)

15.48 At 22:44, Vanessa Ennis answered a call from BTP Control.⁷⁸ Because Rochelle Fallon was on another call at the time, she was not supervising Vanessa Ennis during the call with BTP.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”.⁸⁰ Rochelle Fallon stated that she was unaware of that instruction being given at the time.⁸¹ 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.”⁸²

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.

⁷⁴ [INQ001136/1](#)

⁷⁵ [103/72/19-73/11](#)

⁷⁶ [INQ001165/1](#)

⁷⁷ [INQ001165/1](#)

⁷⁸ [124/33/9-34/16](#)

⁷⁹ [136/26/24-27/8](#)

⁸⁰ [124/34/17-18](#)

⁸¹ [136/27/20-28/1](#)

⁸² [136/27/9-19](#)

- 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 22nd 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.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?"*⁸⁴ She and BTP Control agreed that she would.⁸⁵
- 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.⁸⁶ Given her inexperience, 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.⁸⁷
- 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.

⁸³ [136/27/20-28/19](#)

⁸⁴ [INQ001196/1](#)

⁸⁵ [INQ001196/1](#)

⁸⁶ [125/222/12-223/3](#)

⁸⁷ [INQ002000/29-32](#), [INQ002000/39](#), [INQ002000/44](#)

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.”⁸⁸ Rochelle Fallon informed the LFRS officer that she would contact NWAS.⁸⁹

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.”⁹⁰ In response, NWAS Control asked: “ARE YOU GUYS ON SCENE?”⁹¹ 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.⁹²
- 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.

⁸⁸ [INQ001152](#)

⁸⁹ [136/32/11-32](#)

⁹⁰ [INQ001178/1](#)

⁹¹ [INQ001178/1](#)

⁹² [INQ001178](#)

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 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

⁹³ [INQ001190](#)

⁹⁴ [INQ001190/1-3](#)

⁹⁵ [INQ001159](#)

- 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. 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.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 room talk group on the night of 22nd May 2017. There should have been one.

Contact with GMFRS duty NILO before 23:00

Call to Station Manager Berry (22:40)

- 15.72 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.
- 15.73 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"*.⁹⁸ This was a sensible announcement for Michelle Gregson to make.

⁹⁶ [INQ002000/34-48](#)

⁹⁷ [INQ002000/46](#)

⁹⁸ [123/218/12-25](#)

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”*.⁹⁹ She said that the police had provided an RVP of *“the car park area outside the cathedral”*.¹⁰⁰ Shortly afterwards, she said, *“obviously we are not mobilising at the moment”*.¹⁰¹ Michelle Gregson asked Station Manager Berry if he could speak to the police.¹⁰²
- 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,¹⁰³ 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”*.¹⁰⁴ 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.¹⁰⁷
- 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.¹¹⁰ 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.

⁹⁹ [INQ001198/1](#)

¹⁰⁰ [INQ001198/1](#)

¹⁰¹ [INQ001198/1](#)

¹⁰² [INQ001198/1](#)

¹⁰³ [124/17/9-18](#)

¹⁰⁴ [142/131/12-20](#)

¹⁰⁵ [INQ001198/2](#)

¹⁰⁶ [INQ001198/2](#)

¹⁰⁷ [INQ001198/2](#)

¹⁰⁸ [124/15/16-16/17](#)

¹⁰⁹ [INQ001198/2](#)

¹¹⁰ [124/16/6-14](#)

- 15.78** At the end of the call, Michelle Gregson did not anticipate that Station Manager Berry would have any difficulty contacting the FDO.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"*.¹¹²
- 15.80** At 22:48, Michelle Gregson created the Philips Park log.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.¹¹⁴
- 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.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.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.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.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.¹¹⁹

¹¹¹ [124/22/18-21](#)

¹¹² [124/24/7-25](#), [INQ001237](#)

¹¹³ [124/21/15-22/10](#)

¹¹⁴ [124/29/8-25](#)

¹¹⁵ [124/30/13-31/6](#)

¹¹⁶ [123/64/15-21](#)

¹¹⁷ [INQ004284/4](#)

¹¹⁸ [INQ001193/1](#)

¹¹⁹ [136/21/18-23/15](#)

- 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: *"We've just literally had a call from ambulance now, stating that people are being shot."*¹²⁰ This was a reference by Rochelle Fallon to the call Joanne Haslam took from NWS at 22:38, which was ongoing as Rochelle Fallon was leaving her message for Station Manager Berry.¹²¹ Rochelle Fallon had taken this information from the Arena log.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 *"what I'd seen and what information I thought was important"*.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

¹²⁰ [INQ001229/1](#)

¹²¹ [136/25/1-12](#)

¹²² [136/26/5-11](#)

¹²³ [136/26/5-11](#)

¹²⁴ [119/206/2-4](#)

¹²⁵ [INQ001215/1](#)

¹²⁶ [INQ001215/1](#)

¹²⁷ [INQ001215/1](#)

¹²⁸ [INQ008376/6](#)

¹²⁹ [INQ008376/5](#)

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.
- 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.¹³¹ I will return to this when I have completed my review of other important contact between NWFC and GMFRS.
- 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.¹³² For the reasons I have given, Vanessa Ennis should not have been the person to answer the call from Station Manager Berry. It 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.¹³³

¹³⁰ [123/158/9-160/21](#)

¹³¹ [135/4/1-8](#), [135/66/7-17](#)

¹³² [INQ001148](#)

¹³³ [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.¹³⁴ This training had not been assimilated, as was revealed by the events of 22nd May 2017.¹³⁵ 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 NIOs 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 ***.¹³⁶ Joanne Haslam knew this: she had informed Group Manager Nankivell of that fact seconds earlier. She stated that she was not aware that Station Manager Berry did not know this fact. She assumed that he did know.¹³⁷ 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.

¹³⁴ [123/132/2-13](#), [125/206/16-23](#)

¹³⁵ [125/216/1-218/16](#)

¹³⁶ [INQ008376/8](#)

¹³⁷ [123/130/15-131/15](#)

- 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.¹³⁸
- 15.104 The fact that NWS had a Commander “at scene” was highly significant information.¹³⁹ 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.¹⁴⁰

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.¹⁴¹ 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.¹⁴²
- 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*”.¹⁴³ Janine Carden asked the question “*WHAT TALK GROUPS IT [the incident] ON?*”¹⁴⁴ Lisa Owen responded, “*AT THE MOMENT WE HAVENT TURNED OUT WE ARE JUST CREATING.*”¹⁴⁵ The call concluded with Janine 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.

¹³⁸ [123/136/10-137/4](#)

¹³⁹ [INQ008376/8](#)

¹⁴⁰ [120/105/18-107/7](#)

¹⁴¹ [124/171/23-25](#)

¹⁴² [124/172/11-173/13](#)

¹⁴³ [INQ001234/1](#)

¹⁴⁴ [INQ001234/2](#)

¹⁴⁵ [INQ001234/2](#)

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](#)

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 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.

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.¹⁵⁶ 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 2017.¹⁵⁷ Very shortly before she arrived at NWFC, GMFRS had begun to deploy resources to the scene for the first time.¹⁵⁸

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 2017.¹⁵⁹ She did not relieve Janine Carden, but acted in a supporting role.¹⁶⁰

¹⁵¹ [124/174/6-9](#)

¹⁵² [125/30/5-10](#), [125/188/19-25](#)

¹⁵³ [125/30/17-19](#), [125/189/1-5](#)

¹⁵⁴ [INQ040645](#)

¹⁵⁵ [INQ040645](#)

¹⁵⁶ [125/189/1-190/16](#)

¹⁵⁷ [125/190/20-191/3](#)

¹⁵⁸ [125/192/4-8](#)

¹⁵⁹ [135/18/18-19/20](#)

¹⁶⁰ [135/16/25-17/9](#)

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.¹⁶¹ At 22:52, Group Manager Nankivell was telephoned by Joanne Haslam.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?*"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*".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 ...*".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.*"¹⁶⁶ She went on to say, "*[W]e've created a job at Philips Park Fire Station.*"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

¹⁶¹ [128/194/8-196/11](#)

¹⁶² [128/197/21-23](#)

¹⁶³ [INQ001224/1](#)

¹⁶⁴ [INQ001224/1](#)

¹⁶⁵ [INQ001224/1](#)

¹⁶⁶ [INQ001224/2](#)

¹⁶⁷ [INQ001224/2](#)

¹⁶⁸ [INQ001224/2-3](#)

¹⁶⁹ [INQ001224/3](#)

¹⁷⁰ [128/202/15-203/6](#)

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 NWS 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.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.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.¹⁷⁷ He was also qualified as a NILO.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.¹⁷⁹ It was the result of Station

¹⁷¹ [128/203/24-204/6](#)

¹⁷² [INQ001224/3](#)

¹⁷³ [128/203/24-204/6](#)

¹⁷⁴ [128/204/17-19](#)

¹⁷⁵ [INQ001150](#)

¹⁷⁶ [INQ034363T](#)

¹⁷⁷ [121/21/12-22/4](#)

¹⁷⁸ [121/10/18-23](#)

¹⁷⁹ [INQ041473/33](#)

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 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."¹⁸⁰ 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.¹⁸¹
- 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 NWS had a "Bronze Commander"¹⁸² on the scene by 22:55, and that GMP had provided an RVP near the scene.¹⁸³
- 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.¹⁸⁴
- 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.¹⁸⁵ A pager message was sent to him at 23:04 by Joanne Haslam.¹⁸⁶ He received it at 23:06.¹⁸⁷ 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?"¹⁸⁸ 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

¹⁸⁰ [INQ019078](#)

¹⁸¹ [121/24/23-25/7](#), [121/25/19-21](#), [INQ034369T/1](#)

¹⁸² [INQ008376/8](#)

¹⁸³ [INQ034369T/1](#)

¹⁸⁴ [136/37/19-38/21](#)

¹⁸⁵ [121/153/20-24](#)

¹⁸⁶ [INQ041473/34](#)

¹⁸⁷ [121/154/3-5](#)

¹⁸⁸ [INQ001185/1](#)

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."*¹⁸⁹

- 15.130** 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.
- 15.131** 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."*¹⁹⁰ 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.¹⁹¹
- 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 NWS 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.
- 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

¹⁸⁹ [INQ001185/1](#)

¹⁹⁰ [INQ001185/2](#)

¹⁹¹ [INQ001185/3-4](#)

¹⁹² [INQ008376/8](#)

¹⁹³ [124/53/4-6](#)

¹⁹⁴ [124/53/7-10](#)

¹⁹⁵ [121/169/23-170/8](#)

- 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 any talk groups he wished the NILOs to monitor. Group Manager Nankivell said that he only wanted pagers monitored at that time.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: "*[H]ave you had any more updates that we're ... not privy of?*"¹⁹⁹ Janine Carden answered: "*No we haven't.*"²⁰⁰ She provided information

¹⁹⁶ [INQ001206/1](#)

¹⁹⁷ [INQ001230](#)

¹⁹⁸ [INQ001236](#)

¹⁹⁹ [INQ001140/1-2](#)

²⁰⁰ [INQ001140/2](#)

about the activities of GMFRS officers. Group Manager Nankivell asked:
*"[W]e've got no pumps down at the actual scene of it, have we?"*²⁰¹
 Janine Carden told him that the appliances were at Philips Park Fire Station.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 experienced²⁰⁴ 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 NWS. Had the call with BTP at 23:17 been adequately managed, it should have resulted in important information 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

²⁰¹ [INQ001140/2](#)

²⁰² [INQ041473/58-59](#), [125/41/9-20](#)

²⁰³ [122/199/11-22](#)

²⁰⁴ [122/168/24-169/8](#)

²⁰⁵ [123/144/11-145/6](#)

²⁰⁶ [123/145/17-146/11](#)

²⁰⁷ [69/128/2-9](#)

²⁰⁸ [69/133/22-134/12](#)

- 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.²¹¹ Lisa Owen made no entry in the incident log in relation to the information she had been given.²¹² 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.

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."*²¹³ 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"*.²¹⁴ 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."*²¹⁵
- 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

²⁰⁹ [69/137/22-138/12](#)

²¹⁰ [INQ001176](#)

²¹¹ [125/150/7-24](#)

²¹² [125/150/25-151/4](#)

²¹³ [INQ040474/1](#)

²¹⁴ [INQ040474/2](#)

²¹⁵ [INQ040474/2](#)

information. The contrast between NWS'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 NWS. 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.²¹⁸ 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."*²¹⁹
- 15.161** Area Manager Etches stated that, in asking his question, he was *"seeking further information"*.²²⁰ He stated that he was not seeking information specific to the movements of the police or paramedics.²²¹ In response, Rochelle Fallon confirmed that GMFRS was mustering at Philips Park Fire Station and that NWFC was receiving *"more information from ambulance and police every time they get anything about a fatality"*.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.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

²¹⁸ [129/166/14-25](#)

²¹⁹ [INQ034353T](#)

²²⁰ [129/183/21-185/4](#)

²²¹ [129/185/12-186/3](#)

²²² [INQ034353T](#)

²²³ [129/184/17-185/4](#)

²²⁴ [INQ004290/1-3](#)

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 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."*²²⁸
- 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.²²⁹ 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.²³⁰ 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.²³¹

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

²²⁵ [63/49/19-24](#), [127/193/25-194/9](#)

²²⁶ [INQ019040/1](#)

²²⁷ [127/194/10-18](#)

²²⁸ [INQ001186/2](#)

²²⁹ [123/45/20-23](#)

²³⁰ [123/71/11-72/8](#)

²³¹ [INQ004290/3](#)

²³² [INQ041473/47](#)

²³³ [INQ004290/4](#), [128/31/20-32/11](#), [125/39/24-40/5](#)

- 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 NWS 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, 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 HEADQUARTERS, I’M NEARLY THERE NOW.”*²³⁷ 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.²³⁸ 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

²³⁴ [128/31/20-32/8](#)

²³⁵ [128/32/20-33/3](#)

²³⁶ [INQ004290/4](#)

²³⁷ [INQ001180/1](#)

²³⁸ [121/39/4-40/11](#)

asked: *"HAVE WE GOT A BRIEF OR ANY INSTRUCTIONS?"*²³⁹ In reply, Lisa Owen informed him of the movements of GMFRS personnel, but that *"WE'VE GOT NO INSTRUCTIONS WITH REGARDS TO MOBILISING YET."*²⁴⁰

- 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 ... THAT THEY'VE BEEN SENT HERE FROM THE STATIONS YET WE'VE HAD N WAS STAFF TURNING UP ON THE FORECOURT."*²⁴¹ 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."*²⁴² She stated that it was possible that Station Manager Berry was speaking to the FDO at GMP.²⁴³
- 15.176** 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.²⁴⁴
- 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 N WAS. 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 N WAS to find out what was going on.²⁴⁵ She should also have sought to contact Station Manager Berry.

²³⁹ [INQ001143/1](#)

²⁴⁰ [INQ001143/1](#)

²⁴¹ [INQ001143/2](#)

²⁴² [125/162/10-12](#)

²⁴³ [INQ001143/2](#)

²⁴⁴ [125/153/18-154/20](#)

²⁴⁵ [125/156/25-157/7](#)

GMP, NWS 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?”*²⁴⁷ 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”*.²⁴⁸ Rochelle Fallon said she would ring back.²⁴⁹

15.181 Rochelle Fallon did not know what an FCP was.²⁵⁰ 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.

²⁴⁶ [INQ029819](#)

²⁴⁷ [INQ001161/1](#)

²⁴⁸ [INQ001161/1](#)

²⁴⁹ [INQ001161/1](#)

²⁵⁰ [136/49/2-18](#)

²⁵¹ [INQ001175](#)

- 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 at least 45 minutes and that NWAS had a *"Bronze Commander"*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:
- *"WE NEED AS MANY STAFF TO THE FOYER INSPECTOR HAS ASKED ALL CASUALTIES OUT OF THE AREA ASAP."*²⁵³
 - *"CONFIRMED WITH AMB – THEY HAVE 11 AMB AND A NUMBER OF RESPONSE VEHS EN ROUTE."*²⁵⁴
 - *"PATROLS TO MAKE HUNTSBANK."*²⁵⁵
 - *"CONFIRMED OFFENDER IS DEAD."*²⁵⁶
 - *"INJURED PARTIES ARE BEING MOVED OUT."*²⁵⁷
 - *"SECONDARY CORDON AT HUNTSBANK TO EASE ACCESS OF EMERGENCY VEHICLES."*²⁵⁸
- 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.²⁵⁹ 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.

²⁵² [INQ008376/8](#)

²⁵³ [INQ007214/20](#)

²⁵⁴ [INQ007214/21](#)

²⁵⁵ [INQ007214/21](#)

²⁵⁶ [INQ007214/23](#)

²⁵⁷ [INQ007214/23](#)

²⁵⁸ [INQ007214/25](#)

²⁵⁹ [INQ001158](#)

- 15.189** This was an unacceptably long period of time for NWFC not to be in contact with NWS Control. The contact only occurred because Rochelle Fallon had been asked a question that GMP Control was not able to answer.
- 15.190** Rochelle Fallon asked NWS Control if there was an FCP. NWS Control replied: *"A LOT OF OUR VEHICLES ARE GOING TO THOMPSON STREET FIRE STATION."*²⁶⁰ Rochelle Fallon asked, *"SO HAVE YOU GOT AMBULANCES ON SCENE?"*²⁶¹ It was surprising that Rochelle Fallon asked this question as, in her call with NWS Control at 22:57, Rochelle Fallon had informed NWS Control from the Arena log that *"ALL THE AMBULANCE HAVE BEEN DIRECTED TO THE BOOKING OFFICE."*²⁶²
- 15.191** In the call at 23:50, NWS Control responded: *"WE'VE GOT EVERYBODY THERE."*²⁶³ Given the time that had passed since the previous contact with NWS Control, Rochelle Fallon should have asked for a general update from NWS. It was a further opportunity for NWFC to be provided with the NWS Advanced Paramedic Patrick Ennis's METHANE message.
- 15.192** Although Rochelle Fallon did not ask for it directly, the information provided by NWS 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 NWS 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 NWS 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, NWS had only two vehicles at Manchester Central Fire Station; but had 21 vehicles on Hunts Bank or Station Approach at that time. Gerard Blezard, NWS Director of Operations, who produced and released statements on behalf of NWS 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 simply not understood is a potential barrier to interoperability ... Agreeing and using common terminology is a*

²⁶⁰ [INQ001158](#)

²⁶¹ [INQ001158](#)

²⁶² [INQ001178](#)

²⁶³ [INQ001158](#)

²⁶⁴ [136/49/19-50/25](#)

²⁶⁵ [INQ041992/1](#)

*building block for interoperability.*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"*.²⁶⁷

15.195 It is important that GMP, BTP, NWS 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 NWS had *"ADVISED THAT A LOT OF THEIR APPLIANCES ARE RENDEZVOUSING AT THOMPSON STREET"*.²⁶⁸ Group Manager Levy replied: *"THOMPSON STREET WHAT, BY OUR FIRE 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, NWS did not respond.²⁷⁵

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."*²⁷⁶

²⁶⁶ [INQ004542/7](#)

²⁶⁷ [Cabinet Office, 'Lexicon of UK civil protection terminology', 2010](#)

²⁶⁸ [INQ001233](#)

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](#)

²⁷⁶ [INQ004290/5](#)

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."*²⁷⁷ 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.²⁷⁸ 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?"*²⁷⁹ Rochelle Fallon replied: *"No."* Group Manager Levy asked Rochelle Fallon to record him as the Incident Commander.²⁸⁰ 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"*.²⁸¹ At Manchester Central he had found non-specialist ambulances and this had prompted his question.²⁸²

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.²⁸³

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"*.²⁸⁴ Group Manager Nankivell asked when this RVP was provided. Joanne Haslam stated: *"That was from the initial call."*²⁸⁵

²⁷⁷ [INQ041473/70](#)

²⁷⁸ [INQ018835T/15](#)

²⁷⁹ [INQ001204](#)

²⁸⁰ [INQ001204](#)

²⁸¹ [122/30/1](#)

²⁸² [122/29/17-30/8](#)

²⁸³ [INQ026726/2](#), [126/105/23-108/7](#)

²⁸⁴ [INQ001163](#)

²⁸⁵ [INQ001163](#)

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 the GMFRS response on the night of 22 May 2017 could fairly be described as risk averse.”²⁸⁶*
- 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

²⁸⁶ [INQ042436/36](#) at paragraphs 132 and 133

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 22:40.²⁸⁷ Station Manager Berry should have challenged Michelle Gregson when she stated, *“obviously we are not mobilising”*.²⁸⁸ 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.²⁸⁹

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?”*²⁹⁰ 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.²⁹¹ For an explosion, the GMFRS action plan directed mobilisation to the incident.²⁹² 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.²⁹³

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”*.²⁹⁴ He stated that, although Manchester Central Fire Station was outside the cordon he drew, he ruled it

²⁸⁷ [INQ001198](#)

²⁸⁸ [INQ001198/1](#)

²⁸⁹ [INQ042436/15-17](#) at paragraphs 57 and 61

²⁹⁰ [INQ001198/2](#)

²⁹¹ [INQ019116/3](#)

²⁹² [INQ004404](#)

²⁹³ [INQ001198/2](#)

²⁹⁴ [119/183/13-14](#)

out on the basis that if the incident “shifts” it would be inside the cordon and compromised as a location.²⁹⁵ 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”.²⁹⁶ He stated that he did not think to evacuate Manchester Central Fire Station.²⁹⁷

- 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.
- 15.232** There was no adequate basis for Station Manager Berry’s rejection of the GMP-nominated RVP.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.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.³⁰⁴

²⁹⁵ [119/183/5-20](#), [119/186/4-25](#)

²⁹⁶ [119/184/4-23](#)

²⁹⁷ [119/187/8-12](#)

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

³⁰² [131/164/11-24](#), [121/176/24-177/4](#)

³⁰³ [120/17/16-24](#)

³⁰⁴ [120/16/8-12](#)

- 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.³⁰⁵ 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.³⁰⁶
- 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.³⁰⁷ 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.³⁰⁸ 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.

³⁰⁵ [119/197/19-198/25](#)

³⁰⁶ [119/199/3-200/23](#)

³⁰⁷ [119/204/5-19](#)

³⁰⁸ [119/213/17-214/9](#)

- 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.³⁰⁹
- 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.³¹⁰ 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."*³¹¹ 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 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

³⁰⁹ [119/201/7-202/20](#)

³¹⁰ [119/196/12-25](#)

³¹¹ [INQ001215/1](#)

³¹² [INQ001215/1](#)

³¹³ [119/214/1-24](#)

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, NWS operated a system of NILOs. At no point during the critical period of the response did Station Manager Berry contact his equivalent NILO at NWS, 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.³¹⁴ GMFRS had not, for example, ensured that its own NILOs had the contact details of NWS NILOs.³¹⁵ It should have done so.³¹⁶ Station Manager Berry had received no training on what he should do if he could not speak to the FDO.³¹⁷ 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

15.248 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.³¹⁸ He travelled under blue lights.³¹⁹ 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.³²⁰

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

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](#)

³²¹ [119/192/1-8](#)

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 23:40.³²³ During the journey, he continued to try calling the FDO.³²⁴
- 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 22:57.³²⁵ 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 NWS "Bronze Commander"³²⁶ 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"*.³²⁷ 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

³²² [119/192/1-13](#), [INQ042436/18-19](#) at paragraph 68

³²³ [INQ004300/1](#), [119/195/8-197/18](#)

³²⁴ [120/36/5-9](#)

³²⁵ [INQ041473/16-17](#), [INQ041473/21](#), [INQ041473/28](#)

³²⁶ [INQ008376/8](#)

³²⁷ [120/32/21-35/3](#)

³²⁸ [INQ041473/32](#)

³²⁹ [INQ041473/42](#)

³³⁰ [INQ041473/44](#)

³³¹ [INQ041473/48](#)

Marauding Terrorist Firearms Attack response. Station Manager Berry asked Crew Manager Henshall to mobilise and assist with the response to the Attack. He directed Crew Manager Henshall to Philips Park Fire Station.³³²

- 15.257 Station Manager Berry told Crew Manager Henshall that he *“had tried to get hold of the FDO but couldn’t get hold of them via phone”*.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.³³⁴ At 23:37, Station Manager Berry spoke to Group Manager Fletcher for a second time.³³⁵
- 15.259 At 23:40, Station Manager Berry arrived at Philips Park Fire Station.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.

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.³³⁷ 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”*.³³⁸ 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.”*³³⁹
- 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.³⁴⁰ 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.

³³² [INQ024677/7](#)

³³³ [INQ024677/7](#)

³³⁴ [INQ041473/51](#)

³³⁵ [INQ041473/53](#)

³³⁶ [INQ004300/1](#)

³³⁷ [INQ001237](#)

³³⁸ [INQ001237/1](#)

³³⁹ [INQ001237/1](#)

³⁴⁰ [INQ004281/3](#)

- 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*".³⁴¹
- 15.264** There was one fire appliance at Philips Park Fire Station on the night of the Attack.³⁴² At 22:49, this fire appliance was allocated to the GMFRS response to the Attack.³⁴³ 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. Watch Manager Simister and his team had come on duty at 19:00.³⁴⁴
- 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.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.³⁴⁶ Watch Manager Simister and his team got into their "*fire gear*" and waited for confirmation of the mobilising instruction.³⁴⁷ Eight minutes later, a second pre-alert was automatically transmitted to Manchester Central Fire Station.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.³⁴⁹ I will deal with how Watch Manager Walker came to learn of the Attack in paragraphs 15.273 to 15.277.

³⁴¹ [70/77/23-78/8](#)

³⁴² [70/71/5-8](#)

³⁴³ [INQ041473/19](#)

³⁴⁴ [69/131/13-132/14](#)

³⁴⁵ [69/133/3-21](#)

³⁴⁶ [69/132/21-23](#)

³⁴⁷ [69/133/22-134/12](#)

³⁴⁸ [INQ041473/3](#), [INQ041473/14](#)

³⁴⁹ [69/135/10-20](#)

- 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: 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

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](#)

³⁵⁵ [INQ041473/19](#)

³⁵⁶ [69/139/16-22](#)

³⁵⁷ [INQ041473/1-3](#)

³⁵⁸ [INQ041473/25-26](#)

³⁵⁹ [69/135/21-24](#)

to attend the Arena.³⁶⁰ Helen 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.³⁶¹

- 15.275 In due course, Helen Mottram was diverted by NWS 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 23:06.³⁶²
- 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 15.268.³⁶³
- 15.277 At 22:49, the fire appliance to which Crew Manager Mottram was assigned was mobilised to Philips Park Fire Station.³⁶⁴ He arrived five minutes later.³⁶⁵

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 operatives³⁶⁶ located at Fire Station A. There was one Specialist Response Team appliance at Fire Station A on the night of the Attack.³⁶⁷
- 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 NWS's

³⁶⁰ [INQ040368/1](#)

³⁶¹ [70/6/8-7/9](#)

³⁶² [INQ040368/1](#)

³⁶³ [70/7/18-9/21](#)

³⁶⁴ [INQ041473/19](#)

³⁶⁵ [INQ041473/25](#)

³⁶⁶ [71/27/13-28/10](#)

³⁶⁷ [71/3/20-4/15](#)

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. He explained that he needed to speak to the NILO. Rochelle Fallon called Station Manager Berry at 22:44.³⁷¹ 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.³⁷²

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."*³⁷³

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

³⁶⁸ [71/12/25-18/24](#), [71/24/19-26/12](#), [INQ024677/3](#)

³⁶⁹ [71/30/23-31/18](#)

³⁷⁰ [71/32/5-12](#)

³⁷¹ [INQ041473/11-12](#)

³⁷² [71/32/5-35/14](#)

³⁷³ [INQ001215](#)

³⁷⁴ [INQ001144](#)

- 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".³⁸⁰ This was because shortly before this call Group Manager Nankivell had directed Joanne Haslam to mobilise the Technical Response Unit "with their MTFA kit".³⁸¹
- 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."³⁸² The Major Response Unit appliance is an enhanced response vehicle with rescue capabilities.³⁸³
- 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 Unit appliance.³⁸⁴ By 23:46, these specialist vehicles had arrived at Philips Park Fire Station.³⁸⁵
- 15.291 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.

³⁷⁵ [71/35/19-36/4](#)

³⁷⁶ [INQ041473/38](#)

³⁷⁷ [INQ041473/45](#)

³⁷⁸ [INQ041473/21](#)

³⁷⁹ [INQ041473/31-32](#)

³⁸⁰ [INQ001137/1](#)

³⁸¹ [INQ001224/1-3](#)

³⁸² [INQ001137/1](#)

³⁸³ [INQ001239](#)

³⁸⁴ [INQ001140/1-2](#)

³⁸⁵ [INQ004284/11](#)

Mobilisation of duty Group Manager

Call from NWFC (22:52)

- 15.292 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"*.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.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."*³⁸⁸ Group Manager Nankivell should have challenged this decision when he spoke to Station Manager Berry.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.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 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

³⁸⁶ [INQ001224/1-3](#)

³⁸⁷ [128/202/17-204/6](#)

³⁸⁸ [129/9/14-20](#)

³⁸⁹ [142/153/2-22](#), [INQ042436/25](#) at paragraph 90

³⁹⁰ [INQ001224/3](#)

³⁹¹ [129/5/12-16](#)

³⁹² [129/4/24-5/11](#)

³⁹³ [120/39/25-40/8](#)

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."*³⁹⁵ 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.³⁹⁶ Group Manager Nankivell saw Station Manager Berry *"as the incident commander"*.³⁹⁷ 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.³⁹⁸ 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.

³⁹⁴ [129/4/18-23](#)

³⁹⁵ [120/40/18-23](#)

³⁹⁶ [128/219/7-11](#)

³⁹⁷ [128/216/15-24](#)

³⁹⁸ [120/39/19-21](#)

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 NWS "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

³⁹⁹ [INQ034363T](#)

⁴⁰⁰ [INQ004300/6](#)

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 through iNet, and neither did other GMFRS officers. Area Manager Etches and those other GMFRS officers should have done so.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.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 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.

⁴⁰⁴ [129/180/1-16](#)

⁴⁰⁵ [129/180/17-181/11](#)

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
- 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.⁴⁰⁹ He accepted, in evidence, that he should have asked how long it had been since the explosion.⁴¹⁰

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.⁴¹¹ 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?"*.⁴¹² 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"*.⁴¹³

⁴⁰⁶ [INQ041473/37](#)

⁴⁰⁷ [129/174/9-17](#)

⁴⁰⁸ [129/9/4-20](#)

⁴⁰⁹ [129/176/4-177/3](#)

⁴¹⁰ [129/177/4-7](#)

⁴¹¹ [INQ041473/42](#)

⁴¹² [INQ034353T](#)

⁴¹³ [INQ034353T](#)

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."⁴¹⁴

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.⁴¹⁵ He arrived at the Command Support Room at 23:40.⁴¹⁶

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.⁴¹⁷ Group Manager Nankivell called Chief Fire Officer O'Reilly a second time at 23:23 for approximately 40 seconds.⁴¹⁸ 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.⁴¹⁹

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.⁴²⁰ 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.⁴²¹

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.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

⁴¹⁴ [129/184/17-185/4](#)

⁴¹⁵ [INQ041473/46](#)

⁴¹⁶ [129/189/16-20](#)

⁴¹⁷ [INQ041473/36](#)

⁴¹⁸ [INQ041473/36](#)

⁴¹⁹ [INQ041473/53](#)

⁴²⁰ [129/8/17-9/3](#)

⁴²¹ [129/9/21-10/12](#)

⁴²² [129/8/17-9/3](#)

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.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.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 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.⁴²⁵ At 23:15, a mobilisation to the Command Support Room notification was sent by NWFC to Chief Fire Officer O'Reilly.⁴²⁶

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*".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.⁴²⁸

⁴²³ [132/7/2-11, 132/9/22-11/12](#)

⁴²⁴ [INQ034353T](#)

⁴²⁵ [INQ034363T](#)

⁴²⁶ [132/3/22-4/8](#)

⁴²⁷ [129/17/12-24](#)

⁴²⁸ [INQ001206](#)

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.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.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.⁴³³ 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.⁴³⁴ My conclusion is not based on hindsight, but on the information Chief Fire Officer O'Reilly had at the time.

15.339 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.⁴³⁵ Group Manager Meakin's

⁴²⁹ [129/28/18-29/1](#)

⁴³⁰ [129/28/18-29/1](#)

⁴³¹ [132/5/5-11](#)

⁴³² [INQ014791/5](#)

⁴³³ [132/5/12-6/12](#)

⁴³⁴ [128/57/8-19](#)

⁴³⁵ [128/56/1-5](#)

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."*⁴³⁶ 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 23:15.⁴³⁷

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 02:10.⁴³⁸ In the end, the meeting took place at 04:15.⁴³⁹

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.⁴⁴⁰

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]."*⁴⁴¹ 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]."*⁴⁴²

15.343 The role of Gold Commander in the GMFRS is not to command the incident, but to act in support.⁴⁴³ 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.

⁴³⁶ [121/12/24-13/3](#)

⁴³⁷ [105/86/13-16](#)

⁴³⁸ [INQ026726/2](#)

⁴³⁹ [132/63/1-12](#)

⁴⁴⁰ [121/12/15-13/3](#)

⁴⁴¹ [INQ004450/5](#)

⁴⁴² [INQ004450/5-6](#)

⁴⁴³ [121/10/24-11/16](#), [INQ026714/25](#) at paragraphs 106 to 109

15.345 Chief Fire Officer O'Reilly arrived at the Command Support Room at 23:49.⁴⁴⁴

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?"⁴⁴⁵

15.347 He sent the messages because "that's something we would do for incidents that occurred that we were aware of".⁴⁴⁶

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.⁴⁴⁷ He also sent some messages to the GMFRS command leadership team.⁴⁴⁸

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.⁴⁴⁹ 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.⁴⁵⁰

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.

⁴⁴⁴ [INQ041473/62](#)

⁴⁴⁵ [INQ019040/1](#)

⁴⁴⁶ [133/4/18-5/13](#)

⁴⁴⁷ [INQ041473/52-53](#)

⁴⁴⁸ [133/6/24-7/14](#)

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.⁴⁵¹ 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 NWS NILO. It did not occur to him to do so. He did not have the contact number for the NWS NILO, although he believed he could have got it from NWFC.⁴⁵²

15.354 It was not part of Group Manager Meakin's training to contact the NWS NILO.⁴⁵³ 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.

15.355 While I have criticised Station Manager Berry for not contacting the NWS 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 NWS 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

⁴⁵¹ [121/25/8-12](#)

⁴⁵² [121/28/4-10](#)

⁴⁵³ [121/28/21-29/6](#)

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 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 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

⁴⁵⁹ [121/158/5-21](#)

⁴⁶⁰ [121/177/5-21](#)

⁴⁶¹ [INQ001185](#)

⁴⁶² [121/170/9-171/23](#)

⁴⁶³ [121/173/15-17](#)

⁴⁶⁴ [121/173/9-21](#)

have elements of the Operation Plato action cards in front of them.⁴⁶⁵ 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"*.⁴⁶⁶ Group Manager Levy stated that he agreed with Station Manager Berry's decision on the basis of what Station Manager Berry told him.⁴⁶⁷ 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 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 had.⁴⁷² 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.⁴⁷³

⁴⁶⁵ [121/164/17-165/1](#)

⁴⁶⁶ [121/179/18-180/20](#)

⁴⁶⁷ [121/175/7-15](#), [121/179/18-180/20](#)

⁴⁶⁸ [121/180/21-181/19](#)

⁴⁶⁹ [121/180/7-20](#)

⁴⁷⁰ [120/52/18-22](#)

⁴⁷¹ [121/182/21-24](#)

⁴⁷² [121/181/20-182/8](#)

⁴⁷³ [120/51/21-22](#)

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."⁴⁷⁴

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 I come to Station Manager Lawlor's involvement in paragraphs 15.394 and 15.395.

Call to Group Manager Nankivell (23:26)

15.373 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

15.374 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

15.375 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)

15.376 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

⁴⁷⁴ [121/182/25-183/11](#)

⁴⁷⁵ [129/19/14-20/12, INQ041473/48](#)

⁴⁷⁶ [121/190/1-11](#)

⁴⁷⁷ [127/193/25-194/8](#)

⁴⁷⁸ [INQ019040/1](#)

⁴⁷⁹ [120/48/10-11](#)

⁴⁸⁰ [120/49/5-8](#)

- 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.
- 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.⁴⁸³ At the time, he thought the attack would be *“multi-seated”*.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.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.
- 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 NWS. 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.⁴⁸⁶ 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 MTF [Marauding Terrorist Firearms Attack],*

⁴⁸¹ [128/113/9-21](#)

⁴⁸² [INQ008376/6](#)

⁴⁸³ [119/185/2-8](#)

⁴⁸⁴ [119/186/8-15](#)

⁴⁸⁵ [142/203/6-204/4](#)

⁴⁸⁶ [127/196/3-19](#)

I know the area ... I used to work there".⁴⁸⁷ Group Manager Fletcher stated that he may have told Station Manager Berry that he would have used Manchester Central Fire Station.⁴⁸⁸

- 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"*.⁴⁸⁹ He stated that GMFRS needed to wait for the identification of the FCP, *"which we were expecting to come fairly quickly"*.⁴⁹⁰
- 15.384** Group Manager Fletcher stated that he was not told about the GMP RVP.⁴⁹¹ Station Manager Berry stated that he did inform Group Manager Fletcher of the GMP RVP.⁴⁹² 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 GMP RVP by Station Manager Berry in conversations at around the same time.⁴⁹³
- 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.⁴⁹⁴ 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.⁴⁹⁵ Group Manager Fletcher said that he would try the FDO for him *"to take some of that load off*

⁴⁸⁷ [127/196/17](#)

⁴⁸⁸ [127/196/6-197/7](#)

⁴⁸⁹ [127/198/6-8](#)

⁴⁹⁰ [127/198/2-12](#)

⁴⁹¹ [127/198/13-18](#)

⁴⁹² [120/49/9-13](#)

⁴⁹³ [121/57/6-9](#), [121/175/7-15](#)

⁴⁹⁴ [127/199/11-20](#)

⁴⁹⁵ [120/49/18-20](#), [128/2/12-23](#)

him”.⁴⁹⁶ 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.⁴⁹⁷

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.⁴⁹⁸

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.⁴⁹⁹

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.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*”.⁵⁰¹ Group Manager Nankivell regarded Group Manager Fletcher as having a good knowledge of NIOs, 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.⁵⁰²

⁴⁹⁶ [128/3/21-4/16](#)

⁴⁹⁷ [128/9/19-10/14](#)

⁴⁹⁸ [128/7/9-13](#)

⁴⁹⁹ [126/73/18-74/10](#)

⁵⁰⁰ [INQ042436/31](#) at paragraph 110

⁵⁰¹ [129/15/7-8](#)

⁵⁰² [129/13/8-16/5](#)

- 15.391** During Group Manager Fletcher’s call with Group Manager Nankivell, at 23:18, a GMFRS NILO 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.”*⁵⁰³
- 15.392** The reference to *“inet”* was to iNet, NWFC’s incident log system.⁵⁰⁴ 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.⁵⁰⁵ 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.⁵¹²

⁵⁰³ [INQ019040/1](#)

⁵⁰⁴ [121/159/20-24](#)

⁵⁰⁵ [128/18/3-8](#), [128/49/15-18](#)

⁵⁰⁶ [126/83/8-25](#)

⁵⁰⁷ [126/84/8-9](#)

⁵⁰⁸ [126/84/7](#)

⁵⁰⁹ [126/84/1-25](#)

⁵¹⁰ [128/46/4-47/5](#)

⁵¹¹ [128/47/6-11](#)

⁵¹² [120/56/3-19](#), [INQ004300/1](#)

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.⁵¹³

15.399 Group Manager Fletcher arrived at the Command Support Room about ten minutes after this call, at 23:49.⁵¹⁴

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.⁵¹⁵

15.401 Station Manager Lawlor was not on duty on the night of 22nd May 2017. He was at home asleep following an 80-hour on-call weekend.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.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.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

⁵¹³ [128/47/6-11](#)

⁵¹⁴ [128/49/19-50/8](#)

⁵¹⁵ [62/18/3-21/3](#)

⁵¹⁶ [126/69/18-70/8](#)

⁵¹⁷ [INQ041473/42](#)

⁵¹⁸ [126/79/4-8](#)

⁵¹⁹ [126/89/10-90/1](#)

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 impactful 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

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.

⁵²⁰ [126/90/20-91/18](#)

⁵²¹ [126/85/9-25](#)

⁵²² [126/92/21-93/4](#)

⁵²³ [INQ031123/1-3](#)

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 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,⁵²⁶ Watch Manager Simister informed NWFC that there was “a fireman here whose wife is a paramedic and she’s on scene”.⁵²⁷

Arrival of first Specialist Response Team appliance (23:21)

15.414 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.⁵²⁸ By 23:25, Watch Manager Nolan regarded his Specialist Response Team crew as ready to deploy to an incident.⁵²⁹

Arrival of Group Manager Meakin (23:25)

15.415 Group Manager Meakin arrived at Philips Park Fire Station at approximately 23:25.⁵³⁰ 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.⁵³¹ Station Manager Berry did not know this information at that time.

15.416 Group Manager Meakin then called NWFC at 23:28.⁵³² 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”.⁵³³ 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”.⁵³⁴

⁵²⁴ [70/12/11-16](#)

⁵²⁵ [70/12/23-13/1](#)

⁵²⁶ [69/141/7-17](#)

⁵²⁷ [INQ001176](#), [INQ040474](#)

⁵²⁸ [INQ001147](#)

⁵²⁹ [71/37/20-38/14](#)

⁵³⁰ [121/32/11-14](#), [INQ041473/47](#)

⁵³¹ [121/37/22-38/5](#)

⁵³² [121/35/3-36/2](#)

⁵³³ [121/42/5-6](#)

⁵³⁴ [121/41/17-42/8](#)

- 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 from Lisa Owen.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."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.⁵³⁷ Under GMFRS's approach at the time, Group Manager Meakin was correct.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 NWS 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, NWS 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 NWS response to the Attack and was using Manchester Central Fire Station as an RVP, while it waited to be called forward. At 00:37

⁵³⁵ [121/49/19-51/2](#)

⁵³⁶ [121/35/16-36/2](#)

⁵³⁷ [121/36/3-8](#)

⁵³⁸ [122/11/22-12/6](#)

on 23rd May 2017, it left Manchester Central Fire Station and travelled to the Victoria Exchange Complex.⁵³⁹ Ambulance A720 was not the only NWS 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 NWS staff in Ambulance A720. They would have immediately discovered that NWS 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.⁵⁴⁰
- 15.426 Station Manager Berry stated that he gave Group Manager Meakin “*the information that I had*” in that call.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.⁵⁴²
- 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 responders ready to deploy.⁵⁴⁴ 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.⁵⁴⁵

⁵³⁹ [INQ040368/8](#)

⁵⁴⁰ [121/51/15-17](#)

⁵⁴¹ [120/53/25-54/5](#)

⁵⁴² [121/57/6-16](#)

⁵⁴³ [70/15/25-16/4](#)

⁵⁴⁴ [71/38/23-39/3](#)

⁵⁴⁵ [70/16/5-14](#)

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.⁵⁴⁶
- 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.⁵⁴⁷ This is measured from the time resources are mobilised by NWFC to the arrival of the first appliance on the incident ground.⁵⁴⁸
- 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.⁵⁴⁹ 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.

⁵⁴⁶ [128/62/21-63/7](#)

⁵⁴⁷ [129/203/12-15](#)

⁵⁴⁸ [130/58/9-21](#)

⁵⁴⁹ [121/47/6-15](#)

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.⁵⁵⁰

Arrival of Station Manager Berry (23:40)

15.438 Station Manager Berry arrived at Philips Park Fire Station five minutes later, at 23:40.⁵⁵¹ 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.⁵⁵²

15.439 Crew Manager Mottram stated that he "told the NILOs" that ambulances were being deployed to the scene.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.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,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.⁵⁵⁶

15.441 At 23:42, Group Manager Meakin spoke to Area Manager Etches on the telephone for just over two minutes.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 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."⁵⁵⁸

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.⁵⁵⁹ By 23:45, Group Manager Levy "realised

⁵⁵⁰ [121/158/22-161/5](#)

⁵⁵¹ [119/195/22-196/11](#), [INQ004300/1](#)

⁵⁵² [INQ041473/46](#), [INQ041473/47](#), [INQ041473/50-52](#)

⁵⁵³ [70/15/20-24](#)

⁵⁵⁴ [122/6/17-7/23](#)

⁵⁵⁵ [71/41/7-14](#)

⁵⁵⁶ [122/9/7-17](#)

⁵⁵⁷ [INQ041473/55](#)

⁵⁵⁸ [129/195/9-198/25](#)

⁵⁵⁹ [122/12/11-25](#)

the stresses that Mr Berry had been under over the last hour".⁵⁶⁰ 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.⁵⁶¹

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 NWS 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?"*⁵⁶⁵ 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."*⁵⁶⁶

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."*⁵⁶⁷ This was in reference to the GMP RVP, which Inspector Smith had declared but then replaced minutes later.⁵⁶⁸

⁵⁶⁰ [122/13/5-6](#)

⁵⁶¹ [122/13/1-9](#)

⁵⁶² [122/14/22-15/5](#)

⁵⁶³ [INQ041499/2](#) at paragraph 5

⁵⁶⁴ [INQ039161T/2](#)

⁵⁶⁵ [INQ039161T/3](#)

⁵⁶⁶ [INQ039161T/3](#)

⁵⁶⁷ [INQ018835T/13](#)

⁵⁶⁸ [INQ018835T/12-15](#)

- 15.448 Station Manager Berry rejected this, saying, *"[W]e'll need somewhere to go ... and co-locate with the ambulance service."*⁵⁶⁹ David Myerscough said that he would ask a colleague. When he returned, David Myerscough said: *"Nothing at the moment but it's being updated."*⁵⁷⁰ Station Manager Berry replied: *"We're not going to deploy anywhere until we have a nailed-on co-location point ... a forward control point."*⁵⁷¹
- 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."*⁵⁷² 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"*.⁵⁷³ Station Manager Berry said: *"The ambulance service apparently are at Thompson Street [Manchester Central] Fire Station ... We're going to muster there."*⁵⁷⁴
- 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."*⁵⁷⁵ Station Manager Berry stated that he *"didn't think at the time"* to ask to speak to the FDO or the Force Duty Supervisor.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."*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.

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](#)

⁵⁷⁶ [120/154/25-155/9](#)

⁵⁷⁷ [120/157/22-158/8](#)

- 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. I dealt with some of the content of that call in paragraph 15.142. The call lasted 3 minutes.

⁵⁷⁸ [INQ001233](#)

⁵⁷⁹ [132/11/19-24](#)

⁵⁸⁰ [129/187/11-13](#), [129/189/16-190/1](#)

⁵⁸¹ [INQ042436/26-27](#) at paragraph 94

⁵⁸² [INQ041473/55](#)

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 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 23rd 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 NWS 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.”*⁵⁹⁰ Group Manager Levy’s evidence was that Chief Fire Officer O’Reilly instructed him to wait at Manchester Central Fire Station. He stated

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](#)

⁵⁸⁷ [132/19/14-20/7](#)

⁵⁸⁸ [130/88/20-24](#)

⁵⁸⁹ [INQ041473/64](#), [122/18/4-23/24](#)

⁵⁹⁰ [122/19/14-21](#)

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*".⁵⁹¹

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.*"⁵⁹²

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:

*"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."*⁵⁹³

15.466 Area Manager Etches stated that, once GMFRS resources reached Manchester Central Fire Station, "*[t]hey would find out more*".⁵⁹⁴

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."*⁵⁹⁵

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.*"⁵⁹⁶ 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.*"⁵⁹⁷

⁵⁹¹ [122/22/21-23/2](#), [122/23/9-24](#)

⁵⁹² [132/28/5-29/9](#)

⁵⁹³ [129/205/7-14](#)

⁵⁹⁴ [129/204/19-205/3](#)

⁵⁹⁵ [128/71/6-24](#)

⁵⁹⁶ [128/59/20-60/1](#)

⁵⁹⁷ [128/60/10-17](#)

- 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*".⁵⁹⁸ Chief Fire Officer O'Reilly accepted of himself that he could be "*autocratic*" when a decision needed to be made.⁵⁹⁹
- 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.

⁵⁹⁸ [122/16/9-25](#)

⁵⁹⁹ [132/21/9-22/6](#)

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.

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.⁶⁰⁰

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."*⁶⁰¹

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."*⁶⁰²

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

⁶⁰⁰ [INQ041473/64-65](#)

⁶⁰¹ [INQ041473/65](#)

⁶⁰² [INQ041473/66](#)

⁶⁰³ [INQ018836T/3-4](#)

⁶⁰⁴ [INQ018836T/3-4](#)

⁶⁰⁵ [INQ019097/4](#)

⁶⁰⁶ [INQ019097/1](#)

- 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.⁶⁰⁷ 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.

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.⁶⁰⁸ 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.⁶⁰⁹ 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 some back at Manchester Central Fire Station.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

⁶⁰⁷ [128/74/15-76/22](#)

⁶⁰⁸ [INQ018835T/12-15](#)

⁶⁰⁹ [122/24/18-25/1](#)

⁶¹⁰ [122/25/4-11](#)

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 23rd May 2017.⁶¹¹
- 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.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 23rd 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.*"⁶¹³ Derek Cartwright informed Chief Fire Officer O'Reilly that NWAS had "*one of their ... Golds on the way to police headquarters*".⁶¹⁴ This was a reference to the Strategic Commander Neil Barnes.⁶¹⁵
- 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.⁶¹⁶

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.⁶¹⁷

⁶¹¹ [INQ041473/65](#)

⁶¹² [INQ041473/66-67](#)

⁶¹³ [132/30/7-31/22](#)

⁶¹⁴ [132/31/18-19](#)

⁶¹⁵ [132/31/2-22](#)

⁶¹⁶ [122/28/21-29/3](#)

⁶¹⁷ [130/93/6-14](#)

- 15.493** Stephen Hynes informed Chief Fire Officer O'Reilly that GMFRS "needed to get down there".⁶¹⁸ Chief Fire Officer O'Reilly asked Stephen Hynes, "[W]hat did he need?"⁶¹⁹ Stephen Hynes replied that he "just needed 12 firefighters".⁶²⁰ 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."⁶²¹ Chief Fire Officer O'Reilly also recalled that Stephen Hynes added "that the NWS MTF A [Marauding Terrorist Firearms Attack] resource was still at Manchester Central fire station at the direction of GMP".⁶²² Stephen Hynes stated that the firefighters were "to help with casualty recovery from the scene".⁶²³ Chief Fire Officer O'Reilly said, "Leave it with me, I'll get them there as soon as I can."⁶²⁴
- 15.494** Stephen Hynes' recollection of this short conversation was that he said words to the effect "it's not MTF A Peter. We just require your fire fighters down here."⁶²⁵ 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".⁶²⁶ In fact, as a later message demonstrates, Stephen Hynes wanted "trauma technicians".⁶²⁷ 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.⁶²⁸
- 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 NWS.
- 15.497** After the call, Chief Fire Officer O'Reilly returned to the Command Support Room.⁶²⁹

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.⁶³⁰ Having spoken to Stephen Hynes, it was Chief Fire Officer O'Reilly's

⁶¹⁸ [132/33/17](#)

⁶¹⁹ [132/33/20](#)

⁶²⁰ [132/33/22](#)

⁶²¹ [132/34/4-6](#)

⁶²² [132/46/7-9](#)

⁶²³ [132/33/24-25](#)

⁶²⁴ [132/34/6-7](#)

⁶²⁵ [113/115/9-10](#)

⁶²⁶ [113/115/6-116/10](#)

⁶²⁷ [INQ001149/2](#)

⁶²⁸ [132/204/3-13](#)

⁶²⁹ [132/35/11-19](#)

⁶³⁰ [128/80/25-81/5](#), [129/78/6-8](#), [129/207/7-208/20](#), [130/94/21-23](#), [132/36/15-18](#)

view that non-specialists should be sent in.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.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.
- 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

⁶³¹ [132/34/13-37/15](#)

⁶³² [130/95/17-21](#)

of his conversation with Stephen Hynes. Group Manager Levy queried whether NWS required operatives with Marauding Terrorist Firearms Attack capability. Chief Fire Officer O'Reilly informed him that Stephen Hynes had said NWS did not.⁶³³

- 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 NWS for mobilisation. He wanted Group Manager Levy to know what the Command Support Room was asking NWS 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 NWS to provide Group Manager Levy with a mobilisation 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".⁶³⁷ 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

⁶³³ [122/14/22-15/5](#), [122/29/8-30/22](#)

⁶³⁴ [132/34/25-35/14](#)

⁶³⁵ [132/35/1-24](#)

⁶³⁶ [122/36/7-9](#), [122/36/24-37/5](#)

⁶³⁷ [122/38/20-39/8](#)

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 zoning.⁶⁴⁴ 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.⁶⁴⁵ 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.⁶⁴⁶
- 15.512** 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 rigorously about the zoning of the Victoria Exchange Complex at that stage.

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](#)

⁶⁴⁴ [126/118/8-12](#)

⁶⁴⁵ [INQ026726](#)

⁶⁴⁶ [104/199/1-10](#), [INQ040657/65-66](#)

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.⁶⁴⁷ Station Manager Lawlor informed Group Manager Fletcher of the Operation Plato declaration.⁶⁴⁸ Group Manager Fletcher spoke to Chief Fire Officer O'Reilly about deploying the Specialist Response Team in light of the information about Operation Plato.⁶⁴⁹ Chief Fire Officer O'Reilly replied that just the non-specialist firefighters would be deployed.⁶⁵⁰
- 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 NWS. 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."*⁶⁵¹
- 15.515 Chief Fire Officer O'Reilly's decision at this stage was flawed.⁶⁵² 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.⁶⁵³ 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.
- 15.516 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."*⁶⁵⁴

⁶⁴⁷ [INQ004348/66](#)

⁶⁴⁸ [128/81/14-19](#)

⁶⁴⁹ [128/82/3-7](#)

⁶⁵⁰ [128/81/14-85/8](#)

⁶⁵¹ [132/43/24-44/19](#)

⁶⁵² [130/105/3-14](#)

⁶⁵³ [130/104/10-15](#)

⁶⁵⁴ [INQ001163](#)

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 NWS Control.

15.519 In the call between NWFC and NWS Control, NWS Control said, *"I've got a request from our Gold Commander at the scene."*⁶⁵⁵ This was a reference to Stephen Hynes, who was a qualified Strategic/Gold Commander, but was acting as Operational/Bronze Commander.⁶⁵⁶ NWS 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."*⁶⁵⁷

15.520 In her call with Group Manager Nankivell at 00:21, Janine Carden relayed the substance of what NWS Control was asking for. This included raising the fact that trauma technicians were being requested *"if possible"*.⁶⁵⁸

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."*⁶⁵⁹

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."*⁶⁶⁰

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."*⁶⁶¹

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.

⁶⁵⁵ [INQ041473/73](#)

⁶⁵⁶ [113/105/1-18](#)

⁶⁵⁷ [INQ001149/2](#), [INQ001149/1-3](#)

⁶⁵⁸ [INQ001179](#)

⁶⁵⁹ [129/81/11-15](#)

⁶⁶⁰ [129/80/8-10](#)

⁶⁶¹ [132/204/19-205/3](#)

15.525 Chief Fire Officer O'Reilly accepted during his evidence that he *"should have acknowledged"* the representations made by Group Manager Nankivell *"better"*.⁶⁶² 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"*.⁶⁶³

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]"*.⁶⁶⁴

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 00:20.⁶⁶⁵

15.528 Group Manager Levy informed Station Manager Berry that Operation Plato had been declared.⁶⁶⁶ 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.⁶⁶⁷

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.⁶⁶⁸

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."*⁶⁶⁹ 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.⁶⁷⁰

⁶⁶² [132/104/15-17](#)

⁶⁶³ [132/104/3-22](#)

⁶⁶⁴ [INQ001156](#)

⁶⁶⁵ [INQ041473/73](#)

⁶⁶⁶ [120/78/10-16](#)

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](#)

- 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 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 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.⁶⁷² 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.⁶⁷³ He made telephone calls during the period between 00:27 and 00:33, involving the Command Support Room, Group Manager Levy and

⁶⁷¹ [INQ041473/75](#)

⁶⁷² [130/137/20-138/21](#)

⁶⁷³ [120/80/13-17](#)

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.⁶⁷⁴

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.⁶⁷⁵

15.539 At 00:36:59, the first fire appliances arrived on Station Approach near the junction with Hunts Bank.⁶⁷⁶ 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.⁶⁸² This was unduly risk averse and overly cautious in light of the circumstances.

⁶⁷⁴ [INQ041473/77-81](#)

⁶⁷⁵ [120/81/6-9](#)

⁶⁷⁶ [INQ035612/469-470](#)

⁶⁷⁷ [120/81/17-83/9](#)

⁶⁷⁸ [120/82/17-23](#)

⁶⁷⁹ [120/93/10-21](#)

⁶⁸⁰ [113/161/17-162/21](#)

⁶⁸¹ [120/85/18-86/8](#)

⁶⁸² [120/85/11-17](#)

- 15.544** At 00:43, an NWS paramedic directed a firefighter carrying an oxygen bottle into the railway station through the War Memorial entrance.⁶⁸³ One minute later, GMFRS personnel were spoken to by the NWS Advanced Paramedic Patrick Ennis on Station Approach outside the War Memorial entrance.⁶⁸⁴ At 00:46, firefighters walked past the War Memorial entrance on Station Approach, carrying an oxygen bottle and a first aid kit.⁶⁸⁵ At 00:47, firefighters were captured on CCTV pulling casualty trolleys along Station Approach in the direction of the War Memorial entrance.⁶⁸⁶ Two minutes later, they wheeled the casualty trolley through the War Memorial entrance into the Victoria Exchange Complex.⁶⁸⁷ By 00:54:39, firefighters were present in the Casualty Clearing Station, near the bottom of the staircase to the raised walkway.⁶⁸⁸ 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.⁶⁸⁹ 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."*⁶⁹⁰

- 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.

⁶⁸³ [INQ035612/495](#)

⁶⁸⁴ [INQ035612/499](#)

⁶⁸⁵ [INQ035612/504](#)

⁶⁸⁶ [INQ035612/507](#)

⁶⁸⁷ [INQ035612/509](#)

⁶⁸⁸ [INQ035612/521](#)

⁶⁸⁹ [INQ041473/84](#)

⁶⁹⁰ [132/51/9-52/6](#)

- 15.547 I am less surprised. Chief Fire Officer O'Reilly had intervened to make the mobilisation decision. He had overruled a senior NIO 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, "[H]e'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, "[W]as he happy with that?" CI Dexter responded, "God knows."⁶⁹⁴
- 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.

⁶⁹¹ [INQ040657/68-69](#)

⁶⁹² [INQ040657/70](#)

⁶⁹³ [INQ040657/70](#)

⁶⁹⁴ [INQ040657/71](#)

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 NWS.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 NWS, despite arriving so late on the scene.

15.556 They were too late to offer any assistance to those who died.

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 NWS 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 NWS.

⁶⁹⁵ [INQ035612/495](#)

⁶⁹⁶ [INQ041266/1](#)

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 2017.⁶⁹⁹ 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.⁷⁰⁰
- 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.
- 15.565** 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.
- 15.566** 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

⁶⁹⁹ [INQ042436/36](#) at paragraph 133

⁷⁰⁰ [69/114/19-115/13](#)

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.

15.567 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 NWS or BTP had spoken to the FDO. Nor did it occur to anyone at GMFRS to find out where BTP and NWS 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”.¹ 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 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’.

¹ [INQ035447/9](#)

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](#)

⁹ [INQ041126](#)

SMG and Emergency Training UK's contract

- 16.12** Ian Parry's relationship with SMG did not begin on 1st 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.¹¹ 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.¹²
- 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.¹³ 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"*.¹⁴ By contrast, James Allen described one of the other organisations who tendered as *"the safe option"*.¹⁵
- 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."*¹⁶ James Allen agreed that the situation he was describing was not an ideal state of affairs.¹⁷
- 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

¹⁰ [133/63/24-65/14](#)

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 [INQ025121/4](#)

¹⁷ [90/67/9-19](#)

... 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."¹⁸

- 16.17 'MIMMS' stands for Major Incident Medical Management and Support and was a qualification provided by the Advanced Life Support Group.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.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 "[p]rovide 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**".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 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.²² 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.²³ James Allen agreed that the requirement would have been a "very sensible" idea.²⁴
- 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 independent with relevant expertise.²⁵

¹⁸ [90/133/17-134/19](#)

¹⁹ [133/72/13-73/17](#)

²⁰ [133/82/8-84/17](#)

²¹ [INQ040492/26](#)

²² [90/51/2-15](#)

²³ [90/50/14-51/5](#), [90/52/5-12](#)

²⁴ [90/51/6-10](#)

²⁵ [90/79/11-80/7](#)

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*".²⁶ The event risk assessment was driven by the risk from the attendees, not to them.²⁷ 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*".²⁸ In the event, this inadequate generic risk assessment made no difference, as SMG did not use this part of the Operational Procedures document.²⁹

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*".³⁰ 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.³¹

²⁶ [INQ001359/18](#)

²⁷ [28/119/2-8](#), [28/121/9-122/8](#)

²⁸ [90/90/18-91/5](#)

²⁹ [90/87/14-20](#)

³⁰ [INQ001359/59-63](#)

³¹ [INQ001359/63](#)

- 16.28 The second was entitled “*Medical Incidents*”.³² 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.*”³³ The ‘Medical Incidents’ part continued by setting out a “*Major incident medical emergency plan*”.³⁴
- 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.*”³⁵
- 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.³⁶ 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.³⁷ 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).³⁸ 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.³⁹
- 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.*”⁴⁰ It anticipated that a METHANE message

³² [INQ001359/67](#)

³³ [INQ001359/68](#)

³⁴ [INQ001359/69](#)

³⁵ [INQ001359/71](#)

³⁶ [INQ042751](#)

³⁷ [INQ001359/2](#)

³⁸ [INQ024430](#)

³⁹ [133/126/11-25](#)

⁴⁰ [INQ024430/3](#) at paragraph 3

would be passed on by Medic 1.⁴¹ 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 NWS personnel and ensure a smooth handover.⁴²

- 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 2.⁴³
- 16.34** The ETUK Major Incident Plan indicated that "Medical Teams" will "provide basic first aid ... following triage".⁴⁴ On the night of the Attack, a number of ETUK staff present in the City Room 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. 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

⁴¹ [INQ024430/4](#)

⁴² [INQ024430/4](#)

⁴³ [INQ024430/3](#) at paragraph 4

⁴⁴ [INQ024430/5](#)

⁴⁵ [91/19/2-7](#), [91/19/25-20/12](#)

⁴⁶ [INQ024430/6](#)

⁴⁷ [133/152/21-153/7](#)

⁴⁸ [133/120/17-23](#)

*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 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.⁵¹ 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).⁵² 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.⁵³ It was not reviewed in light of the reissue of the Purple Guide in 2015.⁵⁴ 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’.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.⁵⁶ This is described as “a base provision”, which was said to be subject to an individual event risk assessment.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.

⁴⁹ [133/120/17-23](#)

⁵⁰ [145/79/12-80/8](#)

⁵¹ [INQ025124/3-4](#)

⁵² [INQ025124](#)

⁵³ [90/39/4-15](#)

⁵⁴ [90/155/6-24](#)

⁵⁵ [INQ025124/2](#)

⁵⁶ [INQ025124/3-4](#)

⁵⁷ [INQ025124/3](#)

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”.⁵⁸ The EMT-A was expected to act as Team Leader and “must be MIMMS trained”.⁵⁹ The EMT-B was expected “on all shows normally above 5000 or depending on event risk assessment”.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.⁶¹ The Ambulance Service Experts considered that some of the activities the SMG–ETUK contract expected the EMT-A to undertake would require professional registration.⁶²
- 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.⁶³ Ian Parry was not a registered practitioner in any of those categories.⁶⁴ This meant that he was no longer eligible to undertake either of those courses or any refresher training in them from 2013.⁶⁵
- 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.⁶⁶ 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.⁶⁷
- 16.47** In the CV he drafted in 2015, Ian Parry described himself as “EMT.ALS.PLS. MIMMS”.⁶⁸ He wrote “ALS MIMMS” next to his name on SMG sign-in sheets in 2017.⁶⁹ 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.

⁵⁸ [INQ040492/29](#)

⁵⁹ [INQ040492/29](#)

⁶⁰ [INQ040492/29](#)

⁶¹ [INQ040492/29](#)

⁶² [145/92/10-93/24](#)

⁶³ [133/73/4-74/23](#)

⁶⁴ [133/68/7-12](#)

⁶⁵ [133/74/21-75/1](#)

⁶⁶ [INQ041774/2](#)

⁶⁷ [133/68/20-70/4](#), [133/71/5-73/17](#)

⁶⁸ [INQ041774/1](#)

⁶⁹ [INQ041977/3-4](#)

- 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 Advanced Life Support Group qualifications as important: they were specified in the SMG–ETUK contract.⁷⁰ 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.⁷¹ 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.⁷²
- 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.⁷³ Ryan Billington, an ETUK member of staff, also provided some training.⁷⁴
- 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 return to the issue of ETUK training when considering those staff members on duty on the night of the Attack.

⁷⁰ [INQ041975/2](#) at paragraphs 7 and 8

⁷¹ [90/136/10-137/1](#), [137/133/24-134/23](#)

⁷² [133/88/4-14](#), [91/58/12-24](#), [91/8/22-9/5](#)

⁷³ [133/88/9-89/6](#)

⁷⁴ [91/24/24-25/9](#)

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](#)

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 that there was only one basic stretcher in the first aid room.⁸⁵
- 16.56** Tourniquets were not issued to staff as part of the first aid bags provided by ETUK.⁸⁶ Ian Parry claimed that all staff were trained in the application of a tourniquet.⁸⁷ In fact, many staff were not trained in their use.⁸⁸ The events of 22nd 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.⁸⁹
- 16.59** Regarding first aid and medical equipment, the SMG–ETUK contract stated: "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

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](#)

⁸⁵ [133/151/12-152/18](#), [133/156/17-21](#)

⁸⁶ [91/30/4-6](#)

⁸⁷ [137/184/14-185/9](#)

⁸⁸ [91/22/19-24/15](#)

⁸⁹ [91/23/13-24/15](#), [91/53/24-54/5](#)

⁹⁰ [INQ040492/29](#)

⁹¹ [90/201/5-13](#)

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.⁹⁵ It was attended by "Medic Supervisors – from our first aid contractors, Emergency Training Ltd".⁹⁶ This was one of a number of exercises.

⁹² [137/196/11-16](#)

⁹³ [137/196/11-19](#)

⁹⁴ [91/30/7-15](#)

⁹⁵ [INQ001444/1](#)

⁹⁶ [INQ001444/2](#)

- 16.65 Ian Parry stated: *“There were a number of desktop exercises over the years involving NWS, 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.”*⁹⁷ As I have emphasised elsewhere, full participation in well-run exercises is essential.
- 16.66 Ian Parry also invited ETUK staff to attend *“workshops and tabletop exercises”* in their spare time.⁹⁸ These occurred approximately every six months and included Major Incident response as a topic. They were not attended by all ETUK staff.⁹⁹ 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.

Emergency Training UK and NWS

- 16.69 When asked about the requirement to pass a METHANE message to NWS, Ian Parry asserted: *“[I]t was made quite clear that NWS would refuse to accept a major incident declaration from us.”*¹⁰⁰ He later suggested that the organisation who told him this may have been Greater Manchester Ambulance Service, NWS’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.¹⁰¹ He stated that he had been told that a private healthcare provider’s METHANE message would not be accepted by the ambulance service.¹⁰²
- 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.

⁹⁷ [133/99/9-21](#), [133/155/20-156/1](#)

⁹⁸ [174/218/25-219/15](#)

⁹⁹ [137/135/22-137/6](#), [174/218/25-219/15](#)

¹⁰⁰ [133/99/9-23](#)

¹⁰¹ [133/99/9-100/24](#)

¹⁰² [133/99/9-100/24](#)

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.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.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 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 exchanges as to how an emergency would be managed. It is surprising that this did not happen.

¹⁰³ [144/53/14-16](#), [145/63/18-64/6](#)

¹⁰⁴ [INQ041126](#)

¹⁰⁵ [145/81/6-11](#)

¹⁰⁶ [133/64/15-65/14](#)

¹⁰⁷ [1/22/3-10](#)

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.
- 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.¹¹³ 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.
- 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.

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](#)

¹¹³ [137/159/9-11](#), [137/190/1-12](#), [137/200/18-201/12](#)

- 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 22nd 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 22nd 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 22nd 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.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 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

¹¹⁴ [144/59/14-60/10](#)

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 wrong. The reason he made it was because he had not read the relevant part of the 2015 Purple Guide.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*".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*".¹²¹ I disagree. While such events receive substantial attention, the part dealing with resources at an event does not have an exclusive focus.¹²² Instead, it provides "*some outline guidance*" and "*is not intended to be prescriptive in any way*".¹²³ It encourages a risk-driven approach.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.¹²⁵
- 16.90** The 14 staff ETUK had on duty¹²⁶ on the night of the Attack fell a long way short of the Purple Guide expectation in terms of relevant skills.¹²⁷ None of those present was qualified in any of the protected title professions listed in the Purple

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](#)

¹¹⁹ [133/108/12-23, 137/128/9-23](#)

¹²⁰ [90/80/14-81/10](#)

¹²¹ [90/113/3-22](#)

¹²² [INQ041127/1-3](#)

¹²³ [INQ041127/1-2](#)

¹²⁴ [INQ041127/1](#)

¹²⁵ [INQ041127/2](#)

¹²⁶ [INQ022782/7](#)

¹²⁷ [145/46/2-17](#)

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.¹²⁸

- 16.91** Ian Parry asserted that there was also a trainee nurse among the ETUK staff.¹²⁹ That was not correct. The person in question had not started the nursing course at the time of the Attack.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.¹³¹ 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.¹³² 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.¹³³
- 16.93** Also acting as EMT-B was Ryan Billington, according to his evidence.¹³⁴ He was a second-year student paramedic and 20 years old.¹³⁵ Ian Parry claimed Ryan Billington was in the role of EMT-A.¹³⁶ I reject this evidence. The confirmation email Ryan Billington received booking him for the shift identifies his role as EMT-B.¹³⁷
- 16.94** As a result, there was no one acting in the EMT-A role, as defined in the SMG–ETUK contract.
- 16.95** So far as the other ETUK staff were concerned, they were all retained that night as first aiders.¹³⁸ They had a mix of qualifications. At one end of the spectrum, one staff member was weeks away from qualifying as a medical doctor.¹³⁹ At the other, several did not have formal qualifications beyond a first aid at work course.¹⁴⁰ 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.¹⁴¹

¹²⁸ [91/1/20-22](#), [137/72/15-73/20](#)

¹²⁹ [137/72/3-5](#)

¹³⁰ [154/54/4-13](#)

¹³¹ [INQ040492/50-52](#), [INQ040492/54](#)

¹³² [133/73/18-74/25](#), [133/76/6-10](#), [INQ040492/55](#)

¹³³ [133/133/16-20](#), [137/70/5-6](#)

¹³⁴ [158/97/2-13](#)

¹³⁵ [91/4/11-14](#), [91/54/20-21](#)

¹³⁶ [133/133/16-20](#)

¹³⁷ [INQ041934](#)

¹³⁸ [137/70/7-74/14](#), [91/28/13-29/3](#)

¹³⁹ [137/72/15-24](#)

¹⁴⁰ [133/160/4-161/2](#), [INQ004740/1](#), [INQ006686/1](#), [INQ005027/1](#), [INQ007121/1](#)

¹⁴¹ [18/138/1-140/7](#)

Before the concert

- 16.96** Ian Parry provided the ETUK staff with a briefing before the concert began. The briefing was “generic”.¹⁴² In the briefing, he informed ETUK staff of the crowd profile, crowd numbers, event timings and how many ETUK staff were on duty.¹⁴³ The risk of a terrorist attack was not mentioned.¹⁴⁴ It should have been. Ian Parry was not aware of the threat level at the time.¹⁴⁵ He should have been.
- 16.97** Ian Parry paired the ETUK staff. Each pair was given a radio.¹⁴⁶ One member of ETUK staff was allocated to the Sierra Control Room in the Arena.¹⁴⁷ As Medic 1, Ian Parry was not paired with anyone.¹⁴⁸

Response by Emergency Training UK’s Emergency Medical Technicians

Ian Parry

- 16.98** 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.¹⁴⁹ ETUK staff made their way to the City Room. Ian Parry entered the City Room at 22:36.¹⁵⁰ Six minutes after Ian Parry, Ryan Billington entered the City Room.¹⁵¹ Ryan Billington’s arrival brought the total number of ETUK staff in the City Room to six.
- 16.99** 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.*”¹⁵² This evidence was in contrast with his claim at another stage of his evidence that no METHANE message was sent because he believed NWS would not accept it.¹⁵³ He stated that his “*assumption*” was that SMG staff were informing NWS.¹⁵⁴
- 16.100** As Medic 1, it was Ian Parry’s responsibility to carry out the command functions envisaged by the SMG and ETUK plans.¹⁵⁵ His role was to “*assume overall control until the arrival of the Statutory Emergency Services*”.¹⁵⁶ He stated that the ETUK

¹⁴² [137/76/19](#)

¹⁴³ [137/76/16-25](#), [137/77/19-78/2](#)

¹⁴⁴ [137/77/1-4](#)

¹⁴⁵ [137/77/13-18](#)

¹⁴⁶ [137/80/13-24](#)

¹⁴⁷ [137/83/6-7](#)

¹⁴⁸ [137/80/17-18](#)

¹⁴⁹ [INQ005683/5](#)

¹⁵⁰ [INQ035612/43](#)

¹⁵¹ [INQ035612/74](#)

¹⁵² [133/124/21-125/4](#)

¹⁵³ [133/100/6-24](#)

¹⁵⁴ [137/94/1-22](#)

¹⁵⁵ [INQ024430/1](#)

¹⁵⁶ [INQ024430/1](#)

first aiders acted under his direction and that of Ryan Billington and Elizabeth Woodcock.¹⁵⁷ He stated that the ETUK staff knew their roles but did not follow them on the night of the Attack.¹⁵⁸

- 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.¹⁵⁹ 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 would know their policies”*.¹⁶⁰ 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.”*¹⁶¹
- 16.102** Ian Parry went around the City Room. He informed ETUK staff that if a person was not responding they should move on.¹⁶² 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.”*¹⁶³ 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”*.¹⁶⁴
- 16.103** Ian Parry checked Kelly Brewster.¹⁶⁵ He spoke to those assisting Jane Tweddle¹⁶⁶ and Megan Hurley.¹⁶⁷ He covered Michelle Kiss¹⁶⁸ and re-covered Martyn Hett.¹⁶⁹ He assisted in moving John Atkinson from the City Room.¹⁷⁰ Ian Parry had a tourniquet in his pocket. He did not use it as he forgot he had it on him.¹⁷¹ In his evidence, he said that he covered one or two people whom he thought were dead.¹⁷²

¹⁵⁷ [133/122/14-19](#)

¹⁵⁸ [133/122/9-13](#), [133/123/7-10](#)

¹⁵⁹ [137/99/13-23](#), [137/102/10-24](#)

¹⁶⁰ [137/99/1-4](#)

¹⁶¹ [133/125/9-10](#)

¹⁶² [INQ005621/2](#)

¹⁶³ [137/172/3-5](#)

¹⁶⁴ [137/106/10-18](#)

¹⁶⁵ [154/11/13-12/13](#), [154/12/19-13/18](#)

¹⁶⁶ [151/31/18-25](#)

¹⁶⁷ [153/14/6-14](#)

¹⁶⁸ [151/24/13-15](#)

¹⁶⁹ [156/10/19-22](#)

¹⁷⁰ [158/39/18-40/4](#)

¹⁷¹ [137/172/13-20](#)

¹⁷² [137/106/25-107/8](#)

Ryan Billington

- 16.104** Shortly after Ryan Billington entered the City Room, he broadcast a message over the ETUK radio channel.¹⁷³ He requested that all trauma equipment be brought to the City Room.¹⁷⁴ 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."*¹⁷⁵
- 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.¹⁷⁶ Ryan Billington's message was in accordance with NWAS's triage tool.¹⁷⁷ 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.¹⁷⁸ The conversation with Patrick Ennis continued for over a minute.¹⁷⁹ Ryan Billington provided an initial handover to Patrick Ennis.¹⁸⁰ 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.¹⁸¹
- 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.¹⁸² SMG accepted in its oral closing statement that insufficient equipment was brought into the City Room.¹⁸³
- 16.108** Patrick Ennis left the City Room after he had spoken to Ryan Billington.¹⁸⁴ Having spoken to Daniel Smith, Consultant Paramedic and Operational Commander for NWAS, on the station concourse,¹⁸⁵ Patrick Ennis returned to the City Room at 23:05.¹⁸⁶ Upon his return, Ryan Billington spoke to him again.¹⁸⁷

¹⁷³ [91/43/20-24](#)

¹⁷⁴ [91/43/25-44/4](#)

¹⁷⁵ [91/45/5-16](#)

¹⁷⁶ [144/136/10-137/4](#), [68/33/6-34/13](#)

¹⁷⁷ [INQ013726/1](#)

¹⁷⁸ [INQ035612/158](#)

¹⁷⁹ [INQ035612/165](#)

¹⁸⁰ [91/46/21-47/14](#)

¹⁸¹ [91/47/6-21](#)

¹⁸² [91/48/14-23](#)

¹⁸³ [186/148/18-23](#)

¹⁸⁴ [INQ035612/170](#)

¹⁸⁵ [INQ035612/183](#)

¹⁸⁶ [INQ035612/200](#)

¹⁸⁷ [INQ035612/225](#), [INQ035612/237](#)

- 16.109** By speaking to Patrick Ennis, Ryan Billington undertook the important liaison role between ETUK and NWS. Ryan Billington had had some Major Incident training as part of the paramedic undergraduate course he was undertaking.¹⁸⁸ He had not completed that course at the time of the Attack.¹⁸⁹ He had not undertaken the Major Incident Medical Management and Support training.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.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 NWS. 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 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,¹⁹² Kelly Brewster,¹⁹³ Martyn Hett¹⁹⁴ and John Atkinson.¹⁹⁵

Emergency Training UK's Emergency Medical Technicians conclusions

- 16.112** ETUK lacked highly skilled staff on the night of 22nd May 2017.¹⁹⁶ 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.¹⁹⁷
- 16.113** This lack of highly skilled staff resulted in a lower standard of care being provided to the injured during the period before NWS could arrive. The timing and number of NWS paramedics entering 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.

¹⁸⁸ [91/10/3-13](#), [91/45/25-46/2](#)

¹⁸⁹ [91/1/20-25](#)

¹⁹⁰ [137/134/15-17](#)

¹⁹¹ [91/37/9-20](#)

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](#)

Response by Emergency Training UK's first aiders

- 16.114** Elizabeth Woodcock was designated "Medic 2" by Ian Parry for that shift.¹⁹⁸ She had received very little Major Incident training.¹⁹⁹ 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.*"²⁰⁰ 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.*"²⁰¹ This is consistent with Ryan Billington's evidence on tourniquets.²⁰²
- 16.116** Elizabeth Woodcock entered the City Room at 22:34.²⁰³ She attended to Saffie-Rose Roussos,²⁰⁴ Wendy Fawell,²⁰⁵ Sorrell Leczkowski,²⁰⁶ Kelly Brewster²⁰⁷ and Georgina Callander.²⁰⁸
- 16.117** Marianne Gibson entered the City Room at 22:40.²⁰⁹ She attended to Saffie-Rose Roussos,²¹⁰ Jane Tweddle,²¹¹ Kelly Brewster,²¹² Alison Howe,²¹³ Sorrell Leczkowski,²¹⁴ Megan Hurley²¹⁵ and John Atkinson.²¹⁶
- 16.118** Other ETUK first aiders in the City Room had involvement with those who died. Kristina Deakin checked Martyn Hett²¹⁷ and attended to Georgina Callander.²¹⁸ Sarah Broadbent checked Wendy Fawell.²¹⁹ Craig Seddon assisted in the

¹⁹⁸ [91/37/14-17, 137/71/8-17](#)

¹⁹⁹ [137/166/3-8, 174/218/1-24](#)

²⁰⁰ [174/218/5-18](#)

²⁰¹ [174/219/16-25](#)

²⁰² [91/22/12-24/15](#)

²⁰³ [INQ035612/22](#)

²⁰⁴ [174/17/21-25](#)

²⁰⁵ [152/18/14-18](#)

²⁰⁶ [153/73/5-8](#)

²⁰⁷ [154/11/12-25](#)

²⁰⁸ [155/10/15-18](#)

²⁰⁹ [137/88/18-19](#)

²¹⁰ [174/17/21-25](#)

²¹¹ [151/30/5-11](#)

²¹² [154/9/25-10/10](#)

²¹³ [152/12/10-17](#)

²¹⁴ [153/75/3-76/4](#)

²¹⁵ [153/9/19-10/3](#)

²¹⁶ [158/26/14-18, 158/27/7-21, 158/28/22-25](#)

²¹⁷ [156/10/16-17](#)

²¹⁸ [155/10/19-20](#)

²¹⁹ [152/18/25-19/3](#)

treatment received by Jane Twedde.²²⁰ Zak Warburton checked Angelika Klis²²¹ and Kelly Brewster.²²² Ken O'Connor knelt beside Saffie-Rose Roussos,²²³ covered Angelika Klis²²⁴ and checked Philip Tron.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,²²⁶ and transporting the child of another ETUK staff member away from the scene.²²⁷ A number of ETUK staff also offered assistance in the Casualty Clearing Station.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.

16.121 I accept that this standard of care will not be as high as that provided by an ambulance service.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.²³⁰ Those relating to the City Room “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: “As the view became clearer I could see the scene of devastation and carnage.”²³¹ It was obvious to Miriam Stone that an explosion had occurred.²³²

16.123 Miriam Stone instructed Thomas Rigby, the Showsec Head of Security, to close the City Room.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

²²⁰ [151/32/10-23](#)

²²¹ [150/106/25-107/6](#)

²²² [154/9/4-15](#)

²²³ [174/18/1-6](#)

²²⁴ [150/107/18-20](#)

²²⁵ [151/9/3-13](#)

²²⁶ [INQ007047/1-2](#)

²²⁷ [INQ005027/1-3](#)

²²⁸ [137/102/10-24](#), [137/111/25-112/15](#)

²²⁹ [144/59/16-60/19](#)

²³⁰ [87/20/13-19](#)

²³¹ [INQ005683/4](#)

²³² [87/20/13-19](#)

²³³ [INQ005683/5](#)

for his staff to enter the City Room. Miriam Stone replied that there was *"no obvious visible threat and very little movement in the area and it appeared to be safe visually"*.²³⁴ She stated: *"[A]s far as I can tell, it is safe."*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.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 999.²³⁷ 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"*.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.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 2017.²⁴⁰ Paul Worsley worked for SMG as a Senior Engineer. His duties included setting up equipment and managing the electrical systems.²⁴¹
- 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!'"*.²⁴²
- 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.²⁴³
- 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.²⁴⁴ This was the only trolley-style stretcher used on the night of the Attack to evacuate anyone from the City Room.

²³⁴ [INQ005683/6](#)

²³⁵ [INQ025576/35](#) at paragraph 152

²³⁶ [174/14/10-15/15](#)

²³⁷ [INQ025575/15](#) at paragraphs 82-85

²³⁸ [INQ023493T/49-50](#)

²³⁹ [INQ005683/6](#)

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.²⁴⁵

²⁴⁵ [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.²⁴⁶ 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.²⁴⁷ He instructed them to divert people away from the City Room and to use every alternative exit.²⁴⁸

16.134 Miriam Stone asked Thomas Rigby if there were any Showsec staff who were first aid trained.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].”*²⁵⁰ Thomas Rigby believes that at least five Showsec staff responded to this request.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.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.²⁵³

²⁴⁶ [34/49/20-50/7, INQ005225/2](#)

²⁴⁷ [117/89/18-25, INQ024776/6](#)

²⁴⁸ [117/89/18-25](#)

²⁴⁹ [INQ024776/6](#)

²⁵⁰ [INQ031002/2](#)

²⁵¹ [INQ025754/35](#)

²⁵² [117/86/14-87/8](#)

²⁵³ [117/86/14-87/8, 117/87/18-88/5](#)

- 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
- 16.140** Megan Balmer, a Showsec Supervisor, was by the doors into the Arena facing the concourse.²⁶³ The explosion forced her through the doors. Initially, she ran in the direction of Hunts Bank.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.²⁶⁵ Having requalified in first aid 18 months earlier, she made her way to the City Room.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.²⁶⁷ She checked on Wendy Fawell, but found there was nothing she could do to help.²⁶⁸ She sought to provide assistance to Kelly Brewster.²⁶⁹ She also helped a casualty down to the Casualty Clearing Station.²⁷⁰

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](#)

²⁶³ [INQ007196/2](#)

²⁶⁴ [INQ007196/2](#)

²⁶⁵ [INQ011825/3](#), [117/90/17-20](#)

²⁶⁶ [INQ007196/2](#)

²⁶⁷ [117/90/21-91/20](#)

²⁶⁸ [152/19/9-20/5](#)

²⁶⁹ [154/9/10-17](#)

²⁷⁰ [INQ007196/6](#)

- 16.142** Amy Barratt, a Showsec Door Supervisor, was in the Arena bowl when she heard “a loud bang”.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

²⁷¹ [INQ006661/1-2](#)

²⁷² [INQ006661/1-2](#)

²⁷³ [INQ006661/2-4](#)

²⁷⁴ [174/21/10-14](#)

²⁷⁵ [152/18/19-19/3](#)

²⁷⁶ [152/12/3-23](#)

²⁷⁷ [158/16/1-9](#)

²⁷⁸ [158/31/16-24](#)

TravelSafe

Key findings

- There were three TravelSafe officers on duty at the Victoria Exchange Complex on the evening of 22nd 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.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.²⁸⁰

16.146 On 22nd May 2017, three TravelSafe officers, Philip Clegg, Niall Pentony and Reece McKay, were on duty at the Victoria Exchange Complex.²⁸¹

16.147 At 22:31, Philip Clegg and Niall Pentony were standing on the station concourse²⁸² when they heard “a loud bang” from the direction of the Arena.²⁸³ 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 22:32.²⁸⁴ 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.²⁸⁵ He also checked Nell Jones,²⁸⁶ Elaine McIver,²⁸⁷ Martyn Hett,²⁸⁸ Wendy Fawell,²⁸⁹ Sorrell Leczkowski,²⁹⁰ Chloe Rutherford and Liam Curry.²⁹¹ In the Casualty Clearing Station, Philip Clegg assisted paramedics with John Atkinson.²⁹²

²⁷⁹ [156/59/2-7](#)

²⁸⁰ [INQ022500/2](#)

²⁸¹ [INQ035612/12](#)

²⁸² [INQ035612/4](#)

²⁸³ [INQ041761/1](#)

²⁸⁴ [INQ035612/15-17](#)

²⁸⁵ [154/9/25-10/7](#)

²⁸⁶ [152/26/12-25](#)

²⁸⁷ [156/46/14-47/12](#)

²⁸⁸ [156/9/17-25](#)

²⁸⁹ [152/18/8-11](#)

²⁹⁰ [153/72/17-73/4](#)

²⁹¹ [154/99/14-24](#)

²⁹² [158/11/4-16](#)

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.²⁹³

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.²⁹⁴

16.151 Network Rail and Northern Rail were Category 2 responders under the Civil Contingencies Act 2004.²⁹⁵ 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.²⁹⁶

16.152 Northern Rail staff attended the City Room following the explosion and were actively involved in assisting casualties.²⁹⁷ They did their best to help those affected.

16.153 Emergency responders used equipment located at Manchester Victoria Railway Station on 22nd May 2017.²⁹⁸ At the time of the Attack, there were no stretchers in the railway station part of the Victoria Exchange Complex.²⁹⁹

²⁹³ [16/38/14-39/7](#), [INQ003943/1](#)

²⁹⁴ [16/38/19-24](#), [INQ025591/4](#), [INQ025592/2](#) at paragraph 7

²⁹⁵ [16/40/13-17](#), [INQ025579/5](#) at paragraphs 24 and 25, [Civil Contingencies Act 2004, Schedule 1, Section 24](#)

²⁹⁶ [37/81/15-82/14](#), [INQ000683/1-2](#), [INQ025579/7](#) at paragraph 32

²⁹⁷ [INQ025579/13](#) at paragraphs 63 and 64

²⁹⁸ [INQ025579/13](#) at paragraph 66

²⁹⁹ [INQ025579/13](#) at paragraph 67

Response by staff

- 16.154** Owen Sanderson was the Northern Rail Station Supervisor on the night of 22nd May 2017.³⁰⁰ He was the on-duty Team Leader and Bronze on site.³⁰¹ 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.³⁰²
- 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.³⁰³ PC Roach asked Owen Sanderson to fetch all the station's first aid equipment.³⁰⁴
- 16.156** Northern Rail Train Dispatcher Stuart Craig was on the station concourse when he heard the explosion and saw a flash.³⁰⁵ 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.³⁰⁶
- 16.157** At 22:39, Stuart Craig carried medical equipment into the City Room via the raised walkway.³⁰⁷ Once in the City Room, he put the equipment down and sought to help the injured.³⁰⁸ He assisted in the evacuation of John Atkinson from the City Room.³⁰⁹
- 16.158** By 22:40, Owen Sanderson and a Northern Rail colleague each had a large NHS first aid bag on the station concourse.³¹⁰ This is shown in Figure 39.

³⁰⁰ [INQ029439/1](#)

³⁰¹ [INQ025579/12](#) at paragraph 61

³⁰² [INQ029439/2](#)

³⁰³ [INQ035612/54](#)

³⁰⁴ [74/91/15-92/20](#)

³⁰⁵ [INQ024863/1-2](#)

³⁰⁶ [INQ024863/2](#)

³⁰⁷ [INQ035612/57](#)

³⁰⁸ [INQ024863/3](#)

³⁰⁹ [158/43/21-44/10](#)

³¹⁰ [INQ035612/60](#)

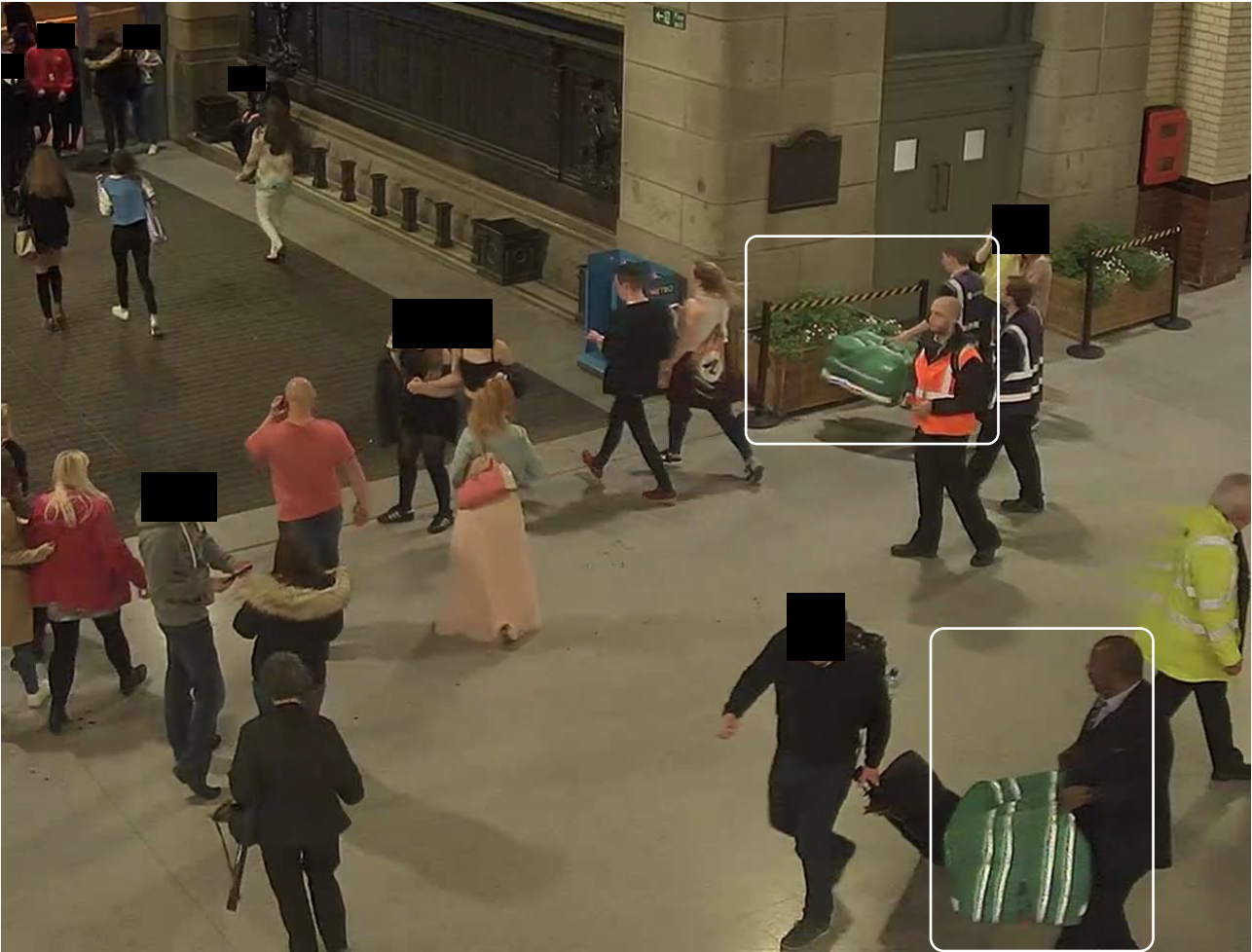


Figure 39: Northern Rail staff with large NHS first aid bags³¹¹

16.159 With the help of STM employee Steven Hawksworth, they carried these bags up the staircase to the raised walkway.³¹²

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.³¹³

16.161 Owen Sanderson had undertaken a basic first aid at work refresher course not long before the Attack.³¹⁴ On the night, he spoke to a number of the injured, seeking to reassure them.³¹⁵

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.³¹⁶

³¹¹ [INQ035612/60](#)

³¹² [INQ035612/70](#)

³¹³ [INQ035612/80](#)

³¹⁴ [INQ029439/3](#) and [8](#)

³¹⁵ [INQ029439/4-6](#)

³¹⁶ [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”.³¹⁷ When the bomb detonated, he saw “*an incredible flash being red black and purple in colour*”.³¹⁸ He felt the shock wave. He was struck in the knee, and his leg

³¹⁷ [INQ029396/5](#)

³¹⁸ [INQ029396/6](#)

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 assist those affected by the explosion.³¹⁹ He tried to help Michelle Kiss.³²⁰

Michael Byrne

16.167 Michael Byrne was waiting in the City Room to collect his daughters.³²¹ After the explosion, he stayed and assisted casualties in the City Room, including Alison Howe³²² and Lisa Lees.³²³

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.³²⁴ Ronald Blake described seeing a large orange flash about four car lengths away from where he was standing, followed by a loud bang.³²⁵ He felt something hit his right inner thigh. He found himself lying on the floor looking up towards his wife, Lesley.³²⁶

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.³²⁷ With the encouragement of the operator, he applied his wife's belt to John Atkinson's right leg as a tourniquet.³²⁸ 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*".³²⁹ 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.³³⁰

16.170 Ronald Blake helped others injured outside Manchester Victoria Railway Station.³³¹ He had no previous first aid training.³³² He provided help while he himself was injured. He further injured himself when carrying down the stairs the makeshift stretcher bearing John Atkinson.³³³

³¹⁹ [INQ029396/7](#)

³²⁰ [151/23/14-20](#)

³²¹ [INQ006321/1](#)

³²² [152/11/21-12/2](#)

³²³ [152/4/23-5/19](#)

³²⁴ [158/60/22-61/11](#), [158/8/6-12](#)

³²⁵ [158/8/6-12](#)

³²⁶ [158/8/13-15](#)

³²⁷ [158/61/21-62/18](#)

³²⁸ [158/63/1-17](#)

³²⁹ [161/88/8-17](#)

³³⁰ [158/57/2-25](#)

³³¹ [158/58/1-3](#)

³³² [158/60/4-7](#)

³³³ [158/71/2-5](#)

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.³³⁴ They immediately went to help an injured girl and, later, a second injured girl in the City Room. They assisted with those children's evacuation from the City Room to the Casualty Clearing Station.³³⁵
- 16.172 They stayed with the two injured girls until Philip and Kim Dick were reunited with their daughter and granddaughter around midnight.³³⁶ Kim Dick expressed her "upset that it took in excess of an hour before any paramedic or medically trained person attended to the girls".³³⁷

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.³³⁸ 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.³³⁹ 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 22:52.³⁴⁰
- 16.174 Bethany Crook went on to assist many in the City Room, including Saffie-Rose Roussos³⁴¹ and Georgina Callander.³⁴² 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."*³⁴³

³³⁴ [90/1/14-24](#), [88/32/15-23](#)

³³⁵ [88/34/7-19](#), [90/3/14-5/4](#)

³³⁶ [88/39/25-40/12](#)

³³⁷ [88/41/6-15](#)

³³⁸ [155/97/9-98/25](#)

³³⁹ [155/99/6-100/8](#)

³⁴⁰ [155/96/23-125/6](#), [175/56/22-105/20](#)

³⁴¹ [175/17/16-19](#)

³⁴² [155/19/22-24](#)

³⁴³ [155/116/18-117/1](#)

Daren Buckley

- 16.176** Daren Buckley attended the concert with his son, who loved music.³⁴⁴ His son enjoyed the concert: he sang every word.³⁴⁵
- 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.³⁴⁶
- 16.178** Daren Buckley left his son with a member of staff and went into the City Room to help.³⁴⁷ The CCTV showed he was in there for over 21 minutes.³⁴⁸ Armed police officers told him to leave.³⁴⁹ Daren Buckley initially refused. He said: *"[N]obody's helping, so somebody's got to help."*³⁵⁰ He stated that the police said it was a crime scene and he had to leave.³⁵¹
- 16.179** Daren Buckley collected his son from the Arena.³⁵² 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.³⁵³

Darron Coster

- 16.180** Darron Coster served with the Royal Military Police for 22 years.³⁵⁴ He retired in 2008.³⁵⁵ Through his military service, he was familiar with the aftermath of a bomb explosion. This enabled him to stay calm in a crisis.³⁵⁶ 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.³⁵⁷
- 16.181** Darron Coster had arranged to collect his son, his son's girlfriend and a friend from the concert.³⁵⁸ 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"*.³⁵⁹ He walked towards it and saw a cloud of dust coming out of the doors leading into the City Room.³⁶⁰ People were evacuating quickly across the raised walkway.³⁶¹ He received a text message from his son to say they were safe.³⁶²

³⁴⁴ [87/2/5-8](#)

³⁴⁵ [87/2/18-20](#)

³⁴⁶ [87/3/3-22](#)

³⁴⁷ [87/5/4-24](#)

³⁴⁸ [87/5/19-24](#)

³⁴⁹ [87/5/25-6/8](#)

³⁵⁰ [87/6/9-14](#)

³⁵¹ [87/6/9-23](#)

³⁵² [87/6/24-7/1](#)

³⁵³ [87/7/21-8/2](#)

³⁵⁴ [88/2/18-3/1](#)

³⁵⁵ [88/3/2-3](#)

³⁵⁶ [88/3/4-11](#)

³⁵⁷ [88/3/16-4/21](#)

³⁵⁸ [88/5/15-24](#)

³⁵⁹ [88/6/20-25](#)

³⁶⁰ [88/6/20-7/10](#)

³⁶¹ [88/7/18-8/2](#)

³⁶² [88/8/3-15](#)

- 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.³⁶³ He then spoke to various people wearing tabards. They were, he said, in *"quite a state"*:³⁶⁴ they did not know what to do and did not seem to have any first aid 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.³⁶⁵
- 16.183** Darron Coster walked around the City Room several times.³⁶⁶ He provided care to a number of people. He applied a tourniquet to a person with a leg injury.³⁶⁷ He used a belt and a handbag strap.³⁶⁸ 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.³⁶⁹ 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.³⁷⁰ 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.³⁷¹
- 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.³⁷² Four or five further police officers arrived at about the same time, followed shortly afterwards by a medic, with three pips on his shoulder.³⁷³ This was the Advanced Paramedic Patrick Ennis. At that point, he thought the *"cavalry had arrived"*.³⁷⁴
- 16.185** Darron Coster stayed in the City Room helping casualties until between 23:10 and 23:30.³⁷⁵ He provided assistance to many in the City Room. He covered Nell Jones with a jumper.³⁷⁶

³⁶³ [88/9/9-20](#)

³⁶⁴ [88/11/1-5](#)

³⁶⁵ [88/10/10-12/22](#)

³⁶⁶ [88/12/23-13/7](#)

³⁶⁷ [88/13/17-14/2](#)

³⁶⁸ [88/14/3-6](#)

³⁶⁹ [88/15/17-17/4](#)

³⁷⁰ [88/17/9-18/5](#)

³⁷¹ [88/19/14-20/17](#), [88/21/22-22/8](#)

³⁷² [88/22/14-24/7](#)

³⁷³ [88/24/17-25/11](#)

³⁷⁴ [88/25/14-17](#)

³⁷⁵ [88/26/11-19](#)

³⁷⁶ [152/27/5-13](#)

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.³⁷⁷ As shown in Figure 40, 52 seconds after the explosion, he is captured on the station concourse CCTV running to the City Room.

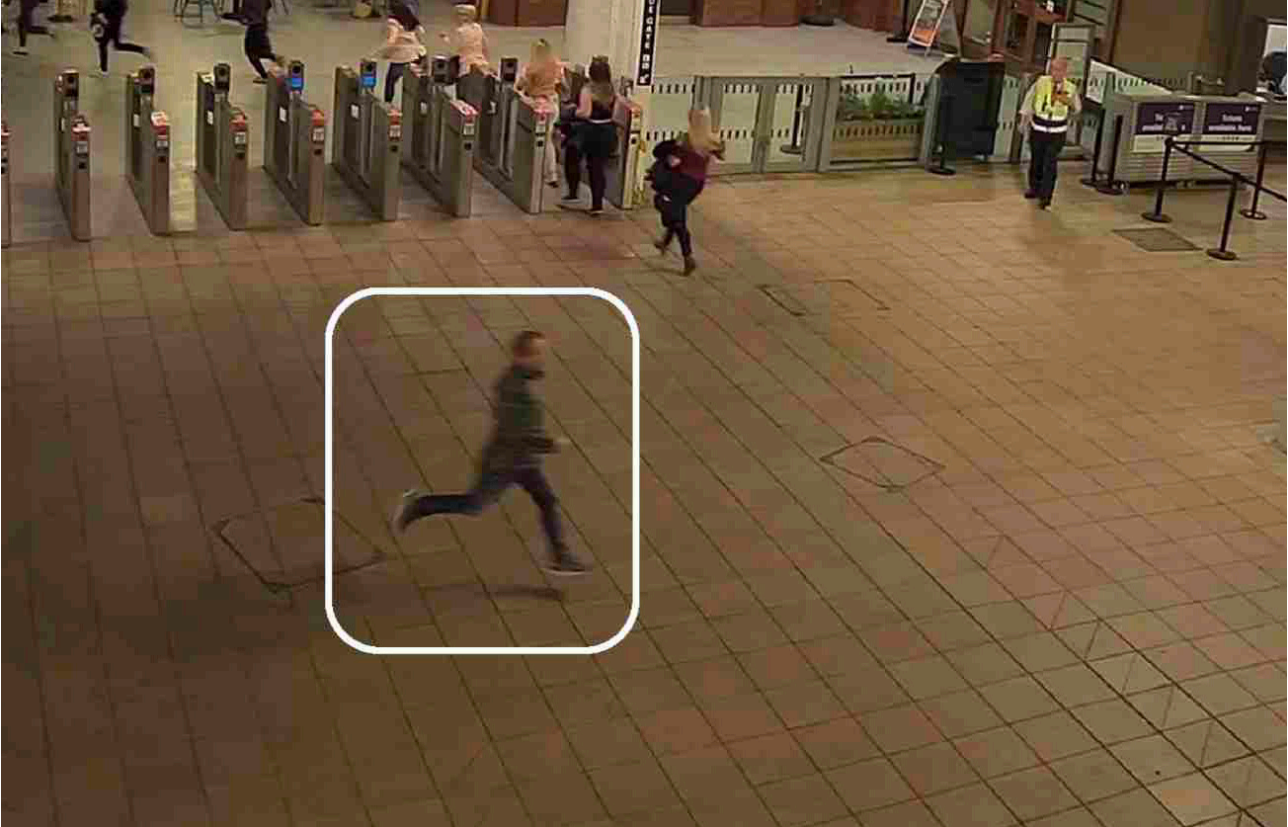


Figure 40: Gareth Chapman running towards the City Room at 22:31:52³⁷⁸

16.187 Gareth Chapman entered the City Room via the Fifty Pence staircase less than two minutes later.³⁷⁹ He covered Megan Hurley, Chloe Rutherford and Liam Curry with T-shirts.³⁸⁰ He gave what assistance he could to others.³⁸¹ He assisted in carrying John Atkinson to the Casualty Clearing Station.³⁸²

³⁷⁷ [153/26/10-21](#)

³⁷⁸ [INQ035612/8](#)

³⁷⁹ [INQ035612/18](#)

³⁸⁰ [153/6/10-13](#), [154/99/18-24](#)

³⁸¹ [153/27/9-23](#)

³⁸² [158/52/8-11](#)

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 *“loud hollow booming sound”*.³⁸³ He made his way to the City Room. He provided assistance to injured people. He sought to provide treatment to Sorrell Leczkowski.³⁸⁴ He also sought to provide treatment to Kelly Brewster, with whom he remained for over half an hour.³⁸⁵

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.³⁸⁶ He had completed first aid at work training through his employer and had received refresher training about one year prior to the Attack.³⁸⁷ He made a 999 call before he entered the City Room.³⁸⁸ He helped Saffie-Rose Roussos for over 30 minutes. He returned to the City Room and assisted others.³⁸⁹

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.³⁹⁰ 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.³⁹¹

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.³⁹² 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.”*³⁹³

16.192 Robert Grew sought to help those he could in the City Room, including Lisa Lees³⁹⁴ and Courtney Boyle.³⁹⁵ When she gave evidence, Claire Booth mentioned Robert Grew and the help he gave to her and her daughter Hollie.³⁹⁶ Robert Grew also spoke to John Atkinson in the City Room.³⁹⁷

³⁸³ [154/19/15-24](#)

³⁸⁴ [153/74/4-11](#)

³⁸⁵ [154/8/21-25](#), [154/10/11-16](#), [154/25/1-40/3](#)

³⁸⁶ [174/161/12-19](#)

³⁸⁷ [174/13/16-20](#)

³⁸⁸ [174/13/16-20](#)

³⁸⁹ [174/17/21-25](#), [174/161/20-162/15](#)

³⁹⁰ [INQ007013/1](#)

³⁹¹ [INQ007013/1](#)

³⁹² [INQ007013/1-2](#)

³⁹³ [INQ007013/2](#)

³⁹⁴ [152/5/24-6/3](#)

³⁹⁵ [150/118/18-25](#)

³⁹⁶ [138/84/15-25](#)

³⁹⁷ [158/16/21-25](#)

Sean Gardner

16.193 Sean Gardner was waiting to collect his daughter outside the City Room at the time of the detonation.³⁹⁸ He sought to provide assistance to Jane Tweddle.³⁹⁹ It was not until after he had given what assistance he could to Jane Tweddle that he was reunited with his daughter.⁴⁰⁰

Thomas Owen

16.194 Thomas Owen heard the bomb go off when he was with his girlfriend in the Arena bowl.⁴⁰¹ 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.⁴⁰²

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.

³⁹⁸ [INQ007087/1-2](#)

³⁹⁹ [151/29/15-18](#)

⁴⁰⁰ [INQ007087/1-2](#), [INQ007087/7](#)

⁴⁰¹ [INQ041648/1](#) at paragraph 4

⁴⁰² [155/9/5-10/14](#)

