

# The Kerslake Report:

An independent review into the preparedness for,  
and emergency response to, the Manchester Arena  
attack on 22<sup>nd</sup> May 2017

**EMBARGOED UNTIL NOON ON TUESDAY 27TH MARCH**



# The Kerslake Report

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## **The names of those who lost their lives**

John Atkinson

Alison Howe

Courtney Boyle

Lisa Lees

Philip Tron

Nell Jones

Kelly Brewster

Michelle Kiss

Georgina Callander

Angelika Klis

Olivia Campbell-Hardy

Marcin Klis

Liam Curry

Sorrell Leczkowski

Chloe Rutherford

Eilidh MacLeod

Wendy Fawell

Elaine McIver

Martyn Hett

Saffie-Rose Roussos

Megan Hurley

Jane Carolyn Tweddle

## Executive Summary

1. At just after 22:30hrs on Monday 22<sup>nd</sup> May 2017, a suicide bomber detonated an improvised device in an area known as the City Room, which is just outside the Arena and which starts a link to Victoria station. For the purpose of this report this City Room will be referred to as the 'foyer'. Around 14,000 people, mainly teenagers and family, had travelled from across the UK to attend the concert of Ariana Grande, which was just coming to an end. The foyer was busy with exiting concert goers, waiting family members and merchandise sellers. The bomb used was substantial, containing nearly two thousand nuts, and had a devastating impact.
2. The bomb killed twenty-two people including many children. Over one hundred were physically injured and many more suffered psychological and emotional trauma. Paramedics treated many walking wounded in the city centre. Hospitals in Greater Manchester treated people with serious injuries, transported by the Ambulance Service, whilst others made their way to hospitals across the wider region.
3. The Manchester Arena attack was the deadliest in the UK since the London bombings on 7<sup>th</sup> July 2005. Although the Greater Manchester Resilience Forum had done many planning exercises, the events of 22<sup>nd</sup> May were something none of those involved had ever encountered before. This was a real-world test of the plans and assumptions.
4. This Review has focused on the response to the attack in the nine days that followed it. There is a lot to be proud of in the response, both for the city-region of Greater Manchester and its emergency services. The benefits of investing in collaborative partnership and emergency planning were demonstrated to the full. We set out in the report and summarise below the highlights of what went well. But we are conscious that we are only touching the surface of hundreds if not thousands of acts of individual bravery and selflessness.
5. As well as celebrating the things that went well however, it is vital that we also learn the lessons of what went less well. This matters for the people of Greater Manchester and beyond who were caught up in the terrible events of that night but

also for other places that might be caught up in such an attack in the future. It is perhaps inevitable that this part of the report will get the most attention in the initial coverage. However, in the Panel's view, the story of the response is overwhelmingly positive.

6. The Mayor of Greater Manchester has made it clear from the beginning that the experiences of bereaved families, the injured and others directly affected should be at the heart of the process. The Panel was in complete agreement with this view. This focus on those caught up in the attack has been integral to the way that the Review has been conducted and the questions that we have sought to answer. It is inevitable that these individual experiences have not all been the same and we have sought to reflect the different views and perspectives in the way that we have written the report.
7. This Review sits alongside and draws on the numerous single and multi-agency debriefings that have been done by the emergency and other services following the attack. The Review comes ahead of the inquests into the deaths of those who lost their lives as a result of the attack. From the outset, the Panel has been clear that it would not address issues concerning the death of the individuals deceased nor any question of the survivability of the injuries sustained by those who sadly died.
8. In the following paragraphs, we highlight some of the things that went well and the major lessons to be learnt. This is by no means comprehensive; the full recommendations of the report are summarised in Chapter 6.

## **What Went Well**

9. First and foremost, the investment in multi-agency planning and exercising as part of the Greater Manchester Resilience Forum resulted in the partner agencies being generally able to act with a high level of confidence. It is notable that there had been a major exercise at the Trafford Centre just months before the attack happened.
10. The actions of the Arena staff, British Transport Police (BTP) and members of the public who stayed to help showed enormous bravery and compassion. Police and

Ambulance personnel were very rapidly on the scene and there followed a remarkably fast deployment of armed officers to secure the area and Ambulance staff to attend to the wounded.

- 11.** At critical points in the evening, key emergency personnel exercised sound judgement in an extremely stressful, chaotic and dangerous environment. Of particular note were the decisions to establish the Casualty Clearing Station on the station concourse and to allow emergency staff and members of the public to remain in the foyer notwithstanding its designation at the time as a 'hot' zone. These were vitally important judgements that significantly influenced the course of events over the evening.
- 12.** The civic response of the city-region was by any measure exceptional and demonstrated the enormous strength of the civic leadership and partnership in Greater Manchester. The early press conference by the Leader of Manchester City Council and the Mayor of Greater Manchester, through to the vigil attended by thousands in front of the Town Hall, stands testament to the determination that Greater Manchester would stay open for business. The strength of the civic leadership had a profound impact on how events played out in the subsequent days following the attack. The voluntary, community and faith sector played a vital role in providing support to those affected and in showing solidarity with minority communities who might otherwise have been vulnerable.
- 13.** The Family Liaison Officers and Bereavement Nurses provided a vital source of support and comfort to many of the families which went well beyond their formal roles. The Panel heard many examples of how they had helped individual families deal with the consequences of the attack. This is just one example of the way in which families were put first by the different agencies involved in responding to the attack.
- 14.** The Panel was deeply impressed with the care and sensitivity with which the deceased were removed from the Arena and then taken to the mortuary.



## The Major Areas for Learning

- 15.** The Greater Manchester Fire and Rescue Service (GMFRS) did not arrive at the scene and therefore played no meaningful role in the response to the attack for nearly two hours. This compares with an average response time for the Service of less than six minutes. The effect of this was that a valuable resource was not available to assist on the scene, particularly with the movement of those who were injured from the foyer to the Casualty Clearing Station. The Fire Service was effectively 'outside the loop', having no presence at the rendezvous point established by the Police, little awareness of what was happening at the Arena and only a very limited and belated presence at Strategic Gold Command.
- 16.** The reasons for the failure of GMFRS to respond adequately to the attack are set out in full in our report. There is not one single reason nor one individual that caused this failure. Rather, it was a combination of poor communication and poor procedures. GMFRS will need to reflect on the wider issues it raises for their operational culture and approach to multi-agency working.
- 17.** The setup of the Casualty Bureau was seriously hampered by the complete failure of the National Mutual Aid Telephony system provided by Vodafone. As a consequence, communication with the families caught up in the attack was badly affected. In particular, the ability to increase capacity by bringing in other Casualty Bureaus across the country was prevented. A restricted local telephone contact service was not up and running until around 03:00hrs. This failure was a cause of significant stress and upset on the night to the families involved, who were seeking to find out more about the situation of their loved ones. A number were reduced to a frantic search around the hospitals of Greater Manchester to find out more.
- 18.** Vodafone have apologised for the failure and are committed to ensuring that it does not happen again. As this is a national contract with the Home Office, we recommend that they should seek urgent guarantees from the company on this matter. There must be tested backup systems in place that eliminate the chance of another failure.

- 19.** The Panel was shocked and dismayed by the accounts of the families of their experiences with some of the media. They spoke of being ‘hounded’, of a ‘lack of respect’, and of ‘sneaky’ attempts to take photos when families were receiving bad news. To have experienced such intrusive and overbearing behaviour at a time of such enormous vulnerability seemed to us to be completely and utterly unacceptable. We recognise that this was some, but by no means all the media and that the media also have a positive and important role to play. We cite some positive examples, particularly in respect of the local newspapers, in our report. However, it is clear to us that the behaviour of some of the press in particular fell well below the standards that are set out in the Editors’ Code.
- 20.** The Panel feels very strongly that this cannot be as good as it gets. We recommend that the Independent Press Standards Organisation should review the operation of its Code in light of these experiences and that there is exploration of ways to enhance the skills in media handling for the Family Liaison Officers.
- 21.** The Panel has commented positively on much of the action taken by Greater Manchester Police (GMP). However, there are two important areas of learning that we have identified. Firstly, the multiple duties that fell to both the Police Gold Commander and to the Force Duty Officer on the night of the attack were extremely wide-ranging and testing. In the case of the Force Duty Officer, the Panel was pleased to hear of GMP’s decision and plan to re-locate the Force Duty Officer’s work station to within the GMP Force Headquarters building. This should help with the communication difficulties experienced by GMFRS and others on the night. The Panel has also concluded that the first meeting of the Strategic Coordinating (Gold) Group, to bring together the strategic leads for the first responders, should have been called earlier than 04:15hrs the following morning.
- 22.** Secondly, there was not a shared communication across the agencies of the declaration of Operation PLATO, which is the agreed operational response to a suspected Marauding Terrorist Firearms Attack, nor was there a shared understanding of its implications. In the event, pragmatic judgements were made on the night that ensured that the response remained effective. However, we think that during any future events, it is essential that this communication across the agencies happens and happens early. We recommend that the Operation PLATO

principles should be reviewed nationally and referred to as the Joint Operating Principles for Responding to a Terrorist Attack, regardless of whether firearms are thought to be involved.

- 23.** The strength of the response for support and care for the families directly affected was not always carried through beyond the early period. In particular, the need for continuing access to appropriate mental health services was highlighted by the families we spoke to. The challenge of delivering this consistently was in part a reflection of the fact that although the attack happened in Manchester, its impact in terms of those affected went well beyond the city-region.
- 24.** The Panel would like to place on record its sincere thanks to all those who contributed, which they did entirely on a voluntary basis. Throughout the Review, we were impressed by the willingness of all those involved to learn the lessons, both for Greater Manchester and beyond.
- 25.** We would like particularly to pay tribute to the bereaved families, whose willingness to recount the terrible events of that evening in order to learn lessons for the future was truly humbling. The Panel owes them a great debt for this. Without their contribution this report would not have been possible.

## Chapter 1 – Introduction

### Background and Rationale for Review – ‘Putting the experience of those directly affected at the heart of the review’

- 1.1.** The attack at the Manchester Arena on 22<sup>nd</sup> May 2017 took the lives of twenty-two people and left hundreds more with both psychological and physical injuries. Whilst all the emergency services are trained to respond to disasters, the events on 22<sup>nd</sup> May were ones none had encountered previously. This was a brutal real-world test of plans and assumptions on a scale that was unprecedented in Greater Manchester. There was much to be proud of in the response, and there were many heroes that night. There is learning to share from both this and from the elements that could have gone better. The Review has tried to think through what might apply in the future in another attack, recognising that any lessons learnt will apply not just to Manchester, but nationally and internationally.
- 1.2.** The Mayor of Greater Manchester, Andy Burnham, wants to ensure that the important learning from this fatal attack is captured and disseminated. He commissioned this Independent Review so that the key messages and lessons could be shared more quickly than happens in any formal statutory inquiry process. The Review cannot draw conclusions about issues that will be addressed in the Coroner’s inquests or the criminal investigation. It does not duplicate the single-or multi-agency debrief process already undertaken by the emergency services and others. The Review has no official powers or status and everyone who contributed did so voluntarily in a spirit of honesty and openness.
- 1.3.** The Mayor was clear from the beginning that the experiences of bereaved families, the injured and others directly affected should be at the heart of the process. In keeping with the recommendations of the report on the experiences of the Hillsborough families by The Right Reverend James Jones KBE which was published during this review<sup>1</sup>, a priority for the Panel has been to ensure that their perspective is captured and their questions addressed as far as possible. This priority informed the methodology and information-gathering process so as to

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<sup>1</sup> The Right Reverend James Jones KBE (2017). ‘The patronising disposition of unaccountable power.’ A report to ensure the pain and suffering of the Hillsborough families is not repeated.

include their participation and experiences. Following an introductory chapter, the experiences of the bereaved, injured and other survivors are presented in chapter 2 ahead of the review of responding organisations from Chapter 3 onwards.

## **Panel Membership**

- 1.4.** The independent Panel was chaired by Lord Bob Kerslake, who was supported by four members with relevant expertise.

### **Lord Kerslake (Panel Chair)**

Lord Kerslake is a former Head of the Civil Service and is President of the Local Government Association. He is Chair of Peabody, Chair of the Centre for Public Scrutiny and Chair of London CIV (Collective Investment Vehicle for London Local Authorities Pension Funds). He was made a life peer in 2015.

### **Hugh Deeming**

Hugh is a research consultant whose interests include community resilience. He is an advisor to the Cabinet Office on community resilience and recovery issues and a Senior Research Fellow at the Emergency Planning College.

### **Alan Goodwin**

Alan is the former Deputy Chief Constable for Derbyshire Constabulary and was the UK national policing lead for civil emergencies, contingency planning and Disaster Victim Identification between 2003 and 2013. Alan was awarded the Queen's Police Medal in 2012.

### **The Venerable Karen Lund**

Appointed as Archdeacon of Manchester in February 2017, Karen was ordained in 1994 in the Diocese of London and has held various ministerial roles including prison chaplaincy and Bishop's Advisor. She has over twenty years' experience as a priest in the Church of England.

### **Margareta Wahlström**

Margareta has over thirty years of international experience in humanitarian relief operations in disaster and conflict areas. She is President of the Swedish Red Cross. In 2008, the United Nations Secretary-General Ban Ki-moon announced

her appointment as Special Representative of the Secretary General for Disaster Risk Reduction.

- 1.5. The Review team also included a full-time administrator, an independent author who attended many of the Panel members' meetings with participants, the services of two independent consultants on specific elements of the Review and logistical support from members of the Greater Manchester Civil Contingencies and Resilience Unit.
- 1.6. The Panel would like to thank all those who contributed, which they did entirely on a voluntary basis. The Panel is grateful to those who shared their experiences, often painful and very personal, so that greater understanding and insight could be achieved. We would like particularly to pay tribute to the bereaved families, whose willingness to tell us about the terrible events of that evening in order that lessons might be learnt for the future was truly humbling.

## Terms of Reference

- 1.7. When the Review was commissioned, the areas to be considered were identified in the Terms of Reference set out below. As work progressed, an additional theme of the role of the media emerged from conversations with families involved, and as such this was added as an issue for the Panel to consider.

## Aim

- i. To undertake an Independent Review of Greater Manchester's preparedness for and response to the Manchester Arena terrorist attack. To advise the Mayor, in the exercise of his Police and Crime Commissioner function, of those aspects of the preparedness and response that were effective and those that may inform future good practice, together with where necessary and appropriate to advise on what steps might be taken to address any areas that may be strengthened or improved.

## Rationale

- ii. In the period from 22<sup>nd</sup> March to 19<sup>th</sup> June 2017, the UK was subject to four separate terrorist-related events, each causing loss of life and life-changing

injuries. The scale, nature and consequences of the Manchester Arena terrorist attack on 22<sup>nd</sup> May were unprecedented in Greater Manchester with a disproportionate impact on children and young people. The United Kingdom threat level from international terrorism at the time of commissioning this Review was at 'severe' and in the days after the Manchester Arena terrorist attack it briefly stood at 'critical'. This underscores the need to do everything possible to ensure all communities are safe and for learning to be shared. There is also a responsibility to identify where Greater Manchester led or delivered good practice and to share this in order to drive the next level of response in the United Kingdom.

## Objectives

- iii. Placing the experiences of those directly affected by the Manchester Arena terrorist attack at the heart of the Review:
- To assess the preparedness of Greater Manchester for the Manchester Arena terrorist attack, including multi-agency planning and capacity development.
  - To explore the effectiveness of the working relationships, cooperation and interoperability between all of the agencies involved during the response to the Manchester Arena terrorist attack.
  - To identify and share good practice to enhance future preparedness and any future response to a terrorist attack both within Greater Manchester and beyond.
  - To identify any gaps or other opportunities to increase preparedness and strengthen any future response to a terrorist attack in Greater Manchester and propose actions to address these.

## Remit

- iv. The Review will cover the multi-agency planning and activity to prepare for a terrorist attack (prior to 22<sup>nd</sup> May 2017). It will also explore the effectiveness of and joint working between services in the response phase (22<sup>nd</sup> May to 31<sup>st</sup> May 2017), together with how effective the response was in supporting those directly impacted by the attack.
- v. The Coronial Service will be one of the agencies included in the Review. However, it is important to note that the nature and extent of the Coroner's

involvement in the Review will be informed by the Coroner's judicial role and the fact that the Coronial investigation is ongoing.

vi. The Review will seek to identify learning in relation to the following:

- Governance and oversight arrangements of the preparedness for a terrorist attack.
- Risk and threat assessment to inform preparedness, but this is not intended to address the adequacy/appropriateness of the assessment of the national threat level.
- Training of responders and exercising of plans prior to the attack.
- Leadership and governance in the response, including command, control and primacy at different locations, together with coordination of effective communication between agencies.
- Interoperability of responders (including cooperation and information sharing) to enable preparedness and to respond effectively.
- The use of plans, policies, procedures and specialist capabilities during the response.
- Clarity of roles and responsibilities during the response.
- Risk assessment to inform the multi-agency response, but this is not intended to address the adequacy/appropriateness of the assessment of the national threat level.
- Warning and informing the public before and during the response.
- Response and provision of support to those physically injured.
- Arrangements for the provision of humanitarian assistance, including family reconciliation and the management of financial donations.
- Arrangements for the identification and care of the deceased and their families.
- Arrangements for managing implications for the transport network and damaged infrastructure.
- Arrangements for consequence management and for ensuring community cohesion.
- Finance and resource capacity to achieve preparedness and to respond, including national and regional mutual aid.
- The process of handover of the response phase to the recovery phase.



## Out of Scope

- vii. The Review will not seek to identify learning in relation to the following:
- The availability and use of intelligence prior to the attack and specifically relevant to the attack, and any question as to whether the attack could or should have been prevented by policing or intelligence organisations.
  - Issues concerning the cause of death of the people who died, the immediate circumstances in which each of the people died, and any question of the potential survivability from the injuries sustained by any of those who died.
  - Ongoing criminal investigations.
  - Any question of civil or criminal liability of the agencies involved.
  - Any questions of individual misconduct which would ordinarily be for organisations themselves as employers to investigate and address should such issues arise.
  - Matters being considered by the Mayoral Commission to tackle violent extremism and promote social cohesion in Greater Manchester.
  - Any activity within the 'recovery' phase i.e. any activity beyond 31st May 2017.

## Relationship with formal statutory processes

- viii. This Review has been undertaken whilst two formal processes are ongoing. The Coroner will be undertaking inquests into the deaths of those who lost their lives as a result of the attack. These have been opened and adjourned until June 2018. This Review will not address issues concerning the death of the individual deceased, the immediate circumstances in which each of the deceased died, and any question of the potential survivability of the injuries by any of those who died. There is also an ongoing criminal investigation. The Panel has received advice throughout the process from the Coroner, Crown Prosecution Service and from lawyers. Whilst the Panel has sought to answer questions raised by families and members of the public, it cannot comment where an area is covered by the above processes.

## Methodology – Information Gathering

- 1.8. From the outset, the Panel knew that bereaved families and others impacted by the attack would all have different perspectives and that they needed to be seen as individuals with individual experiences. It was anticipated that whilst many might prefer not to participate, some would want to talk to the Panel. The Panel wishes to thank every participant who made a contribution and recognises that for many this was emotionally demanding.
- 1.9. Commencing work on 1<sup>st</sup> September 2017, the Panel invited contributions from anyone who had something to say. All bereaved families received a letter inviting them to participate.
- 1.10. The work of the Review was publicised through the media following the launch and a website was set up.
- 1.11. The Panel commissioned the National Society for the Prevention of Cruelty to Children (NSPCC) to support its work based on their expertise in working with children and young people. People could contact the Panel through the NSPCC to make their contribution by email or on a dedicated phone line. The NSPCC also supported meetings with individual family members, with groups of responders and with National Health Service (NHS) staff. Some 200 contributions from bereaved families and friends, those physically and psychologically injured, their relatives and friends and from people who were at the Arena were received via the NSPCC.
- 1.12. In addition, contributions were sought from and meetings held with media, business, voluntary sector, faith and community leaders.

**1.13.** All the relevant agencies involved in responding to the Arena attack and known to the Review were invited to participate. Panel members met with a number of senior and frontline staff from the following:

- British Transport Police
- Coroner's Office
- Emergency Training UK - Arena medical and first aid providers
- Fire Brigades' Union
- Greater Manchester Combined Authority
- Greater Manchester Fire and Rescue Service
- Greater Manchester Health and Social Care Partnership
- Greater Manchester Police
- Greater Manchester Police Federation
- Manchester City Council
- Ministry of Defence
- Network Rail
- National Health Service Trusts
- North West Ambulance Service
- North West Counter Terrorism Unit
- North West Fire Control
- Northern
- SMG – Manchester Arena operating company
- Transport for Greater Manchester

In addition, the Panel was invited to sit in on the multi-agency debriefs which are formal means of organisational learning that looked at the strategic and tactical response to the events of 22<sup>nd</sup> May.

**1.14.** The Panel also looked at written evidence. This included agency timelines, training records and relevant policies and doctrine. This did not include routine access to police witness statements.

**1.15.** In order that the emerging findings from its work were properly informed, the Panel viewed footage obtained from numerous CCTV cameras located in and around the Arena and the adjacent Victoria train station.

- 1.16.** In addition, members of the Panel undertook various visits as part of their work including to see individual families in their homes, to the Arena, Victoria station, GMP Force Command Module, North West Fire Control and to see the specialist resources of the Fire and Ambulance services.
- 1.17.** An interim report providing an early update on the work of the Review was published in January 2018. This contained a recommendation that public bodies adopt the recommendation within ‘The patronising disposition of unaccountable power’ by The Right Reverend James KBE to sign up to a ‘Charter for Families Bereaved through Public Tragedy’.
- 1.18.** In writing this report and drawing its conclusions, the Panel acknowledges that there will be findings yet to emerge and that there are ongoing official investigations. However, agencies were asked to check the accuracy of the facts known at this time, which are described within this report, prior to its publication.
- 1.19.** Whilst many people who participated in the Review were directly affected, they represent only a small proportion of those who might have contributed. As already stated, the personal experiences related to the Panel are individual and unique to that contributor. The Panel has considered all contributions in its bid to identify learning for the future, however the Panel recognises that the comments they have received may not be fully representative of the overall experience of all those directly affected.
- 1.20.** This report necessarily uses many technical terms and concepts which will be new to many readers. The following section introduces the key concepts which will help to understand the discussion in subsequent chapters. There is also a glossary at the end of the report which lists all the acronyms e.g. North West Ambulance Service is NWAS.

## The Structure of Integrated Emergency Management in the United Kingdom: Key Concepts

- 1.21.** To conduct the Review, it was important for the Panel to understand some of the principles and protocols that underpin how responder agencies work together in emergencies. This section will therefore introduce key concepts of Integrated Emergency Management and subsequent sections will describe how responder agencies are encouraged to work together through an interoperability framework and through adopting joint principles for specific events.
- 1.22.** Emergency preparedness, response and recovery in the United Kingdom are built on the concept of delivering multi-agency Integrated Emergency Management<sup>2</sup>. This is achieved through a process of collaboration, communication and coordination between agencies and organisations that have been designated as Category 1 and Category 2 Responders<sup>3</sup> under the Civil Contingencies Act 2004. In each area, these responders interact through a statutory process referred to as the Local Resilience Forum; in Greater Manchester this partnership process is called the Greater Manchester Resilience Forum.
- 1.23.** Under the Civil Contingencies Act 2004, Greater Manchester Resilience Forum partners bear statutory duties to cooperate; to share information; to assess risks in their area; to plan for emergencies; to communicate with the public; to ensure their own business continuity and to provide business continuity advice to businesses.
- 1.24.** In addition to delivering these statutory functions, Greater Manchester Resilience Forum members also link to a wider range of partners, including private sector and third-sector organisations. In doing so, these organisations have sought to develop an inclusive working relationship within which collaboratively to plan, train and exercise contingencies for dealing with emergencies. These activities include numerous exercises that have been held to test the response to incidents at a range of public venues<sup>4</sup>.

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<sup>2</sup> The six phases of Integrated Emergency Management: Anticipation, Assessment, Prevention, Preparation, Response, Recovery Management

<sup>3</sup> Category 1 Responders are the main organisations involved in most emergencies at a local level (e.g. emergency services - Police, Fire and Rescue etc. - along with health sector and local authority partners). Category 2 responders are those organisations involved in some emergencies (e.g. utilities and transport companies) (HM Government, 2012: p.7).

<sup>4</sup> GMP (2017) Manchester Arena Overview: a submission to the Kerslake Arena Review. GMP.

- 1.25.** In accordance with Integrated Emergency Management principles during emergencies, single-and multi-agency response activity is conducted through the application of a structured coordination framework.
- 1.26.** Figure 1<sup>5</sup> illustrates how individual responder organisations manage their activities through a three-tier Gold, Silver and Bronze structure. Using this structure, organisations maintain command and control over their own resources, with respective Gold Commanders defining each organisation’s strategic direction, Silver Commanders interpreting the direction and ensuring sufficient solutions are developed and resources made available to deal with the emergency, and Bronze Commanders managing the actual activity at the scene.
- 1.27.** In order to operate their own command and control arrangements the emergency services (and some other partners) have their own control room facilities. However, whereas GMP operates its own Force Control Rooms and NWS operates its own Emergency Operations Centres, GMFRS’s operations are coordinated through North West Fire Control, which is a public sector company that handles 999 calls and mobilises fire and rescue teams and equipment for four North West fire and rescue services<sup>6</sup>.
- 1.28.** In emergencies which require a multi-agency response, the responder organisations should come together to pool their management resources. Operational, Tactical and Strategic are tiers of command adopted by each of the emergency services and are role, not rank, related. These functions are broadly equivalent to those described as Bronze, Silver and Gold in other documents about emergency procedures.
- 1.29.** In Greater Manchester, the convening of Strategic and Tactical Coordinating Groups occurs at the Force Command Module, which is situated in a purpose-built suite at the GMP Headquarters. The Force Command Module is located approximately four miles from the GMP Force Control Room, which is located at Clayton Brook. The Force Duty Officer oversees the function of the Force Control Room and adopts the role of the incident commander in serious incidents.

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<sup>5</sup> Deeming, H. and Otley, C (2018) A Review of recovery processes following Storm Desmond’s impacts on Cumbria (5th/6th Dec 2015). Penrith, UK. A report prepared by HD Research under commission from Cumbria Local Resilience Forum.

<sup>6</sup> Cumbria, Lancashire, Greater Manchester and Cheshire

- 1.30.** During terrorist incidents, the Strategic and Tactical Coordinating Groups are most often chaired or coordinated by a senior police officer. As part of the coordination process, organisations retain ‘command’ of their own resources (e.g. fire officers give orders to firefighters by utilising their rank structure and Gold, Silver and Bronze hierarchy). Therefore, when operating in these coordination groups, the Chair does not command the group but provides a central point of leadership through which to coordinate the multi-agency response. This point is clearly illustrated in Her Majesty’s Government guidance<sup>7</sup>:

*“The police are particularly likely to field a Strategic Coordinating Group chair where there is an immediate threat to human life, a possibility that the emergency was a result of criminal activity, or significant public order implications. Under these circumstances the same person may be the Police Gold Commander and the Strategic Coordinating Group Chair. **These two roles however should be clearly distinguished.**” (p.71: emphasis added.)*

- 1.31.** Emergency response in the UK is also underpinned by the concept of subsidiarity, meaning decisions should be taken locally where possible. However, major and terrorist-related incidents require the coordination of a wider range of resources than are available to any individual local resilience partnership<sup>8</sup>.
- 1.32.** In the context of the Arena attack it is therefore important to note that Figure 1 also illustrates the Strategic Coordinating Group’s relationship with the national strategic level as discussed later in the report. This level came into operation following the attack.

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<sup>7</sup> HM Government (2013) "Emergency Response and Recovery Non-statutory guidance to complement Emergency Preparedness" (online) Accessed 04/05/17, from <https://www.gov.uk/guidance/emergency-response-and-recovery>

<sup>8</sup> Cabinet Office (2013) Central Government Arrangements for Responding to an Emergency: Concept of Operations (CONOPS). London, Cabinet Office.

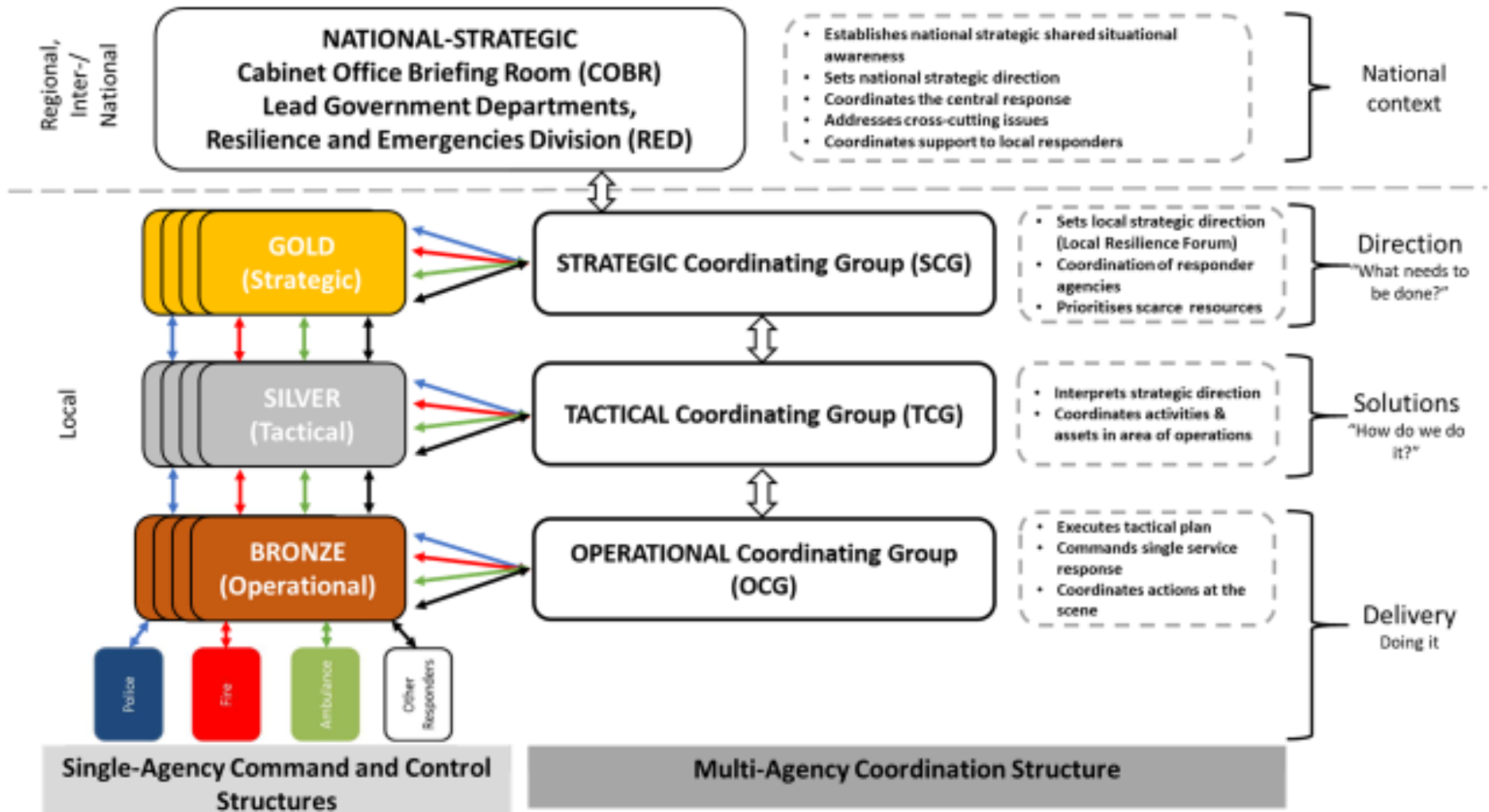


Figure 1



## Joint Emergency Services Interoperability Principles (JESIP)

**1.33.** Since 2013 the emergency services and, increasingly, other responder agencies have been collaborating in order to enhance the multi-agency command, control and coordination of response to major incidents. This activity has led to the development and adoption of the JESIP Interoperability Framework, which is underpinned by five key concepts. Application of these concepts has been shown to enable responders to work together effectively<sup>9</sup>:

- Co-location
- Communication
- Coordination
- Joint Understanding of Risk
- Shared Situational Awareness

**1.34.** During major incidents, Greater Manchester's responder agencies operating at the Strategic and Tactical level should engage these principles by co-locating Strategic and Tactical assets to the GMP Force Command Module. At the operational level, the respective Bronze scene commanders are encouraged to co-locate and hold multi-agency briefings by forming what Review participants referred to as 'scrums'.

**1.35.** At the Force Command Module responders are able to work at designated stations which can link to their own organisations' IT systems and operations rooms, whilst also communicating directly with other responder agencies co-located with them.

**1.36.** Likewise, 'scrums' at the incident scene, which tend to occur at multi-agency Forward Control Points, ensure that participants are able to deliberate and then feed consistent and potentially critical information and requests up and down the command chain.

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<sup>9</sup> JESIP (2016) Joint Doctrine - the Interoperability Framework (Edition 2 - July 2016). London, Joint Emergency Services Interoperability Principles (JESIP).

- 1.37.** The three-tier, three-group structures mentioned in the previous section, together with co-location of emergency services, facilitate the prioritisation of actions and the deployment of assets to be coordinated. All partners are able to deliberate and agree a joint understanding of risk and a shared situational awareness and, from there, to employ their respective capabilities and capacities<sup>10</sup> most effectively.
- 1.38.** Remote from the Force Command Module, responders may also operate their own separate command and control facilities. These work in collaboration with the corresponding control rooms to support decisions made by the Strategic Coordinating Group and Tactical Coordinating Group and to enable effective deployment of the respective single agency's resources to the incident scene. For Greater Manchester partners, these include the NWS Regional Operations Coordination Centre and the GMFRS Command Support Room. Manchester City Council also has an emergency control centre in the Town Hall and Transport for Greater Manchester has its own coordination facility. As with the Force Command Module, however, none of these particular facilities is operational on a 24-hour basis and, therefore, any of them may require setting up in the early stages of a major incident.
- 1.39.** In terms of applying the key principle of achieving a Joint Understanding of Risk, JESIP also introduces a framework through which all responders can carry out a consistent risk assessment procedure. The Joint Decision Model<sup>11</sup> outlines a five-stage risk assessment process through which responders can work. The model is designed as a simple and consistent tool that all responders can use repeatedly to assess risk as the situation develops.

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<sup>10</sup> Capability: the equipment, systems and/or skills, which demonstrate an ability to respond to and recover from a challenge (e.g. an Armed Response Vehicle (ARV) and crew is regarded as a capability). Capacity: the limits of specific capabilities (e.g. three ARVs represent a higher capacity to contain an incident than one)

<sup>11</sup> <http://www.jesip.org.uk/joint-decision-model>

**1.40.** As with the joint understanding of risk, the JESIP principle of Shared Situational Awareness is also founded on the importance of responders using a consistent reporting framework. This framework is defined by the acronym METHANE through which responders are trained to communicate regularly to reconsider the following information:

- M** - Major Incident declared?
- E** - Exact location
- T** - Type of incident
- H** - Hazards present or suspected
- A** - Access - routes that are safe to use
- N** - Number, type, severity of casualties
- E** - Emergency services present and those required

**1.41.** Given the inherent complexity of a multi-agency response, it is clear that multi-agency communication and coordination, both laterally and hierarchically through the system, are critical to the effectiveness of the whole Integrated Emergency Management structure.

### **Joint Operating Principles – Marauding Terrorist Firearms Attack (MTFA)**

**1.42.** Since the coordinated terrorist attack in Mumbai in 2008, which resulted in the death of 164 people, the UK has been developing Joint Operating Principles for responding to a similar attack on these shores. These contingencies are sensitive in nature, but the Panel has been granted full access to review them.

**1.43.** As described by Lord Harris in his review of London's preparedness for a major terrorist incident, one of the key components of Joint Operating Principles is that responders to Marauding Terrorist Firearms Attacks operate in 'hot', 'warm' and 'cold' zones (Figure 2). Current Joint Operating Principles (version 4) are very clear that these zones describe dynamically determined boundaries that refer to 'the firearms threat/threat from live terrorists, rather than solely an Improvised Explosive Device threat'.

**1.44.** In this context, the 'hot zone' refers to an area where active terrorist activity is occurring. Joint Operating Principles stipulate that only suitably trained and

equipped police firearms officers should move forward into this zone to stop terrorist actions. By contrast, a 'warm zone' is regarded as an area where active terrorist activity has stopped, but cannot be guaranteed to be safe, for example the possibility of an Improvised Explosive Device may remain.

- 1.45.** 'Warm zone' categorisation allows non-police responders wearing appropriate personal protective equipment, e.g. ballistic protection, to be deployed to both triage, treat and evacuate casualties to the 'cold zone' and to extinguish any fire. Joint Operating Principles allow for discretion on the 'warm zone' but not the 'hot zone'.
- 1.46.** The 'cold zone' is defined as an area where no terrorist threat remains, so this categorisation allows the deployment of non-specialist responders to continue casualty management and other duties.
- 1.47.** Joint Operating Principles also define Operation PLATO as 'the agreed national identifier for the response to a no-notice Marauding Terrorist Firearms Attack'. In other words, whilst 'Marauding Terrorist Firearms Attack' describes the incident type, Operation PLATO describes the agreed response to that type of incident. In practice, this means that in the event of a Marauding Terrorist Firearms Attack occurring without warning anywhere in the UK, that area's police force would declare Operation PLATO and this should set in train a structured and coordinated multi-agency response. This multi-agency response is founded on the proviso that once a Marauding Terrorist Firearms Attack is suspected by the Police and Operation PLATO is declared, then this information is shared with partner agencies' emergency control rooms immediately.
- 1.48.** Joint Operating Principles also promote the need for responder organisations to understand that a Marauding Terrorist Firearms Attack will constitute 'an extraordinary event with unprecedented demands placed upon all aspects of the [responding] organisation's response'.
- 1.49.** With hindsight, it is clear that the Manchester Arena attack was neither a Marauding Terrorist Firearms Attack nor did it escalate into a Marauding Terrorist Firearms Attack. However, it is the Panel's opinion that what did transpire from the detonation of a single Improvised Explosive Device in the foyer of the Arena did

objectively represent an 'extraordinary event' which undoubtedly placed 'unprecedented demands' upon all organisations involved.

- 1.50.** Instead of a situation in which only firearms officers deployed to the immediate scene, what transpired was much more complex. The explosion immediately drew many unprotected responders, e.g. members of the public, Arena staff, on-and off-duty staff from responder organisations and the family and friends of concert goers, directly into the high-risk, effectively 'hot'<sup>12</sup>, blast zone.
- 1.51.** The Arena attack has also illustrated to the Panel that, contrary to the terrorist-attack response that evolved on the night, what Figure 2 actually represents is a hypothetical situation, rather than the reality that was faced by responders to the Arena<sup>13</sup>.

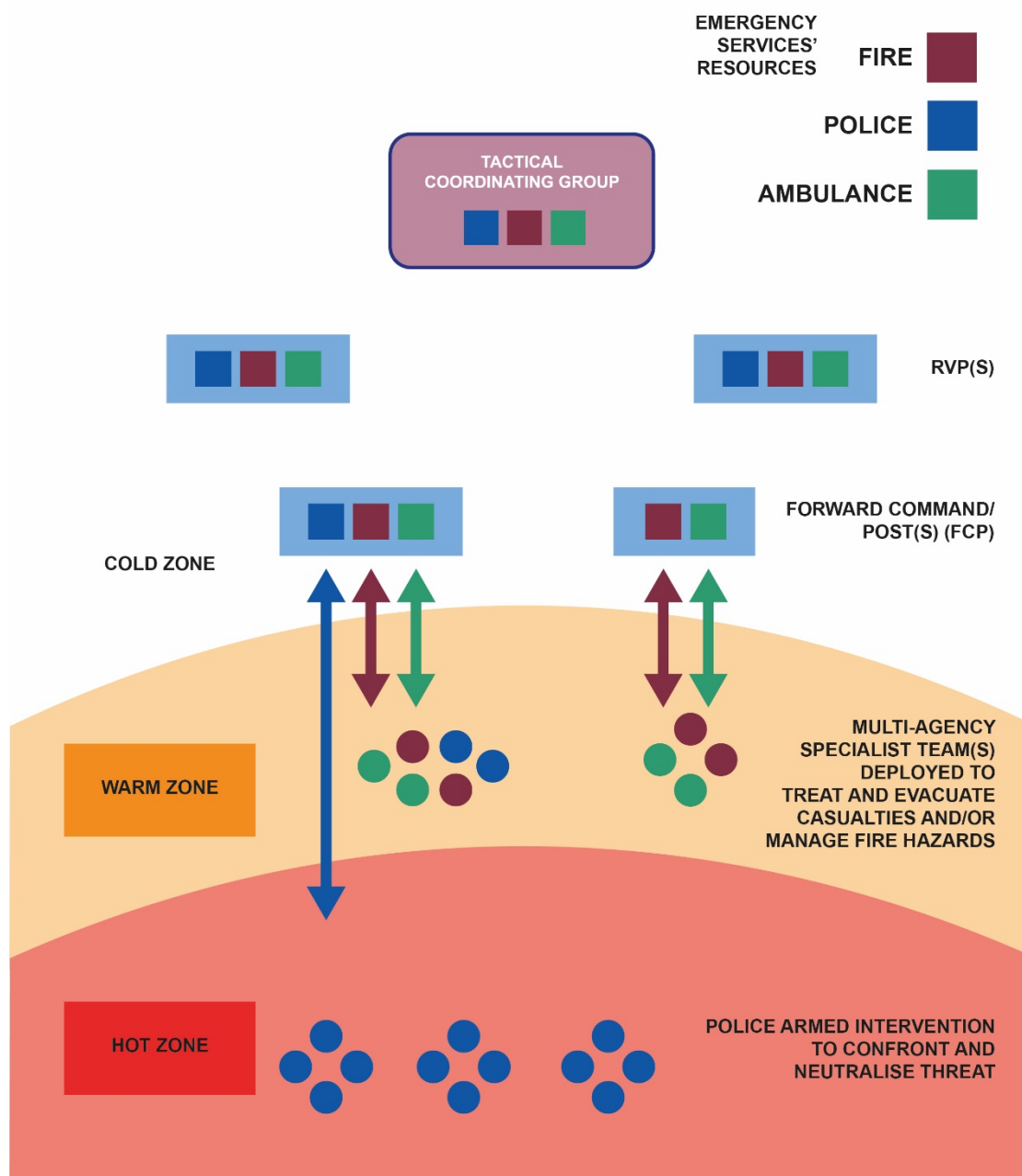
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<sup>12</sup> Until it was proven otherwise.

<sup>13</sup> The Westminster and Borough Market attacks in London illustrated similar disparities between theory and 'real life'.

## EXAMPLE OF AN INITIAL JOINT EMERGENCY SERVICES RESPONSE TO AN MTFA INCIDENT

THE BELOW DIAGRAM IS INDICATIVE OF A STANDARD JOINT OPERATING MODEL FOR RESPONDING TO AN MTFA. IT IS NOT INTENDED TO REPRESENT A PRESCRIBED MODEL OF RESPONSE.



**Figure 2:** Emergency service deployment and response to an MTFA in the various zones of an attack (Joint Operating Principles, Version 4)

## **Greater Manchester Emergency Management Plans**

**1.52.** As part of their statutory duties Greater Manchester Resilience Forum members have developed a set of emergency plans. These locally contextualise their roles and responsibilities, either generally or specifically in relation to particular activities before, during and in recovery from emergencies. The multi-agency response to the Arena attack was directly informed by six of these plans:

- Greater Manchester Resilience Forum Generic Response Plan
- Greater Manchester Resilience Forum Evacuation Guidance
- Greater Manchester Resilience Forum Sheltering Evacuees (Rest Centre) Plan
- Greater Manchester Resilience Forum Mass Casualties Plan
- Greater Manchester Resilience Forum Mass Fatalities Plan
- Greater Manchester Resilience Forum Recovery Guidance

## **Diagrams of the Location of the Attack**

**1.53.** In order to assist the reader in understanding this incident, there are diagrams below showing the layout of the Manchester Arena, of the foyer area where the bomb was detonated and of the immediate locality.

The Manchester Arena

# ARENA MAP

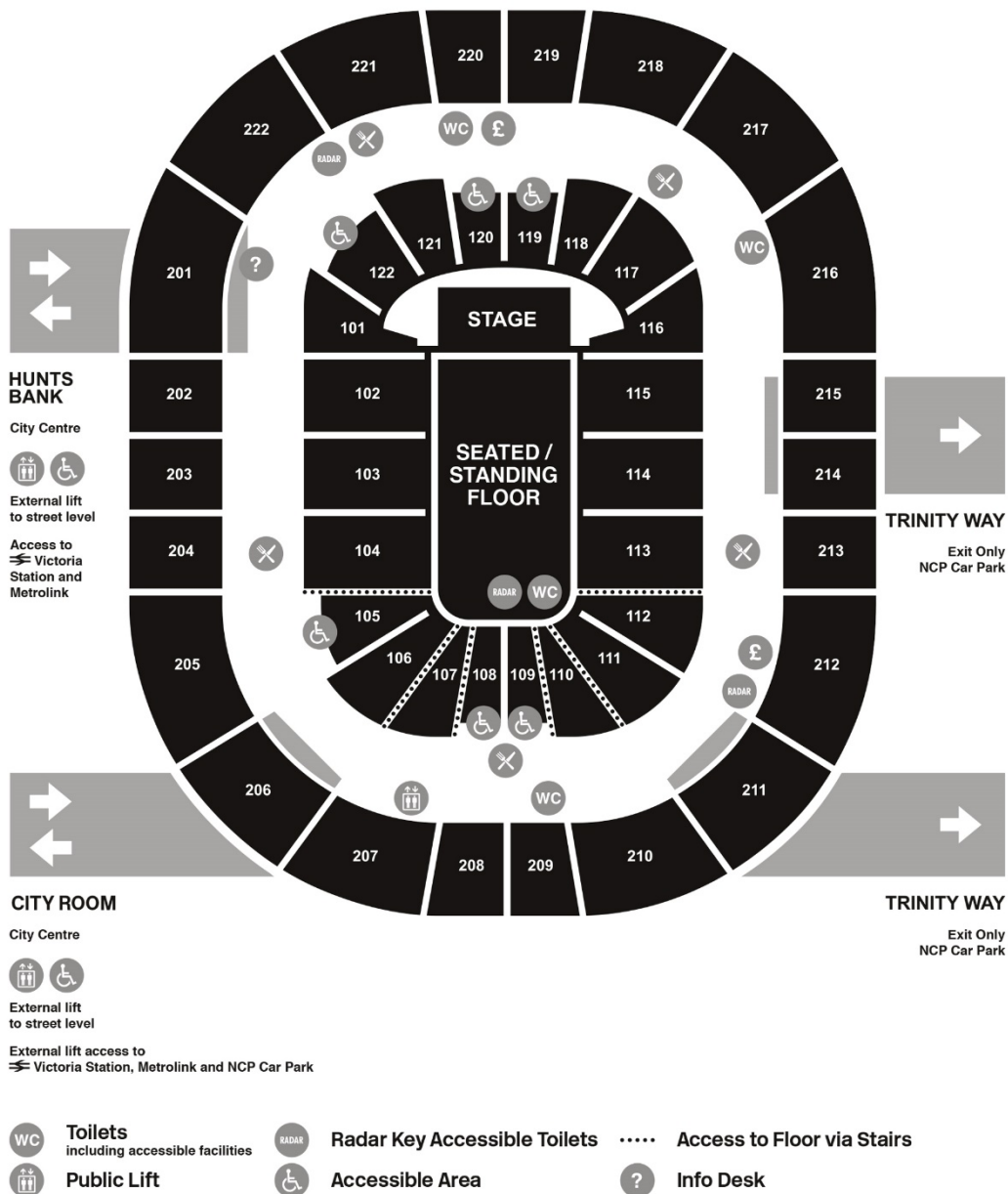
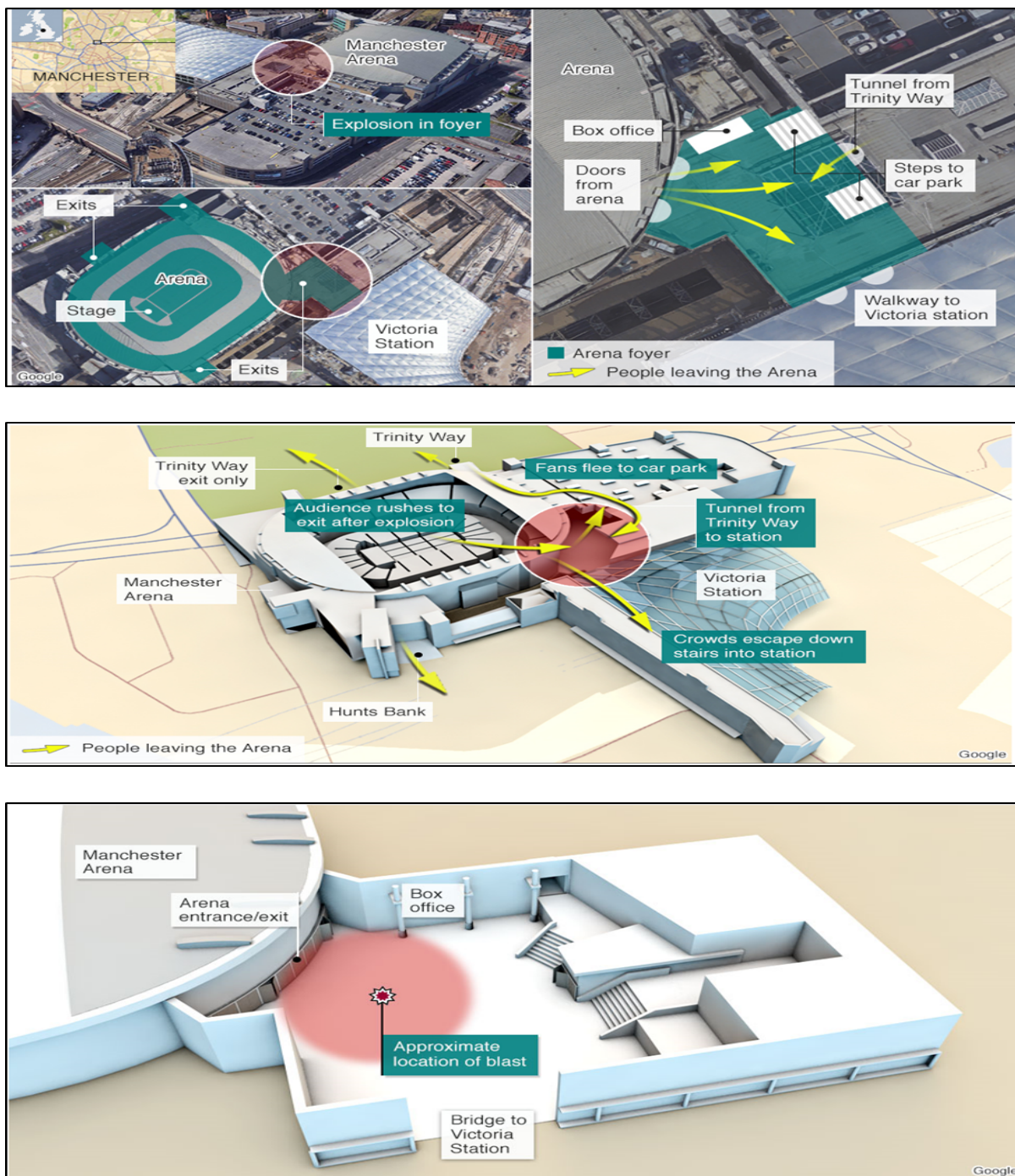


Figure 3: The internal configuration of the Manchester Arena (image courtesy: SMG Ltd.)





**Figure 4: Three media-sourced graphics illustrating different perspectives of the Manchester Arena and initial understandings of the attack (source: BBC)**

## **Chapter 2 – Those Directly Affected: The Experiences of the Bereaved, Injured and Concert Attendees and their Friends and Families**

This chapter describes the experiences of those affected as told to the Panel. It includes quotes from people who participated in the Review whether speaking to the NSPCC or directly to the Panel. Where the Panel has exact words these have been quoted. Where the words are from notes taken from a conversation or a phone call, these reflect the actual words as closely as possible. Signposting to additional support was provided to those requiring it throughout this process.

In this section, there are a number of observations made to the Panel which are shared here without reaching a finding but where it is suggested the relevant organisations take note of the comments. Where it has been possible for the Panel to reach a finding or conclusion, the matter is addressed further in Chapter 5.

- 2.1.** The attack at the Manchester Arena impacted on the lives of thousands of people. Those most severely affected were in the foyer and its immediate vicinity: the twenty-two people who lost their lives and their family and friends; the gravely injured; those who witnessed the immediate aftermath of the explosion whether as concert goers or waiting relatives and friends, and those who gave assistance, putting their own safety aside. Communities spread throughout the north of England and beyond mourned the loss of their friends, colleagues and neighbours.
- 2.2.** Some 14,000 people were at the concert along with Arena personnel, stewards from Showsec and staff providing first aid and emergency medical cover from EMT-UK. Whilst most of the audience was able to get home safely, with some unaware of what had happened, for many the experience of evacuating from the venue and being so close to the attack has had a lasting impact.
- 2.3.** The concert at the Manchester Arena on Monday 22<sup>nd</sup> May 2017 was the only performance in the north of the United Kingdom during the American artist Ariana

Grande's tour. Those attending had travelled from far and wide to be there. The singer's fan base is composed primarily of young girls and the audience of 14,000 that night included many excited groups of teenagers and children accompanied by family members. Ten of the twenty-two people who lost their lives were aged between eight and nineteen years old, and seventeen were female.

- 2.4.** Also impacted were the large numbers of people whose lives were touched by the attack albeit from a distance. These include members of the general public who were affected by the disruption to the transport network, business owners and staff who were unable to access their workspace, and residents in communities where police raids and arrests occurred.
- 2.5.** The Review received over 200 contributions from bereaved families and friends, those physically and psychologically injured, their relatives and friends, and from people who were at the Arena on the night of the attack as concert goers. Many of the responses received shared the experience of more than one person, such as a couple, parent and child or larger family group. This chapter tells the story of the attack from the perspective of those who were directly affected.
- 2.6.** Most contributed to the Review by contacting the NSPCC by email or on a dedicated telephone line. Responses varied in the issues covered, the amount of detail and the feelings expressed. Many responses contained raw emotion sharing pain, anger and distress, and many were full of appreciation, gratitude and relief. The Panel also met with some contributors to hear their experiences in person. The Panel heard from family and friends of eleven of the twenty-two people who died.
- 2.7.** Each response has made a valuable contribution to the work of the Review and enabled the Panel to gain an understanding of the events on the night and the response. Whilst many of the contributions talked about similar issues, the experiences and stories shared with the Review were diverse, including sometimes conflicting versions, which demonstrated further to Panel members the importance of seeing each contribution as individual and personal to that participant. The Panel wishes to thank every participant who made a contribution and recognises that for many this was emotionally demanding.

## Security at the Venue

- 2.8.** Many of the respondents who attended the concert observed that they felt there was insufficient security at the venue. Bag searches were commented upon as being inconsistent, with some saying their bags were not checked at all. Some raised questions about what they considered to be limited security on exit and some commented that they thought there should have been a larger police presence at the venue. Many respondents stated they believe there should be much tighter security at concert venues. The Panel does however feel it important to point out that the bomber had not attempted to gain entry to the actual venue, but had remained in the foyer, which was outside of the security zone.

*“The security could have been better and there should have been more searches.”*

*“No one was searching handbags on the way into the Arena.”*

*“Many staff didn’t do bag checks or any other security checks ... some people did get checked and others didn’t.”*

*“The problem was on the way out where barely any security was present.”*

## Leaving the Arena

- 2.9.** People who participated in the Review and who were at the Arena as concert goers described their experiences trying to leave the venue. Most were frightened, often trying to keep children with them safe. Many respondents did not know at the time what had happened. Some thought staff at the Arena should have been able to assist more whilst there were also positive comments about the bravery of stewards.

*“We were on our way out of the Arena when the explosion went off, leaving through the exit with all the steps, everyone rushed to leave and there was a lot of panic around. Me and my friends were scared running down the stairs as there were so many people. This was understandable and so was the pushing and shoving to leave the Arena as quickly as possible. When we got to the bottom of*

*the steps, there were hundreds of people in the road and on the pavement who were all very scared and distressed. The police were already there.”*

*“The staff in the Arena were trying to contain the crowds and calm them down. I believe the tour manager came onto the stage in a bid to calm people down.”*

*“It was only when I got home, I realised the seriousness of the event I had been caught up in.”*

*“... I thought it was just a balloon. The exit led us outside in the opposite direction of the foyer. It was a two-hour drive home so I didn't find out what had happened until gone midnight.”*

*“As we passed we were greeted by a member of Arena staff who told us to get home safely and get away from the Arena as quickly as possible. We managed to get to our car and drive away still not understanding what had happened other than hearing the loud explosion and seeing a lot of distressed and upset people, mainly young children. As we drove down the M62, we saw what seemed like hundreds of emergency services vehicles heading for Manchester.”*

*“Me and my friend were some of the first people to exit onto the concourse which is when we heard the explosion. We ‘froze’ for what felt like ages but was probably only seconds and luckily there was an exit straight in front of us which we were able to run out of. As we opened the doors we were able to hear sirens which was amazing as the emergency services were there in seconds. We were able to get to my car and drive out of the car park before the police cordoned off the roads.”*

*“The evacuation procedures could have been better, people were led down narrow corridors which led to increased panic.”*

*“The sheer stampede after the explosion was scary because everyone was just running to the exit and no one really knew what had actually happened.”*

*“When the bomb went off, me and my daughter had to scramble over the seats as the stairs were blocked and we didn't know where the other exits were. There was*

*no clear direction as to where to go and concern that there may be another device or shooter.”*

*“When I was in the main Arena, the stewards had formed a human wall to stop people going towards the smoke, which I believe was extremely brave.”*

*“The problem was on the way out there was hardly any security present.”*

*“I was with my friends in block 215 when the bomb went off. I want to point out that the people in our block were very calm and orderly at exiting the Arena considering a bomb had just gone off although no one knew exactly what it was, it was most certainly a frightening unknown sound, one which caused me and my friends and everyone in the Arena considerable cause for concern. Upon going down the stairs from our block we were surrounded by the most caring members of the public, all of whom just wanted to leave in the best manner possible. I saw people understandably scrambling from the building on news reports but in block 215 this was not the case and I wish to point that out and how proud I was of everyone for leaving as safely and quickly as they could.”*

*“I would like to praise a security staff member who escorted the girls from the Arena and used their phone to call me.”*

*“I ended up at the Trinity Way exit ... as soon as the member of staff had evacuated people, he took me for first aid.”*

*“The stewards from the Arena were fantastic and were trying to calm everyone down.”*

*“I felt the evacuation was done as calmly as possible considering.”*

*“I had no idea where to go or who to ask for help and nobody seemed to actually know what had happened. People were saying a balloon had burst, others saying it was a bomb. At this time, I was still panicking not knowing how to get to safety. I just followed the crowd to the nearest exit. On running to the car, I noticed some people were injured. I had to drive past the Arena. I could see everything was cordoned off and police and ambulances everywhere.”*

*“I didn’t know how I would get home as I had arrived by train. Later in the early hours I decided to walk towards Manchester city centre. I managed to locate a black cab who charged me £75. I did not experience the free taxi service I read so much about.”*

*“Having walked for some time, I came across a Travelodge that was taking people in that had been at the Arena. People who were not customers that were staying overnight were provided with somewhere warm to sit and wait and contact loved ones.”*

## **Immediate Response of Emergency Services**

- 2.10.** The immediate response of the emergency services was the main area of focus for many participants and was commented on by nearly three-quarters of respondents. A common perspective was that there were too few paramedics in the foyer assisting the injured. Some felt there was a delay in treatment and transfer to hospital. Many were concerned at the need to use makeshift stretchers, insufficient first aid equipment and the lack of blankets. In general, there was praise for the prompt arrival and professional approach of emergency services from participants who were not injured.

*“The emergency services were brilliant, I was genuinely shocked by how fast they got to the Arena, and they could not have done a better job.”*

*“The Arena staff who looked after me were wonderful and a major factor in saving my life especially a young lady in the first aid room.”*

*“The respondent praised the police who gave assistance ... these were ‘normal’ police officers who came off the street to help. They had no special protective gear, however, they remained as long as possible and tried to assist the injured.”*

*“An off duty nurse and doctor were doing what they could to assist the injured outside the Arena. I can’t praise the first aiders enough who were dealing with those casualties who managed to walk out of the foyer. They had so many to deal with and were relying on members of the public with little or no experience.”*

*“The police were at the venue within minutes with the respondent stating that she had ‘complete faith’ in them and the fact they appeared to have a clear strategy.”*

*“It took around five minutes to escape the Arena and within that time at least ten ambulances were already on scene.”*

*“I did approach an officer and asked him where to go, and he was very calm and extremely helpful.”*

*“I had no clothes on my upper body and I was shaking with cold.”*

*“First responders left first aid kits for us but the dressings were inadequate for the size, depth and number of wounds.”*

*“Metal railings were used to carry out all the injured people from the Arena. Me and six police officers carried X to the station. I assisted with five or six people being carried out.”*

*“I was carried out of the Arena on an advertising board. There was a lack of first aid equipment for people to access. They had small first aid boxes on their belts and were not allowed to collect more from stores as the zones were closed off.”*

*“Without a shadow of a doubt, we need trauma kits and stretchers in all arenas and public places. This should be done as soon as possible.”*

## **Healthcare**

- 2.11.** In general, respondents felt that healthcare at the venue for those severely injured was too slow. Many say they waited a long time on the floor for attention and treatment. Many also expressed gratitude to those who supported them and provided comfort.

*“The time it took for me to receive medical treatment in the Arena is a mystery, why did it take nearly two hours to be moved?”*



*“The time it took to get my friend to hospital was far too long.”*

*“I feel I waited for a long time for any emergency assistance after the explosion.”*

*“The police woman helped me and I knew she was aware of me, this made a massive difference to me.”*

- 2.12.** Once at hospital, most respondents were positive about the treatment and care they received. Some told the Panel that they were still receiving treatment for physical injuries several months later.

*“The NHS staff were amazing ... genuinely cared for and supported ... nurses held my hand during flashbacks.”*

*“The hospital seemed well prepared for such an incident and kept families honestly updated.”*

*“Medical teams were waiting to assess and treat people as they arrived ... medical staff updated us every fifteen minutes on his progress.”*

*“I was taken by ambulance around 1am to Manchester Royal Infirmary ... I was comforted by a policeman while the medical staff worked ... I was very aware of his presence and how reassuring it was.”*

*“The surgeon who treated me on the night visited every day I was in High Dependency and this care extended throughout my time at the hospital.”*

*“Once I started receiving medical attention, this was fantastic. The staff at the hospital worked extremely hard and were incredible.”*

*“The hospital response was brilliant. All was set up to respond to the needs of the injured and their families. The use of passwords to ensure the families were not subject to unwarranted intrusions was really helpful.”*

## Finding Family and Friends

- 2.13.** The Review heard that many people experienced confusion in trying to find their missing relative or friend. Not knowing what to do, where to go or whom to contact added to the trauma experienced. Some respondents described the help they received from hotels, restaurants and bars in the city centre. A significant number went on a frantic search of the hospitals across Greater Manchester. Comments about the police 'helpline' (the GMP Casualty Bureau) were universally negative with many respondents telling of their frustration at repeatedly ringing the line and being asked for the same information every time.

*"I went to the Manchester Royal Infirmary and was told by police to 'just wait' ... after two hours I decided to go to Salford Royal ... no news ... I decided to continue driving round Manchester until I heard news about where to go next."*

*"My daughter was offered support from a kind lady at Premier Inn."*

*"I thought the manager at Park Inn was superb and his organisational skills were unbelievable."*

*"I felt that the police officers at the hotel could have been better informed as they were not aware that the family should have been at the stadium."*

*"The family began calling round hospitals and the police trying to see whether anyone knew where she was. The family called the helpline seven times and were given seven different reference numbers."*

*"I remained in Manchester whilst relatives and friends followed ambulances to various hospitals across the region in the hope of finding X. This continued throughout the night."*

*"The helpline contacted me the following afternoon to ask if X had been found but offered no other help."*

## Experiences of the Bereaved

- 2.14.** For those who were bereaved, many found the time it took to receive the news too long and question why they could not have been advised much sooner. Those respondents who were already sure in their own minds and had given identifying information to the helpline (the GMP Casualty Bureau) found this particularly difficult. Many were waiting at the Etihad Stadium Friends and Family Reception Centre, set up by Manchester City Council, for many hours on the 23<sup>rd</sup> with other families in the same situation. Appreciation was expressed by many for the care, sensitivity and consideration shown to them at the Etihad. The Family Liaison Officers and Bereavement Nurses were found by many to be invaluable.

*“We were completely overwhelmed and quite moved by the help and support that was there for us ... the facilities were there, the food, the drink – we didn’t have to think about anything because we couldn’t.”*

*“Although some people complained about the lack of information, everyone did their best ... as a family we felt we were informed as far as was humanly possible.”*

*“I think the Etihad was really good ... a good base for families.”*

*“The arrangements at the Etihad were excellent ... it couldn’t have been handled better.”*

*“It all clicked together ... blankets, chargers, paracetamol ... everything you could need.”*

*“I went to the Etihad Stadium at around 5am ... I only found out she had died at 8pm.”*

*“I just wanted to know if X was dead. We all just needed to know.”*

- 2.15.** Many of those who were bereaved told the Panel of the visit organised to pay their respects at the site before the station re-opened. Most found this something they were glad to have done and felt it was done thoughtfully. Others told the Review

that they wanted an individual private visit rather than attending with other bereaved families, but this did not prove possible.

*“We went to the vigil that was in the train station ... and they made it so beautiful ... there was a stand with their names on, everybody was there for that reason.”*

*“My family found the vigil at the train station for the families of the twenty two people who lost their lives comforting.”*

*“I did attend the vigil for the twenty two families at the station and this felt helpful as we were all in the same boat.”*

- 2.16.** Family Liaison Officers from GMP and other forces were mentioned by many respondents. Most found them to be a great support in the first week. They were described as ‘angels’, ‘heroes’, ‘so supportive’ and ‘deserving of medals’. One family told the Review that having different Family Liaison Officers for different family members and seeing them as individuals with varying needs was very important for them. Some respondents told the Review that they found their Family Liaison Officer to be insensitive and overfamiliar.

*“They’ve been there through everything, if there is anything we need answers to we know we can ring them.”*

*“She was acting like she was the family’s best friend, but she was not.”*

*“Her compassion and professionalism went far beyond anything we had expected.”*

*“She was absolutely gorgeous: she gave me the worst news ever of my life. She cried with me from the beginning. The next day she was taken away: she was taken off the job. I don’t know what the reasons were, I wasn’t given a reason.”*

*“Without their support, this would have been much harder to bear and we’ll always be eternally grateful to them both.”*

*“We trust them, which is great for us.”*

*“My family have not received a Family Liaison Officer from the police. The police have been good telling X what is happening, they have been transparent and it makes my family feel secure. They inform me of things like ‘it will be in the papers tomorrow’. It helps the family be prepared.”*

- 2.17.** Some of those bereaved talked about the arrangements made for them to see their deceased loved one.

*“Our expectations were that he’d be pulled out of a freezer ... the reality was that he was actually lying in a room set up like a hospital room, he was in a bed, his head was on a pillow and he was covered up with a duvet. The room had a pleasant temperature and he looked as if he was in a deep coma rather than dead. The nurse gave me a little cuddly toy telling me it was with him throughout the whole time he entered the building. We were given time alone with him and were allowed to hug and kiss him. The nurses were available to comfort us before and after.”*

*“We were only given an hour ... it felt impersonal.”*

*“All the little bits and pieces, his wallet came back, the respect that’s been shown, because not only were his cards there but there’s a little bag in the wallet that contained every fragment of every card that was chipped and broken. They sent it all back, they haven’t just binned it. They sent every little particle back.”*

*“All the jewellery was in individual boxes, all cleaned up.”*

*“The clothing they had worn that night was sent away to be professionally cleaned by the police. The police then made an appointment to visit and presented them with a separate box each. The items inside were unbelievably clean, neatly stacked, tissue in between and lots of care.”*

- 2.18.** Some of the bereaved respondents and those who had injured relatives from outside Manchester described how they were given accommodation and support in Manchester.

*“We stayed for three weeks in a Manchester hotel which was paid for ... we didn’t want to leave without her.”*

*“The hospital offered a bungalow in the grounds ... they couldn’t do enough.”*

*“The family was moved to a hotel ... was worried that she did not have enough money but was told not to worry, that all expenses were covered.”*

*“For that two-week period we didn’t have to think about anything ... everything ran smoothly and that for us was massive, huge ... we had family rooms so other family members could stay ... we really appreciated the ‘little brownie packs’ with emergency toiletries.”*

*“The community response was really helpful. I was told not to worry about anything. Food, toiletries and accommodation were provided during her time in Manchester.”*

## **The ‘We Love Manchester’ Fund**

- 2.19.** Participants in the Review made a number of comments about the Fund. Those who received a payment often expressed gratitude to the public who made donations. The level of generosity shown for this terrorist attack was beyond that of any other UK terrorist attack. The Panel also heard from respondents who were unhappy with finding that they were not, at least initially, included amongst those eligible for the Fund. The distinction between ‘physical’ and ‘psychological’ injury attracted particular negative comment from those with psychological injury. Comments were also made about the bad feelings caused by the distinction made between the bereaved and the severely injured.

*“I have found the whole experience with the Fund extremely stressful and upsetting.”*

*“We were really, really grateful for the Fund being set up, to the people behind setting it up and the way the country has supported us.”*

*"I have had no money from the Fund despite being directly impacted and unable to work due to my trauma and mental health since the incident."*

*"We are grateful to the general public who did the Fund."*

*"We weren't happy it was put in the public domain ... the fact that every member of the country now knows what's in our bank account."*

*"If you ask me about the money, or the way it's been publicised, it makes me feel ill, but I do have to live, and we do have to pay bills, so we are grateful."*

*"The Fund has helped some people but not others ... lessons should be learned and the government should set up their own emergency fund for future attacks ... Victims need time off work, need to concentrate on their families, hospital visits. They don't need to worry about where the money is coming from in the first few months after an attack."*

*"My family feel very angry and let down by the government as there has been no help, support or funding in any way ... if it wasn't for the generosity of the public ... we would probably be homeless."*

*"The emotional and financial pressure, on top of the physical injuries, makes things very hard. I feel that the government need to start supporting people who were seriously injured now, not in a year's time."*

*"I am self-employed but unable to work due to my injuries. The Fund has provided money for rent and to live off but I feel that I am banging my head against a brick wall for support. The Fund has offered two lump sums but we were not told when they will arrive or how much we will receive. We do not understand why the Fund are so secretive about where the money is going and why the bereaved families were given more money than those living with injuries."*

*"It took me over four months to be recognised as a seriously injured party and for any funds to be allocated."*

*“One asks what would have happened to us all if people’s generosity and unity hadn’t pulled together and donated?”*

## **Guidance and Support for those Affected**

- 2.20.** Many respondents told the Review that following the attack, they did not know who they could turn to for support. For the bereaved, this included wanting impartial advice on practical and financial matters. The Panel heard that many people had been in touch with a wide range of charities, both local and national. Some respondents reported receiving an excellent service but others had a much more mixed experience.

*“After the Manchester attack, my family did not know who to turn to for counselling ... can a trauma booklet be produced and given to future victims telling them the exact thing to do after an attack?”*

*“It is difficult to know who to trust.”*

*“We do not know what we are entitled to or how to get help. The worry and stress are impacting daily life and recovery. Help to navigate daily life would be a great benefit as life seems to be about forms.”*

*“I began contact with Victim Support on 26<sup>th</sup> May, they have been my rock ever since.”*

*“Victim Support have been helpful with home visits, information, phone calls and emails.”*

*“In the early days, I spoke to Victim Support but did not believe they had the correct training ... the manager continued to contact me.”*

*“British Red Cross contact has been positive.”*

*“I felt very supported by the Red Cross and Swan Bereavement Nurses.”*



*“There were people in uniform tee shirts providing pop-up counselling in St. Ann’s Square ... a woman tried to pull X aside asking ‘were you in the Arena? Do you want to talk?’ and this was insensitive.”*

*“The Foundation for Peace and local Victim Support have been amazing.”*

*“Survivors’ Assistance Network has been really good.”*

*“Can all GPs in the UK use the same guidelines? It’s like no one knows what to do or which way to turn.”*

*“It was the little things that made it feel like someone was actually there for me as a family and was looking out for me.”*

## **The Response from Manchester**

- 2.21.** Many respondents commented on the response from the people of Manchester, local businesses and civic leaders. Appreciation was expressed by most.

*“The response from the city of Manchester and its people was incredible.”*

*“Manchester was fantastic in how they responded.”*

*“I feel that the vigil, poem and benefit concert showed a lot of support and community spirit, made it seem like people did care about what happened.”*

*“Helpful things were the outpouring of love and support from the city.”*

*“I thought that Manchester came together really well and the tributes were fabulous, the flowers were dismantled with respect and care, which was lovely to see.”*

*“I loved the community spirit of Manchester, how they all came together in defiance and raised money all from good will.”*

*“I did go to the memorial in Manchester as my son wanted to go to St. Ann’s Square. I felt this was really poignant, felt right. The children were able to pay their respects and this was really important.”*

*“Me and my daughter attended St. Ann’s Square to put flowers down. We both thought this was helpful to have somewhere to go and gave us a reason to go back into Manchester.”*

*“I found visiting St. Ann’s Square and laying flowers was helpful for me and made me feel included.”*

*“The Mayor led by example, he was brilliant throughout, he and the rest of the council gave us time and responded with feeling. The personal touch meant a lot to us.”*

*“The people of Manchester did a fantastic job of boosting the morale of those affected, making us feel as though we were not alone.”*

*“In a nutshell, what services have done for us, after that horrific time was fantastic and we couldn’t have asked for more.”*

*“Whoever we spoke to, we felt as though we were being listened to, that they made sure they had time for us. You could tell that they cared.”*

- 2.22.** Some respondents made specific mention of the personal visits made by the Chief Constable and Mayor of Greater Manchester.

*“The Chief of Police, Ian Hopkins, stayed for one and a half hours and Andy Burnham also stayed over an hour. These visits felt significant, practical and helpful.”*

*“A personal visit from Andy Burnham was a very nice gesture and we felt that he genuinely cares.”*

*“The first time I met Ian Hopkins was at the hospital. He showed such true emotion. I was humbled and touched.”*

*“Andy Burnham and the Chief of Police both visited the family home separately. They were both helpful. The Chief of Police answered some difficult questions.”*

## **Outside Manchester**

- 2.23.** Many respondents commented that they believed that Manchester residents received more help and support. People from other parts of the United Kingdom told the Panel that they felt that they were overlooked, ignored or forgotten.

*“From first-hand experience, mainly in the time following the attack, I felt isolated being from outside Manchester, and that I didn’t know what to do in terms of my mental health.”*

*“The only criticism is of how Manchester responded with the publicity campaign. The media storm around this became wholly focused on Manchester as a city as if only people from Manchester had been affected.”*

*“Something that has annoyed me, is that the media has depicted everyone who attended the concert as coming from Manchester. I am from ... and felt that the services which have been publicised have been targeted at those living in Manchester. I feel there has been very little support for other people living in other areas and that people who are struggling really won’t know where to turn.”*

*“I feel other families and individuals who attended the concert may have had access to additional sources of funding or support, but feel like mine may be left out. I feel this may be because of my family being outside of the vicinity of Greater Manchester.”*

*“I feel like I’ve been let down, left, there is no help for me but there is help for people in Manchester.”*

## **Access to and Provision of Mental Health Support**

- 2.24.** Taking an overview of the many comments received on the topic of the impact on the mental health of those directly affected by the attack, it is clear that the

experiences on the night have left many people, adults and children, with ongoing problems. Respondents described a wide variety of issues which have had an impact on their ability to live their lives, for example being unable to return to university or loss of employment, ongoing fear of crowded places and a range of anxieties and diagnoses such as post-traumatic stress disorder. Many were angry or disappointed that they had not been contacted after the attack to see how they were.

- 2.25.** Many respondents described how they did not know what support was available or how to access relevant provision or whether how they were feeling was a normal response. Some people told the Panel about the specific therapeutic or counselling intervention which they had been able to access. Others have been supported through more informal services. It was apparent that some of the support provided did not meet respondents' needs. Some participants paid privately to get the support they needed and some had employers who paid.
- 2.26.** Respondents identified services for children and young people as being particularly hard to access, with waiting lists of several months. The response from schools varied, with some respondents stating that their children had been supported well at school with specialist psychological provision, whilst others described how the school had failed to recognise the child's trauma.
- 2.27.** Feedback about the NHS Manchester Resilience Hub (established after the attack to coordinate the care and support for children, young people and adults whose mental health has been affected by the attack wherever they may live) was largely positive, although many commented they would have liked something sooner. Participants appreciated the three-monthly contacts from the Hub and felt reassured that someone was there for them.

*"I think the services set up to help those struggling with their mental health following this event are great too and I feel happy knowing there is always someone I can talk to if I need to."*

*"I do however feel that there is a lack of counselling for young people."*

*“The counselling support provided in the hospital did not appear to have the skill level or approach for this type of situation. The counsellor was super-intrusive coming into the room at 7am.”*

*“I contacted the Resilience Hub and both me and my daughter filled out the questionnaire. Someone contacted us straight away and felt that my daughter needed further support, which was arranged quickly. I felt there was lots of support available. I also felt it helpful that the Hub were going to keep sending questionnaires every three months to check how people are doing.”*

*“My son was referred for counselling through the Manchester Resilience Hub and is on a waiting list for CBT as they feel he may have Post-Traumatic Stress Disorder. The counsellors from Reflections in Oldham are brilliant.”*

*“My GP was extremely helpful and made a referral to CAMHS, however, there is a seven-month waiting list.”*

*“My daughter has been referred to CAMHS for PTSD and low mood, however, there is an eight month wait for this.”*

*“The counsellor at my daughter’s school is very good and offered to do some sessions for me too. I went back multiple times and found it helpful.”*

*“The caller said she was told how she was feeling was normal and that they would call her in three weeks. This wasn’t helpful as at the time she needed to speak to somebody.”*

*“I feel as though the email received in October could have been sent earlier to those who had been affected by the attack. I feel as though I have come a long way since May. I’m less jumpy, having less nightmares and emailing my story was nice to get it off my chest.”*

*“The attack has affected my mental health to the extent that I have been unable to start my university course as planned. My mental health deteriorated, I had to seek private psychotherapy after being diagnosed with PTSD and anxiety.”*

*"I have been in touch with the Survivors' Network as well as the Manchester Resilience Hub and they all provided great support. The Foundation for Peace have written to the children's school with tips on how to support them."*

*"My place of work paid for private counselling sessions; I was a mess and did not stop crying for the first three sessions. I have not been in work since the attack. I spend most of my time talking to a war veteran who gives me support."*

## Communications

- 2.28.** There was a range of opinions expressed by those who had been at the Arena on the night of the 22<sup>nd</sup> but were not amongst the bereaved or most gravely injured. Of those who mentioned communication, the majority said they felt forgotten and as if they did not matter. It was clear to the Panel that many respondents believed their identity and contact details were immediately available to agencies who might have wanted to contact them. Some noted that participating in the Review was their first chance to 'get it off my chest'. Facebook groups, Twitter and especially GMP tweets were identified as helpful. Some wanted to put the experience behind them and found ongoing media coverage unhelpful.

*"I feel that there should be a system or register where information from the booking is used to contact everyone who was in attendance at events in the event something like this has happened, in order to tell them who to speak to and what support is available."*

*"I found it unhelpful that I was not contacted by anybody in the first few weeks and began to think there was no support for me."*

*"I feel that what was missing was that the survivors were not contacted within days of the incident to see if they needed anything and to acknowledge they were being thought about. I think that the ticket website would have had the opportunity to do this along with the authorities."*

## The One Love Manchester Tribute Concert

- 2.29.** Held on 4<sup>th</sup> June, over 50,000 people attended the One Love concert. Free tickets were offered to those who had been at the Ariana Grande concert on 22<sup>nd</sup> May. Respondents to the Review who had been given tickets generally felt it had been a positive experience but some who had not received free tickets despite being at the original concert were angry and disappointed to have missed out.

*“Me and my daughter attended the benefit concert – it was one of the most overwhelming and uplifting experiences of my life. It had such a positive impact on my daughter’s adjustment to what had happened and helped us work through some minor PTSD-like symptoms. My daughter now considers Manchester her spiritual home, her favourite place.”*

*“The One Love concert was a lovely touch especially for my sister as she has suffered with hearing loud noises and being in busy crowds from the bombing and so to be surrounded by people who were at the attack and could also share their experiences made her less anxious.”*

*“Me and my daughter didn’t get tickets, which was a complete and utter farce.”*

*“I attended the One Love concert with my partner after the attack and found the support from everyone very heart warming. The police presence made me feel more at ease and the ambulance service helped calm my nerves as I was about to leave the concert. I can’t thank them enough for this.”*

## The Experience of Families with the Media

- 2.30.** Following the attack a large number of media, both broadcast, print and online, came to Manchester. In the course of its interviews with families of the bereaved and with those who were injured, the Panel received some strong feedback on the how some of the media had played their role.

- 2.31.** Most participants who commented on their experience of the media in the attack aftermath were negative. People talked about feeling ‘hounded’ and ‘bombarded’. Some described being put under pressure to participate in TV programmes.
- 2.32.** At the hospitals, families attending to look for missing loved ones and visiting the injured described having to force their way through scrums of reporters who ‘wouldn’t take no for an answer’. One mother, who was herself seriously injured as was her daughter, spoke of the press ringing her on her mobile whilst she was recovering in hospital. A member of staff on her ward spoke of a note offering £2,000 for information being included in a tin of biscuits given to the staff.
- 2.33.** At the Etihad there were concerns with people feeling accosted by media crews. Specific mention was made of photos being taken through the glass windows of family being given news of bereavement. There were descriptions of people having to run to cars with coats over their heads to escape. Similarly, someone described having to be taken into hospital to see their injured child via a staff entrance because of the behaviour of some media representatives at the main entrance.
- 2.34.** Several people told of the physical presence of crews outside their homes. One mentioned the forceful attempt by a reporter to gain access through their front door by ramming a foot in the doorway. The child of one family was given condolences on the doorstep before official notification of the death of her mother. Another family told how their child was stopped by journalists whilst making their way to school.
- 2.35.** In the case of one family, which has subsequently been reported, the daughter was visited by a reporter at their home and given condolences on the death of her brother whilst her parents were at the Etihad Stadium. This took place on the morning following the attack. The family were not told that their son was likely to be among the fatalities until later that day.
- 2.36.** There were at least two examples of impersonation. One respondent talked on the phone to someone saying they were a Bereavement Nurse; whilst another described talking to someone who they felt sounded to be more like a journalist but who purported to be from the police.



- 2.37.** Some families mentioned the repeated use of their loved one's photo causing renewed upset each time. International media used an image taken inside the foyer in which the deceased could be identified. Families were angered by personal Facebook and other social media accounts being accessed and information and photos used without permission. Inaccurate details about their loved ones, such as a wrongly spelled name, caused considerable upset.
- 2.38.** More positively, a number of families spoke in praise of sympathetic reporting by the Manchester Evening News and other papers local to the bereaved.
- 2.39.** Those involved in the Disaster Victim Identification process told the review that the media had respected the dignity of the deceased and the privacy of the families when making visits to see their loved ones.
- 2.40.** A selection of the quotes from families interviewed are set out below:

*"The whole family felt 'hounded' by the press."*

*"They sneakily took a photo of my sister when we were getting the news."*

*"The family felt that the media were mostly respectful. There were a lot of reporters at the house but only one was difficult."*

*"The information in the Manchester Evening News was correct but when national press picked it up it would change."*

*"Press and TV journalists went to her school and phoned the hospital pretending to be from the police."*

*"By far the worst thing was the press."*

*"They ... are a disgrace, they don't take no for an answer, they have a lack of standards and ethics."*

*"The press were not respectful of grief."*

*"I spoke to someone on the phone posing as a bereavement nurse."*

*"The most distressing part was the press making statements up."*

*"They ... lifted photos and stories from his Facebook page."*

*"One tried to push his way into the house, put his foot inside the house to try to get in."*

*"Our local paper ... they've been amazing."*

*"The press and media have been horrible in response to this. The press got hold of family members' mobile numbers and 'bombed' them."*

## Chapter 3 – What Happened 22<sup>nd</sup> – 31<sup>st</sup> May: The Emergency Services

This chapter lays out a factual account of the response of the different emergency services on the night of the attack and for the nine following days. Chapter 5 further explores the response and lays out the Panel’s analysis, conclusions and recommendations.

The Panel’s Terms of Reference mean that a major part of the Review has involved the need to collect, collate and analyse information in order to develop a clear picture of the multi-agency activity that underpinned the response to the Arena attack.

- 3.1.** From this information, it is clear that the response was delivered as a multi-agency effort, with Greater Manchester Resilience Forum members and partners working together in ways that illustrated the importance of the Greater Manchester Resilience Forum’s planning, training and exercising regime. This undoubtedly underpinned Greater Manchester’s preparedness for such an event.
- 3.2.** As will be discussed, at the height of the incident, 70 to 100 people from across Greater Manchester’s organisations and agencies were actively collaborating within the GMP Force Command Module to deliver the multi-agency response.
- 3.3.** Likewise, at the scene of the explosion, a multi-agency operation evacuated the injured from the Arena foyer, stabilised them and moved them on to the most appropriate hospital for their injuries. At the same time, a significant police firearms response was operating to ensure safety at the Arena and across the wider city-region, where numerous other potentially terrorism-related incidents were being reported.
- 3.4.** The task of the Panel in conducting the Review was, however, to advise the Mayor of Greater Manchester of:

“...aspects of the preparedness and response that were effective and those that may inform future good practice, together with where necessary and appropriate

to advise on what steps might be taken to address any areas that may be strengthened or improved.”

- 3.5.** Accordingly, it was important that the Panel should explore and gain an understanding of, not only the overall outcomes of the response effort, but also of the ways in which the different protocols, practices and assets employed by the different organisations either enabled or restricted the effectiveness of each agency’s contributions to the multi-agency response.
- 3.6.** Whilst the Panel understands that many different organisations collaborated in the response to the attack, in terms of issues raised with the Panel, the procedures and actions of the emergency services received most attention.
- 3.7.** This chapter therefore presents a series of detailed narrative timelines which describe the responses by:
- British Transport Police (BTP)
  - Greater Manchester Police (GMP)
  - North West Ambulance Service (NWAS)
  - Greater Manchester Fire and Rescue Service (GMFRS)
  - Military<sup>14</sup>
- 3.8.** Chapter 4 presents the Panel synopsis of all the contributions to the response made by the community, businesses and agencies beyond the emergency services.

## **Timeline of Major Events 22<sup>nd</sup> – 25<sup>th</sup> May 2017**

### **Monday 22<sup>nd</sup> May**

22:31hrs	BTP at Victoria station run to sound of explosion in Arena foyer
22:32hrs	First BTP officers arrive in foyer
22:33hrs	First call to GMP reporting explosion at Arena
22:42hrs	First paramedic arrives at Victoria station

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<sup>14</sup> The military is not categorised as a formal responder under the Civil Contingencies Act (2004). However, the effectiveness of its role in assisting the civil authorities during the Arena response is most appropriately discussed in this section.

- 22:43hrs First armed police arrive in the foyer
- 22:46hrs Road closures commence nearby
- 22:49hrs Twelve ambulances at scene
- 22:58hrs Movement of injured from foyer to station concourse commences

### **Tuesday 23<sup>rd</sup> May**

- 00:37hrs Three fire engines arrive at scene
- 02:30hrs Reception Centre at Etihad Stadium opened by Manchester City Council
- 02:46hrs All injured transported from scene
- 04:15hrs Strategic multi-agency meeting at GMP Force Headquarters
- 08:30hrs First meeting of the Coroners, GMP Senior Identification Manager and the Deputy Senior Identification Manager
- 10:00hrs Meeting of Mass Fatalities Coordinating Group
- 12:00hrs Police confirm first arrest
- 15:35hrs First victim's body moved to temporary body storage facility at the scene; last body removed to temporary facility at 21:07hrs
- 16:00hrs Family Liaison Officers allocated to all families at Etihad Stadium with missing relative
- 18:00hrs Vigil in front of Manchester Town Hall
- 20:10hrs First body transported to mortuary (with police escort front and back)

### **Wednesday 24<sup>th</sup> May**

- 03:20hrs Final victim's body transported to mortuary (with police escort front and back)
- 16:00hrs Meeting of bereaved families with the Coroner and Greater Manchester Police

### **Thursday 25<sup>th</sup> May**

- 18:00hrs National two-minute silence marked by mass attendance at vigil in St. Ann's Square

## Geographical Map of Key Locations

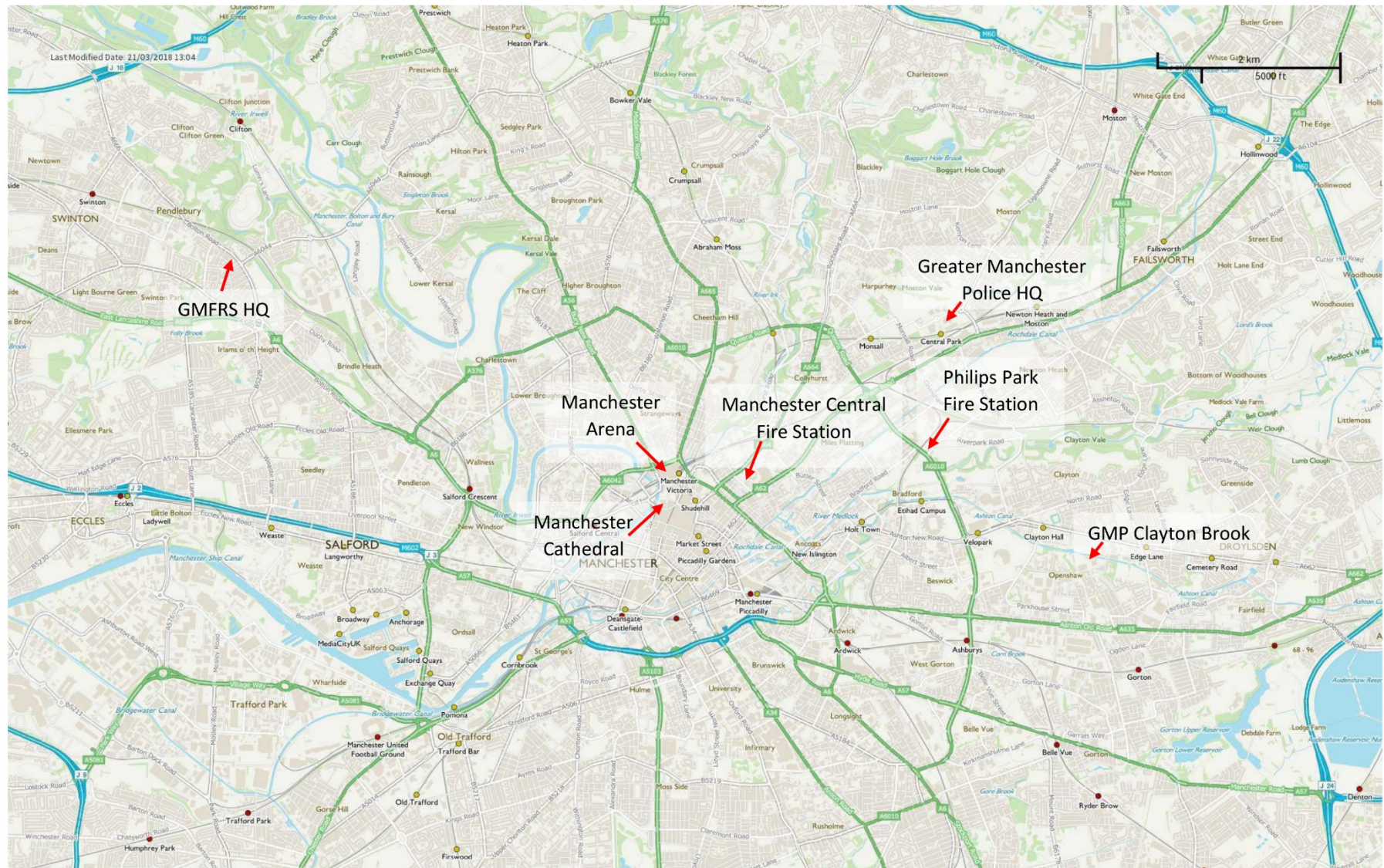
- 3.9.** To assist the understanding of where some key locations mentioned in the report are, relevant to the response, the map below identifies various buildings.
- 3.10.** Again, just to add a background understanding about scale and proximity of the buildings, etc. to each other, below is a list of distances taken from a generic online mapping system.

### **Manchester Arena to:**

- Manchester Cathedral, 0.2 miles, 4 minutes on foot
- Manchester Central Fire Station, 0.6 miles, 12 minutes on foot
- Philips Park Community Fire Station, 2.6 – 3.1 miles, 8 – 16 minutes by car
- GMP Clayton Brook, 4.2 – 6.0 miles, 12 – 26 minutes by car
- GMP Force HQ, 2.9 – 3.0 miles, 9 – 16 minutes by car
- GMFRS HQ, 4.0 – 4.6 miles, 10 – 18 minutes by car

### **GMP Force HQ to:**

- GMP Clayton Brook, 3.8 – 3.9 miles, 10 – 16 minutes by car
- GMFRS HQ, 6.0 – 6.1 miles, 16 – 20 minutes by car



## The Response of British Transport Police to the Arena Attack

- 3.11.** As Victoria station and the Manchester Arena are owned by Network Rail, British Transport Police (BTP) has the primary responsibility for policing both locations. On the night of the incident there were four BTP officers directly assigned to the Ariana Grande concert. Following the explosion, this team responded to the foyer of the Arena within 30 seconds.
- 3.12.** At the same time, officers working in the BTP offices, which are situated in the Peninsula Building, 150m from Victoria station, heard the blast and immediately ran toward the scene thinking, initially, that they had heard a train crash. This meant that within ten minutes, nineteen BTP officers had converged in and around the foyer.
- 3.13.** Due to this early presence, initial command of the scene was taken by a BTP Sergeant who started an assessment of the situation in the foyer area and provided a METHANE<sup>15</sup> update to the BTP Force Control Room. At 22:39hrs a major incident was declared for BTP from the scene. The BTP officers started to work with Arena staff and others to provide first aid to the injured.
- 3.14.** Realising the severity of one young casualty's injuries, officers decided to transport her directly to hospital themselves, even before paramedics had arrived. Once NWAS paramedics did arrive (from 22:42hrs onward), the management of casualties was passed to NWAS.
- 3.15.** BTP officers described to the Panel how the sheer scale of the challenge meant they were faced with confusion and distress all around the station and Arena, with devastation in the foyer. In addition to this they had perceived a genuine risk of a secondary Improvised Explosive Device having been planted somewhere nearby. The BTP Sergeant reflected on how he had thought of the vulnerability of responders if there had been a follow-on attack.

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<sup>15</sup> METHANE: the agreed multi-agency messaging framework for assessing and sharing information between the responding agencies, which is explained in chapter 1.



- 3.16.** With the arrival of GMP officers to the foyer, control of the scene was handed over to the more senior GMP Inspector, who became the Police Bronze. Once the paramedics started to triage the casualties, BTP staff worked with Arena staff, GMP and members of the public, using improvised stretchers to carry the injured down onto the rail station concourse and into the Casualty Clearing Station. A Casualty Clearing Station is set up in the close vicinity of the scene of an emergency by the Ambulance service in liaison with the Medical Incident Commander to assess, triage and treat casualties and to direct their evacuation to the most appropriate hospital to treat their specific injuries.
- 3.17.** Having been the initial responders, BTP officers then worked alongside the officers from GMP in a seamless joint operation with overall management of the response at the scene being transferred to GMP at the appropriate time.
- 3.18.** Over the course of the following week, BTP officers were present at the Force Command Module at GMP Force Headquarters and worked in close collaboration with Transport for Greater Manchester and the rail operators through the formation of a Transport Cell, to ensure Victoria station and other impacted transport links were returned to operation with appropriate speed.
- 3.19.** During the night, a total of 63 BTP staff were deployed to the scene. Over the course of the nine-day response phase, BTP specialists also attended and assisted in incident management from the following specialisms:
- Working at Heights
  - Operations Support
  - Scenes of Crime
  - Disaster Victim Identification
  - Trauma Risk Management
  - Duty Management
  - Criminal Investigation

## Debriefing and Welfare

- 3.20.** Concern for the welfare of BTP staff commenced with the supervisor's approach to managing the initial presence of staff and others in the foyer and throughout the casualty evacuation phase. Once all casualties had been moved from the foyer a 'hot-debrief' was held.
- 3.21.** BTP also activated its welfare and debriefing resources from an early stage. These included the deployment of a Trauma Risk Management Team who began the process about identifying and ensuring support for the mental health of officers alongside the active and ongoing involvement of the BTP Chaplaincy.

## The Response of Greater Manchester Police to the Arena Attack

### Greater Manchester Police Notification of the Arena attack: The Force Control Room and Force Duty Officer

- 3.22.** On the evening of Monday 22<sup>nd</sup> May the Force Control Room, responsible for all police incidents across Greater Manchester, was operating on normal core staffing levels, as befitted the anticipated demand for a normal Monday night shift.
- 3.23.** Following the first call reporting a possible explosion at the Arena, which was received into the Force Control Room at 22:33hrs, a log was created and sent to the Force Duty Officer, a GMP Inspector. Initially the Force Duty Officer was not clear of the type of incident occurring but alerted Armed Response Vehicles to make their way toward the Arena.
- 3.24.** Even after the first Armed Response Vehicle arrived at the Trinity Way entrance to the Arena (22:41hrs), it was still not clear that an explosion had occurred. However, as more calls were received by GMP, the Force Duty Officer authorised the Armed Response Vehicles to deploy in role. Soon after, Armed Response Vehicles arrived at the Hunts Bank entrance to Victoria station and it became clear that GMP was dealing with a major incident.

- 3.25.** Within eleven minutes of the initial call, six Armed Response Vehicles, containing twelve Authorised Firearms Officers, had arrived on scene. The Authorised Firearms Officer designated as Operational Firearms Commander gave the Force Duty Officer a situation report, listing casualties and fatalities and notifying him of a possible Improvised Explosive Device. There was also an initial belief at the scene that injuries may have been gunshot wounds. The level of this firearms response was significant.
- 3.26.** This information led the Force Duty Officer to suspect the possibility that a Paris-style attack could be in progress, involving a terrorist Improvised Explosive Device and Marauding Terrorist Firearms Attack. In a context where he knew that around 14,000 people were in the Arena vicinity, this provided impetus to mobilise additional firearms officers toward the scene. The Force Duty Officer considered that with the information provided, the Arena itself was potentially a 'hot' zone (see Chapter 1).
- 3.27.** At 22:47hrs the Force Duty Officer, acting on the information available, declared the Operation PLATO contingency for a Marauding Terrorist Firearms Attack. At the same time the Force Control Room received confirmation that an explosion had occurred.
- 3.28.** Acting as the Initial Tactical Firearms Commander, until relieved by a dedicated Tactical Firearms Commander, the Force Duty Officer had responsibility for firearms authorisations and tactics. The declaration of Operation PLATO meant that the Force Duty Officer was also required to notify sixteen other agencies of the declaration, including GMFRS, NWAS and the military. However, GMFRS and NWAS were not informed of the declaration of Operation PLATO at this time.
- 3.29.** Alongside these actions, the Force Duty Officer activated the Force Command Module at GMP Force Headquarters, which was set up by an on-site duty Silver Commander and other staff who attended from home. These were assisted by a senior duty supervisor released by the Force Duty Officer from his team, once he had received additional support. The duty Silver Commander and the on-call Gold Commander rapidly assumed command positions, establishing a command structure.

- 3.30.** The Force Duty Officer is the main point of contact for many agencies in the initial stages of an incident. As is inevitable during a major incident, there were many simultaneous demands on the Force Duty Officer with many incoming and outgoing phone calls.
- 3.31.** The Force Duty Officer's work station has four separate lines coming into a single telephone. In addition to this, after 18:00hrs, all media enquiries coming into GMP are directed to the Force Duty Officer. On notification of the events, the Force Duty Officer contacted the duty press officer and requested them to attend the Force Command Module.
- 3.32.** Therefore, in a situation where the Force Duty Officer was acting as Initial Tactical Firearms Commander, whilst also activating elements of Operation PLATO, initiating the police Gold/Silver Command structure and monitoring normal police activity across Greater Manchester, the Force Duty Officer's phone was constantly busy. This meant that although the Force Duty Officer is supported by staff within the Operational Communications Branch some responders simply could not contact this team.
- 3.33.** Although now in place, due to the then lack of an Inter-Agency radio link, neither could the Force Duty Officer initiate talk-through between the GMP control room and those of NWS and GMFRS. The Force Duty Officer did, however, know that both GMFRS and NWS were aware of the attack from operators who were in contact with those partner agencies' control rooms.
- 3.34.** At this point, the Force Duty Officer had to decide whether to implement a withdrawal of all responders from the foyer, as is laid down within Marauding Terrorist Firearms Attack protocols. The Force Duty Officer decided that to tell these responders to evacuate would have been unconscionable. Accordingly, but in clear consideration of the Joint Operating Procedures, the Force Duty Officer used professional discretion and left the responders in place. This decision was based on an assessment that the presence of substantial and increasing police firearms capabilities at the scene would reduce the risk from any Marauding Terrorist Firearms Attacks significantly. The Force Duty Officer had also deployed explosive-sensing search dogs from GMP and other local forces to the Arena, so the risk of an undetected Improvised Explosive Device would also be reducing.

**3.35.** As the incident at the Arena was ongoing, GMP were also dealing with a series of other incidents around Greater Manchester. The most significant of these included:

- The lockdown of Piccadilly train station by armed officers in the belief that a further attack might be imminent (23:10hrs)
- A potential active shooter and a suspect package left behind Manchester Cathedral – this involved a further scene for GMP officers to guard which, in view of the circumstances, was treated as a potential terrorist attack (23:35hrs)
- A suspicious package at North Manchester General Hospital (00:18hrs)
- A number of reports received in relation to the Royal Oldham Hospital, these ranged from a man who had barricaded himself in, shots fired, through to bangs and flashes being heard and seen. The hospital went into lockdown and a number of firearms officers were dispatched to the scene (00:39hrs)
- A potential further explosive device at the Mitre Hotel on Cathedral Gates which was disrupted by a military Explosive Ordnance Disposal team (01:30hrs)
- An enforced vehicle stop by armed officers
- The Football Museum was on lockdown post incident. It was 02:00hrs before it was declared safe and people were allowed to leave.

**3.36.** Along with any other examples these additional incidents clearly evidence the ongoing extent of GMP's need for command and focus well beyond the confines of the Arena area and the initial explosion.

**3.37.** By 23:23hrs the Force Duty Officer was supported by the arrival of a Ground Assigned Tactical Firearms Commander on scene. The Ground Assigned Tactical Firearms Commander took the command and control for Piccadilly train station and the Arena and the Force Duty Officer could then manage other developing situations.

**3.38.** At 00:15hrs the Silver Tactical Firearms Commander took command and control of the firearms operation in its entirety, releasing the Force Duty Officer from any command and control of firearms operations.

- 3.39.** A Military Liaison Officer had started to travel toward Greater Manchester on hearing media reports and 'en route' to the Force Control Room received notification of Operation PLATO from the Force Duty Officer. As a result of this the Military Liaison Officer was able to gain important initial situational awareness by working alongside the Force Duty Officer, before relocating to the Force Command Module.

## Greater Manchester Police: Coordination of Operational Response

- 3.40.** Following the initial influx of BTP officers into the foyer, operational GMP officers were also arriving, with a GMP Inspector soon taking over the police management of the foyer from the BTP Sergeant who had taken initial control.
- 3.41.** The Inspector focused on coordination within the foyer, including oversight of the collaboration of GMP with NWAS paramedics in providing first aid and assisting with evacuation. Although not formally declared as the GMP 'Bronze' Commander, some of the Inspector's activities did meet those criteria, e.g. giving initial briefings to arriving GMP officers on the concourse (prior to the Ground Assigned Tactical Firearm Commander's arrival). Another GMP Inspector had responsibility for cordons.
- 3.42.** In order to attain situational awareness, the Inspector stayed in the foyer beside the door onto the walkway. This became a dedicated meeting place where he could regularly discuss proposed actions and progress with the Advanced Paramedic and the Ground Assigned Tactical Firearms Commander.
- 3.43.** The coordination between NWAS, BTP, GMP, Arena staff and station staff combined with these individuals' selfless willingness to remain in the foyer, meant that, from the Inspector's perspective, the evacuation proceeded efficiently and without a clear need for additional resources, for example from GMFRS.
- 3.44.** Once the casualties had all been evacuated, and the priority became to secure the foyer as a crime scene, the Inspector handed over to the GMP Crime Scene Manager.

## Greater Manchester Police: Coordination of Armed Response

- 3.45.** Within ten minutes of the initial call, four Armed Response Vehicles had arrived at the scene and within thirteen minutes the total had reached seven Armed Response Vehicles. This equates to the arrival of fourteen Authorised Firearms Officers on scene, all of whom were fully trained and equipped to search for and to stop terrorist activity and/or to provide cordon security for other responders. Whilst these officers focused on conducting an emergency search, which included providing protection to members of the public and emergency responders at the scene, some also became involved in attending to casualties.
- 3.46.** The declaration of Operation PLATO by GMP meant that the Force Duty Officer was empowered to initiate mutual aid arrangements with neighbouring police forces and national structures including the military. Accordingly, the Force Duty Officer activated these arrangements, which rapidly drew in further Armed Response Vehicle capacity and additional firearms capabilities from across the country, including Counter-Terrorism Specialist Firearms Officers and military assets.
- 3.47.** Within one hour, 106 Authorised Firearms Officers were deploying to the Greater Manchester area to provide direct assistance to GMP in response to the attack. All GMP personnel and vehicles could be tracked in the Force Control Room using an Automatic Resource Location System, however resources from outside Greater Manchester had to be tracked by other means.
- 3.48.** The coordination at the scene provided by the Ground Assigned Tactical Firearms Commander (arriving at 23:23hrs) focused on the Commander's perception that there was no immediate ongoing attack (i.e. no 'hot zone'). However, his assessment was that the situation still held sufficient risk, including the need to negate the risk of concealed attackers and a secondary Improvised Explosive Device, for 'warm-zone' designation and still required the extra capabilities that an Operation PLATO declaration would bring to Greater Manchester.
- 3.49.** The Ground Assigned Tactical Firearms Commander's priority was, therefore, to use armed police to search the Arena and this involved speaking with the Venue Security Manager, the Counter-Terrorism Specialist Firearms Officers who were undertaking emergency search tactics, armed response vehicle officers and

working with the explosive-sensing search dogs. In addition, armed protection was deployed for the foyer, the Casualty Clearing Station that was being set up by NWAS on the concourse, for the multi-agency Forward Control Point and for the officers on the gradually evolving outer cordons. Some firearms staff therefore moved from searching the building, where sufficient resources were deployed, to outside locations where they were needed as a visible presence to reassure and create a safer working environment.

- 3.50.** All Authorised Firearms Officers have received advanced training in trauma care, however, their role on the evening was to carry out a search in order to protect people at the site. No Authorised Firearms Officers were directed to carry out any medical assistance since their primary role was security of the site. However, the scale of the convergence of NWAS resources onto the concourse greatly assisted the respective services' personnel to focus on their primary roles.
- 3.51.** Some redeploying Authorised Firearms Officers did, however, drop their personal trauma packs in the foyer so that others could use them.
- 3.52.** With the large numbers of other officers now arriving and the cordons around the Arena coming into place, the evacuation of casualties from the foyer by unarmed police and others continued until all the injured had been moved down into the concourse-based Casualty Clearing Station.
- 3.53.** Whilst the Casualty Clearing Station was in operation the Ground Assigned Tactical Firearms Commander was the on-scene Commander for GMP for the incident, allowing the operational GMP Inspector to be GMP Bronze and to focus on the evacuation of the foyer and its security as a crime scene.
- 3.54.** The Ground Assigned Tactical Firearms Commander took part in JESIP 'scrums' with the NWAS Bronze and rail staff who were also working on the station concourse. These 'scrums' bolstered the development of shared situational awareness. Notably for this incident, as the firearms threat did not move, the on-scene commander was able to stay in the area and so inter-agency coordination was maintained.



- 3.55.** The Ground Assigned Tactical Firearms Commander had to risk-assess the scene to be able to accurately brief other partners to achieve joint situational awareness. This is a challenging and variable task at any incident, therefore, it was not until one hour after the Ground Assigned Tactical Firearms Commander's arrival that the first shared risk assessment was undertaken.
- 3.56.** One of the outcomes of this 'scrum' was the pragmatic decision, agreed between the Ground Assigned Tactical Firearms Commander and the NWAS Bronze, to declare Operation PLATO as being 'on standby', rather than active, in the train station concourse area. This use of discretion by the officers allowed for NWAS casualty clearing operations to continue in situ, but in the shared knowledge that if further attacks occurred in the immediate vicinity then 'hot/warm zone' casualty evacuation protocols would be instantly reinstated.

### Greater Manchester Police: Strategic and Tactical Coordination Groups – the Force Command Module

- 3.57.** In accordance with the Greater Manchester Resilience Forum Generic Emergency Plan, once the magnitude of the attack became clear, the Force Duty Officer activated the Force Command Module at GMP Force Headquarters.
- 3.58.** The Force Command Module rapidly became a hub of activity, as personnel from responder agencies started to congregate there.
- 3.59.** The magnitude and multi-agency nature of the ongoing incident meant that the full Force Command Module suite was used, with all workstations employed. Over the course of the night it was estimated that between 70 and 100 people were operating within this room whilst, in accordance with protocols, the Counter Terrorism Unit set up its operations in a different suite.
- 3.60.** The role of the Strategic Coordinating Group is clearly laid out in the Greater Manchester Resilience Forum Generic Response Plan:

"The purpose of a Strategic Coordinating Group is to take overall responsibility for the multi-agency management of the emergency and to establish the policy and

strategic framework within which tactical and operational command and coordinating groups will work.” (p.19)

- 3.61.** The role of the Tactical Coordinating Group’s role, by contrast, is more focused on coordinating the actual delivery of an effective multi-agency response to a major incident, i.e. by ensuring the on-scene responders are provided with all the resources they require.
- 3.62.** The Greater Manchester Resilience Forum Generic Response Plan specifies that GMP are required to notify and advise relevant partners of the establishment of a Strategic Coordinating Group / Tactical Coordinating Group. There is no evidence this occurred, yet it is clear from the convergence of many Gold and Silver commanders into the room that prior planning, training and exercising had worked in building the expectation that the Force Command Module would provide the focal point of strategic coordination.
- 3.63.** Throughout the night of the attack coordination across the strategic and tactical work streams occurred within the main Tactical Suite of the Force Command Module, with the Police Gold Commander and Tactical Coordinating Group Chair choosing to share multi-agency situational awareness by means of ‘round the room’ updates. These updates, the first of which occurred at 01:20hrs, involved the room being brought to silence, before selected individuals apprised the others of their own organisation’s status. It is of note that at this time there was no Fire Gold or Silver Commanders at the Force Command Module, only the tactically trained National Inter-Agency Liaison Officers.
- 3.64.** The Greater Manchester Resilience Forum Generic Emergency Plan suggests that “in dynamic, fast moving-incidents, the Strategic Coordinating Group can meet regularly, for example once every two hours.”
- 3.65.** A Strategic Coordinating Group meeting was held at 04:15hrs.

## Greater Manchester Police: Follow-on Operations

- 3.66.** Throughout the following week, GMP officers and resources were deployed in a range of operations. This included principal involvement in the Counter Terrorism

operation, which culminated in raids, arrests and searches around Greater Manchester. During these operations, GMP was fully supported by other agencies with the complex coordination required being split between the dedicated Counter Terrorism intelligence and operations team and the Force Command Module.

- 3.67.** The nature of this activity was unprecedented in Greater Manchester during a period of critical threat. The response involved hundreds of officers from almost every force in the country, commanded by GMP, many of whom cancelled annual leave to fulfil the roles. Activity took place under scrutiny of the Government and in conjunction with National Counter Terrorism Command, through regular Cabinet Office Briefing Room (COBR) coordination meetings.
- 3.68.** Many of the raids which took place were of such high risk that officers were supported by experts from the military and GMFRS to ensure activity could be conducted in as safe a manner as possible. A significant amount of community engagement work was undertaken at this time to mitigate potential increases in community tensions. This was given oversight by a Consequence Management Operation.
- 3.69.** GMP was also involved in the coordination of numerous supporting community activities, affording a safe environment and community reassurance. This included the policing of many events commencing with a city centre vigil less than 24 hours following the attack, together with other significant events including the Great Manchester 10k Run and Games, VIP and Royal visits. To the police and other agencies managing these activities, whilst engaged in or supporting the anti-terrorism activity outlined above, was an enormous challenge which was nonetheless, effectively achieved.

### Greater Manchester Police: Identification of the Victims and Support for the Bereaved

- 3.70.** Whilst it is not within the Panel's terms of reference to discuss the criminal or coronial investigations in detail, this section of the report describes the processes through which the victims of the attack were formally identified and how support was provided for the bereaved.

## Disaster Victim Identification

- 3.71.** Where an emergency or major incident results in fatalities, the processes and procedures for identifying deceased persons and the support that is given to family and friends during the identification process is known as Disaster Victim Identification.
- 3.72.** Disaster Victim Identification takes place at the same time as investigations into the cause of an incident and any criminal culpability arising from it. Disaster Victim Identification principles are founded upon the recommendations of Lord Justice Clarke's report following the Marchioness disaster in August 1989, when 51 people lost their lives on the River Thames. These Disaster Victim Identification principles are subject to international agreement through Interpol, with common standards and procedures adopted by most countries with a Disaster Victim Identification capability, including the United Kingdom.
- 3.73.** These principles are:
- Provision of honest and, as far as possible, accurate information at all times and at every stage
  - Respect for the deceased and the bereaved
  - A sympathetic and caring approach throughout
  - The avoidance of mistaken identification.
- 3.74.** Where Disaster Victim Identification is activated in response to an incident involving fatalities, a Senior Identification Manager is appointed to manage the Disaster Victim Identification elements on behalf of the police service, working closely with the incident Coroner. The Senior Identification Manager is appointed by the Police Gold Commander and must have successfully completed the national accredited Senior Identification Manager course. Amongst other duties, the Senior Identification Manager has responsibility for the Casualty Bureau, recovery of the deceased and the family liaison strategy.

## Casualty Bureau

- 3.75.** The Casualty Bureau is the initial single point of contact for receiving and assessing information about people believed to be involved in an incident. The Senior Identification Manager is responsible for managing the Bureau and for appointing a manager to implement the Casualty Bureau strategy.
- 3.76.** The primary aims of the Casualty Bureau<sup>16</sup> are to:
- Provide information for the investigation process
  - Trace and identify people involved in an incident
  - Reconcile missing person records with casualty and survivor/evacuee records.
- 3.77.** When it became clear to the Police Gold Commander that there were a number of confirmed fatalities as a result of the terrorist attack on the Manchester Arena, she directed that a Casualty Bureau be established to deliver the primary aims as set out above.
- 3.78.** The Casualty Bureau manager was mobilised and attended the designated premises at Sedgley Park, Prestwich at approximately 00:00hrs on Tuesday 23<sup>rd</sup> May 2017, where arrangements were then put in place to activate the necessary telephony and computer systems to receive and collate casualty data.
- 3.79.** The Senior Identification Manager was mobilised by the Police Gold Commander at around 00:30hrs on 23<sup>rd</sup> May and, having secured the necessary briefings and spoken with the Casualty Bureau Manager and the Duty Senior Investigating Officer at the scene at around 01:00hrs, was in a position to take up a command role at GMP Force Headquarters at around 02:45hrs.
- 3.80.** Whilst this was happening, a significant number of calls were received by GMP via other channels, primarily via the 999 and 101 telephone numbers, from members of the public concerned about the whereabouts and safety of their loved ones. As the dedicated Casualty Bureau was not yet operating, the details of these calls

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<sup>16</sup> College of Policing Authorised Professional Practice – Casualty Bureau.

were recorded and retained until such time as they could be passed to the Casualty Bureau.

- 3.81.** Under nationally agreed arrangements through the Home Office, the telecommunications company Vodafone is contracted to activate the necessary telephony, not only to provide the host police service (in this case, GMP) with a dedicated telephone number through which all calls can be routed but also to enable other police forces to stand up their Casualty Bureau and thereby assist the host police force with additional call-taking capacity throughout periods of high volume. This arrangement between the Home Office and Vodafone has been in place since 2009. The facility is referred to as the National Mutual Aid Telephony system.
- 3.82.** In accordance with these established arrangements, the GMP Casualty Bureau Manager attempted to activate the National Mutual Aid Telephony facility but this was unsuccessful due to a problem with the technical infrastructure of the system. As a result, a single national telephone number could not be allocated for the incident and the facility was not available whereby other police forces' Casualty Bureaus could be called upon to assist with call taking. As a consequence, GMP's call-taking capacity was restricted for several hours to those staff physically located within its own Casualty Bureau. During this time, a local (0161) number with limited capacity was utilised in the absence of a national (0800) number which would have been activated as part of the National Mutual Aid Telephony arrangements.
- 3.83.** This arrangement remained in place until 07:00hrs on Tuesday 23<sup>rd</sup> May, at which point a further local (0161) number was activated and a further eight call-taker positions established in anticipation of a surge in calls from people waking up to the news of the attack at the Arena. Although there were no definitive statistics available due to the absence of the National Mutual Aid Telephony arrangements, the Panel was informed that a minimum of 600 calls were received between midnight and 08:00hrs on 23<sup>rd</sup> May.
- 3.84.** These local (0161) numbers were provided to the public from around 03:00hrs on the 23<sup>rd</sup> May but they were not specifically referred to as Casualty Bureau numbers. In television addresses given by the Chief Constable and subsequently

posted on social media, they were described as ‘an emergency number available for those who are concerned about loved ones or anyone who may have been in the area’. The Panel is aware from conversations with families and others directly affected that these numbers were variously described as ‘helplines’, albeit they were in fact the direct channel into the Casualty Bureau.

- 3.85.** Later that morning, the National Mutual Aid Telephony issues were resolved and the Casualty Bureau became fully operative using the nationally provided (0800) number, which was then widely publicised in all press releases and via social media. With this facility now in place, a total of fourteen other police forces activated their Casualty Bureau in support of GMP and, at its height, a total of around 260 call-takers were deployed to the public-facing work of the Casualty Bureau. In addition, the ‘Reconciliation Team’ within the Casualty Bureau worked to match missing person reports with known casualty information. This was all made available to the Senior Identification Manager and the wider Disaster Victim Identification process in order to assist with the identification of those who were killed or injured in the attack.
- 3.86.** The Casualty Bureau remained in place for approximately four weeks. After the initial volume of incoming calls from the public had decreased and the identification of the deceased victims had been completed, the Casualty Bureau continued to collate casualty information from a total of 43 hospitals (19 in the North West area and 24 others beyond). A syndicate of GMP’s Major Investigation Team coordinated comprehensive updates of 375 casualties across the 43 hospitals, which were supplied to the Casualty Bureau twice a day in order to maintain an accurate and up to date overview of casualty information.

## Recovery of the Deceased

- 3.87.** Once the scene of the attack had been secured and all living casualties had been evacuated, arrangements were made for the careful and sensitive recovery of the deceased victims from the scene to the mortuary, as part of the Disaster Victim Identification process.
- 3.88.** Greater Manchester, in line with all other areas of the country, has had a Mass Fatalities Group in place for many years, bringing together all the agencies likely

- to be involved in responding to incidents or events of this nature, including the police, the Coroner, local authorities and others. As well as developing effective strategies and processes for dealing with mass fatalities events, the Mass Fatalities Group coordinates all inter-agency training and exercising in order to achieve the necessary preparedness for response if required. When relevant incidents occur, members are drawn from the Mass Fatalities Group to form the Mass Fatalities Coordinating Group, which has responsibility for planning the removal and identification of those who have died as a result of the incident.
- 3.89.** The Mass Fatalities Coordinating Group met for the first time at 10:00hrs on Tuesday 23<sup>rd</sup> May, following a meeting at 08:30hrs that morning between the Senior Identification Manager, the Deputy Senior Identification Manager and the Senior Coroner in whose area the Mass Fatality Mortuary was situated. Overnight, the Mass Fatalities mortuary staff had activated their processes and attended the mortuary to make the necessary preparations to receive deceased victims from the scene. This was done by midnight on the night of 22<sup>nd</sup> May, in liaison with the Senior Coroner, who agreed with the arrangements in place.
- 3.90.** At the scene, the bodies of the deceased victims were recovered one by one, each with appropriate dignity and sensitivity in line with Disaster Victim Identification and Lord Justice Clarke's principles. There were substantial health and safety risks to the recovery process, not least of which was the unstable condition of the glass ceiling damaged in the blast and with the potential to drop large shards of glass into the foyer below. However, through close working relationships between the Disaster Victim Identification teams and GMFRS, this risk was mitigated without undue delay to the recovery process.
- 3.91.** Each victim was taken individually to the designated mortuary in a private ambulance, with a police escort front and back, at a funereal pace as a mark of respect to each. Exactly the same transport arrangements were used to convey the deceased victims from the hospitals to which they had been taken immediately after the attack.
- 3.92.** The body of the attacker was removed and immediately transported in a completely separate vehicle, to another Coroner's jurisdiction, outside of Greater



Manchester, for forensic and post-mortem examination. This was completed first to support the needs of the counter-terrorism investigation.

- 3.93.** Although the recovery of each of the victims in turn was completed as quickly as possible, there were forensic considerations to be addressed, both in respect of the criminal investigation and the coronial process, which inevitably added to the time taken for the whole operation. However, the Panel was provided with evidence of the close, professional and compassionate working relationship between the Disaster Victim Identification and Counter Terrorism teams to ensure that each individual recovery was conducted in as short a time as possible. As a result, the last recovery was completed by 03:20hrs on the morning of Wednesday 24<sup>th</sup> May.
- 3.94.** The post-mortem examinations of the deceased victims started on 24<sup>th</sup> May and were conducted by three teams, each headed by a pathologist. Individual examinations took a number of hours each and involved the use of CT (computed tomography) scanning equipment, including that provided and supported by the military, odontology (dental examination) and what is termed an invasive post-mortem examination, which was required in this circumstance.
- 3.95.** The Panel was told by some families that they were not aware of the level of intrusion involved in the post-mortem examination of the deceased victims and were distressed to learn that this had taken place. Three Senior Coroners and the Senior Investigating Manager did meet with families on 24<sup>th</sup> May to explain their roles and the procedures required to meet the needs of the coronial process, including the extent to which post-mortem examination was necessary. However, it was not possible for all families to be present at that meeting. For example, some may have been at hospital with other injured family members and were therefore understandably not in a position to attend. The Panel is not aware that this information was made available to those absent from the Coroner's meeting.
- 3.96.** All the deceased victims were formally identified to the standards specified by the Coroner and were authorised for release to their families by 8<sup>th</sup> June 2017 at the latest. All of those involved in the mortuary processes worked every day without a break until that was achieved, in order that the families received their loved ones back at the earliest opportunity.

## Family Liaison

**3.97.** The aims of family liaison<sup>17</sup> in general are to:

- Work with the family in order to investigate the murder or death of a loved one
- Analyse the needs, concerns and expectations of the family in order to identify all the relevant and realistic action that should be taken in the context of their human rights and the police professional obligations.

**3.98.** In the aftermath of a mass fatality or mass casualty incident, an important element of the response is to identify those families directly affected and to deploy a Family Liaison Officer to each family at the earliest opportunity in order to fulfil the key aims set out above. A prompt and effective Casualty Bureau is key to achieving this as it is through appropriate handling of the information coming in, that those most directly affected can quickly be identified and Family Liaison Officers allocated.

**3.99.** The delays in getting a fully functioning Casualty Bureau up and running on the night of 22<sup>nd</sup> / 23<sup>rd</sup> May are documented above.

**3.100.** Of paramount importance to the Disaster Victim Identification process is the need to arrive at accurate, reliable identifications of the deceased to ensure that there is certainty for the coronial process and perhaps more importantly to avoid the associated trauma of misidentifications, as have occurred in some mass fatality incidents elsewhere in the world over recent years. At the Arena, the deceased victims were removed one by one and personal belongings and clothing were examined to help provide an indication of the identity of the person concerned (for example, the presence of a driving licence).

**3.101.** As each of the deceased victims was recovered from the scene, information was passed back to the Senior Identification Manager who made the necessary arrangements at the Etihad Stadium for a Family Liaison Officer to be allocated to

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<sup>17</sup>College of Policing Authorised Professional Practice – Working with Victims and Witnesses.

those directly affected. A team of Bereavement Nurses together with British Red Cross psychosocial volunteers also attended the Etihad Stadium.

- 3.102.** Family Liaison Officers were allocated, albeit on a gradual basis, as information was received regarding each victim with the result that all families at the Etihad Stadium were allocated a Family Liaison Officer by 16:00hrs on 23<sup>rd</sup> May. From this time, families were informed by the Senior Identification Manager or his nominee that whilst no formal identification had yet been made, all the indications were that their loved one(s) had died in the attack, although each family will have been told at slightly different times. This was done in line with Lord Justice Clarke's principle of openness and honesty with families at all times. Some families of the seriously injured were also allocated a Family Liaison Officer which, whilst not forming part of normal Family Liaison Officer arrangements, was done with the intention of providing further support to those families.
- 3.103.** The Family Liaison Officers and the Bereavement Nurses remained allocated to the respective families from that point onwards, under the direction of the Senior Identification Manager via the Family Liaison Coordinator. Where families were resident outside of the Greater Manchester area, they were generally assigned a Family Liaison Officer from their local police force in order to enhance the availability of support. Wherever these Family Liaison Officers were drawn from, they remained under the direction of the GMP Family Liaison Coordinator to ensure consistency of the service provided.
- 3.104.** Whilst the initial purpose of being allocated a Family Liaison Officer has now passed, i.e. to support the family through the identification process, they continue to provide a link between the families and the ongoing criminal investigation. They continue to be under the direction of the Family Liaison Coordinator but that officer now reports to the Senior Investigating Officer rather than the Senior Identification Manager.

## Greater Manchester Police: Debriefing and Welfare

- 3.105.** The Panel was told of the welfare arrangements put in place for those members of GMP who were directly involved in the response to the attack on the Arena. These arrangements were delivered jointly between GMP and the GMP Federation (the

staff association representing police officers up to and including the rank of Chief Inspector) and were very much borne out of experience of supporting officers through challenging incidents in previous years. The welfare arrangements were initiated at an early stage by the Chief Constable soon after the attack to ensure staff welfare was treated as a priority.

- 3.106.** Very quickly after the explosion and the deployment of police responders to the scene, the Police Federation, working alongside GMP, mobilised three Trauma Risk Management trained officers to support those responders. One of the measures put in place was the requirement for all GMP officers and staff to report off duty at the end of their shift via attendance at a designated conference room at GMP Force Headquarters. Here, officers and staff were provided with food, drinks, private use of telephones and other practical support before making their journey home or back to their normal place of duty. A simple form was introduced to capture the precise role every GMP officer and staff member had performed on the night, their tour of duty and anything else of note relating to that officer or staff member. This simple arrangement, although not universally appreciated at the time, proved immensely useful when the welfare needs of individuals were being addressed in the longer term.
- 3.107.** Every GMP staff member deployed to the incident was provided with the contact details for both the Force and the Police Federation's confidential counselling services (the two are delivered by different providers). The Panel was informed that there was a substantial take-up of these services, the providers of which were described as impressive in the way they increased capacity at the time of high demand. Allied to this, the Police Federation extended access to their counselling provider beyond the 'federated ranks' to include all members of the 'GMP family', such as Police Community Support Officers, non-warranted police staff and senior officers above the rank of Chief Inspector.
- 3.108.** In relation to debriefing after the incident, the Panel notes that well coordinated measures were put into place swiftly by the Police Federation and GMP to support all involved in the GMP response. However, levels of welfare provision for police officers and staff attending Manchester as mutual aid from their home Forces is not known to the Panel. In the event of such large scale mutual aid deployment in

future, there would be merit in the host police force establishing links to ensure joined up welfare provision.

## **The Response of the North West Ambulance Service to the Arena Attack**

### **North West Ambulance Service: Notification of the Arena Attack**

- 3.109.** At 22:32hrs on 22<sup>nd</sup> May a call was handled in the NWAS Cumbria and Lancashire Emergency Operations Centre reporting an explosion at the Ariana Grande concert at the Manchester Arena. Subsequent calls handled in the Greater Manchester Area and Cheshire & Mersey Area Emergency Operations Centres reported a variety of descriptions of the event including ‘speaker exploded’ to ‘multiple gunshots’.
- 3.110.** Within five minutes, resources were deployed and contact was made with GMP and GMFRS. Deployments included NWAS on-call Commanders, Paramedic responders, a Hazardous Area Response Team and an Ambulance Intervention Team Commander who were mobilised to the scene. BTP declared a Major Incident at 22:39hrs reporting 60 plus casualties and a NWAS Advanced Paramedic on scene declared a Major Incident at 22:46hrs.

### **North West Ambulance Service: Response to the Arena**

- 3.111.** An Advanced Paramedic, who had been monitoring NWAS incidents on the computer in his office near the Arena, was able to self-deploy as other units were being tasked to respond to the multiple call logs that were being created.
- 3.112.** The Advanced Paramedic arrived at the scene, parking on Hunts Bank, and walked into the station (22:42hrs). As he entered he was told by a police officer on the concourse that the incident was ‘a suicide bomber’. He then went up the stairs from the concourse, along the walkway and into the foyer itself (see Figure 4). Here he made a rapid assessment of the situation and then walked back onto the walkway from where he gave a full situation report to the NWAS control room, declaring a Major Incident as part of a METHANE message (see Chapter 1).

- 3.113.** At this point a NWAS Silver Level Trained Manager entered the concourse, after deploying from home following a short telephone conversation with the on-duty NWAS Silver Commander. He had parked at the GMP designated rendezvous point at the Cathedral car park and walked in, noticing injured people on the station approach, but needing to assess the full scene before commencing any sort of casualty care.
- 3.114.** Other ambulances were, at this time, being directed toward the NWAS rendezvous point at the GMFRS Manchester Central station on Thompson Street, less than a mile away from the Arena.
- 3.115.** The two NWAS officers liaised on the walkway stairs and considered their Immediate Action Casualty Management Plan. This involved the Advanced Paramedic returning to the foyer to carry out casualty triage and the Silver Level Trained Manager taking on Bronze responsibilities whilst also setting up a Casualty Clearing Station in the station entrance way.
- 3.116.** As GMP Firearms Officers were deploying into the concourse area in numbers, the NWAS staff were confident in setting up the Casualty Clearing Station in this location because, due to the increasing density of firearms support, it was rapidly becoming in their opinion an increasingly safe place.
- 3.117.** The Advanced Paramedic then returned to the foyer and started to triage the casualties according to standard principles. This level of 'sieve' triage involves a basic expert assessment that allows for the casualty's condition to be categorised (Table 1). The triage process was also used to confirm the death of those who were deceased in the foyer.

Category	Priority	Extraction	Patient Condition
Immediate	Priority 1	Less than 1 hour	Casualties needing immediate life-saving resuscitation and/or surgery.
Urgent	Priority 2	Less than 4 hours	Stabilised casualties needing early treatment, but delay is acceptable.
Delayed	Priority 3	May be treated on site	Casualties requiring treatment, but a longer delay is acceptable.
Expectant	Priority 4 <sup>19</sup>		Casualties severely injured who are unlikely to survive even if treated aggressively.
Deceased	Dead		No further medical intervention useful.

**3.118.** This sieve triage ensured that the highest priority casualties (P1, P2) would be moved out of the foyer first whilst not stopping those P3 casualties who could walk out of the foyer themselves or with minimal assistance from doing so. The Advanced Paramedic then started to ensure that the more seriously injured were moved according to the seriousness of their injuries.

**3.119.** This process involved the Advanced Paramedic mentally creating separate zones in the area, in each of which he identified a first aider (responder or public) who appeared to be managing the casualties around them. He then ensured that this person understood the order in which that group of casualties should be evacuated. During his discussion with the Panel, the Advanced Paramedic unreservedly praised the actions of all these other responders and the public ‘zero responders’ working around him.

**3.120.** Concurrently, a team of NWS Hazardous Area Response Team technicians arrived on the concourse where they were briefed by the NWS Bronze. This briefing included the technicians being told that the foyer had not yet been

<sup>18</sup> LONDON RESILIENCE 2015. London Resilience Partnership Mass Casualty Plan. London Resilience Partnership.

<sup>19</sup> An incident declaration of P4 casualties has, to date, never been required in Britain (Greater Manchester Mass Casualty Plan: p.10).

declared safe and, therefore, that their safety could not be guaranteed if they moved forward. The team considered this warning and decided that the best plan would be that two technicians, who were not wearing ballistic protection, would go into the foyer whilst the remaining members of the team set up the Casualty Clearing Station. Two volunteers from the team immediately moved up into the foyer to assist the Advanced Paramedic, taking their trauma packs and other equipment with them.

- 3.121.** Additional medical packs were taken directly to the foyer by Northern staff and by the Arena medical team. In addition to this GMP firearms officers who were moving through the foyer to search the Arena also dropped their personal-use trauma packs so first aiders could make use of them too.

### Casualty Portage and Stretchers

- 3.122.** As the Advanced Paramedic was triaging the casualties in the foyer, he was approached by BTP, Northern and Arena staff who suggested to him that they could start to evacuate the casualties. The Advanced Paramedic agreed with this idea and a process was started to take the injured downstairs to the Casualty Clearing Station in order of priority.

- 3.123.** At this time, there were no stretchers available, so the responders rapidly improvised by using display boards and metal crowd barriers to carry the injured. Individuals who witnessed this stated how amazed they were to see how this portage was carried out through rapidly developing teamwork.

### North West Ambulance Service: Casualty Clearing Station

- 3.124.** The Casualty Clearing Station was set up very quickly by the Silver Level Trained Manager following his discussion with the Advanced Paramedic on the stairs. It was initially set up in the passage way between the concourse and the taxi rank outside the station entrance but was rapidly extended onto the railway station concourse due to the number of casualties being evacuated from the foyer.

- 3.125.** After an hour, management of the Casualty Clearing Station and overall NWSA Bronze Command was handed to a Gold Level Trained Manager upon arrival of



this manager at the scene. This allowed the Silver Level Trained Manager to focus on management of the Casualty Clearing Station.

- 3.126.** Due to the experience-based confidence of the Gold Level Trained Manager and Silver Level Trained Manager in initiating Greater Manchester's Mass Casualty Dispersal Plan (which was at the time only in draft form and had not been formally agreed), there was minimal need for the Gold Level Trained Manager to engage the Tactical Coordinating Group at the Force Command Module to assist in the arrangements for casualty reception at the hospitals. Rather, this was done directly from the Casualty Clearing Station with a dedicated Forward Medical Liaison Officer identified to oversee the casualty collection and evacuation. In accordance with the plan, the respective priorities (e.g. P1) and types of casualties were stabilised in the Casualty Clearing Station and then dispatched to the receiving hospitals. The last casualty was transported to hospital at 02:46hrs.

### North West Ambulance Service: Operational Coordinating Group – the JESIP 'scrum'

- 3.127.** An immediate issue identified by the NWAS Gold Level Trained Manager on his arrival at just after 23:20hrs was the apparent lack of presence on the concourse of the Bronze Commanders from GMFRS and GMP. However, this issue was rectified on the part of police because the GMP Operational Bronze status was the GMP Inspector in the foyer. The GMP Ground Assigned Tactical Firearms Commander led the 'scrum' discussions as he held the key safety information. Although the Inspector (Bronze) could not join in the 'scrums' on the concourse due to the need to stay in the foyer, he was connected to these multi-agency meetings by a police constable who acted as the Inspector's representative. The Inspector also liaised regularly with the Ground Assigned Tactical Firearms Commander at the foyer doorway.
- 3.128.** The key information about security of the scene during the 'scrums' came from the GMP Ground Assigned Tactical Firearms Commander and other information from the GMP Bronze. This liaison with NWAS Bronze assisted with good joint situational awareness and was helpful in progressing tasks. For example, as a result of this liaison, the GMP Ground Assigned Tactical Firearms Commander being able to negotiate directly with the Force Command Module in order to get

Transport for Greater Manchester to send coaches to evacuate P3 casualties from the station approach to hospital.

- 3.129.** The Ground Assigned Tactical Firearms Commander also actively worked to reassure casualties in the Casualty Clearing Station when the area was searched by explosive-sensing search dogs and also before the controlled explosion occurred in the Cathedral Gardens (01:17hrs).
- 3.130.** Following the arrival of GMFRS units, the first full multi-agency briefing with all partners (including Northern) present occurred at 00:59hrs. By this time the NWAS contingent was aware that Operation PLATO had been declared by GMP, but that it was 'on stand-by'.

## North West Ambulance Service: The Force Command Module – Gold and Silver Coordination

- 3.131.** Both the NWAS Duty Gold and Silver Commanders were informed of the incident at the Arena by telephone and after initial consultations with other senior managers both made their way directly to the GMP Force Command Module.
- 3.132.** This incident rapidly turned into the first live activation of the Greater Manchester NHS Partnership Mass Casualty Plan since it had been exercised three weeks previously (Exercise SOCRATES)<sup>20</sup>. The freshness of memories in relation to this exercise and the fact that the NWAS Gold Commander had been on a Multi-Agency Gold Incident Command refresher course recently meant that from the strategic and tactical level, things worked well.
- 3.133.** Tactical management of the incident from the Force Command Module involved the deployment of multiple assets, with deployments managed through collaboration between Bronze, Silver and the NWAS Emergency Operations Centres and Regional Operations Coordination Centre. The total deployment consisted of:

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<sup>20</sup> The scenario for Exercise SOCRATES in March 2017 had been a simultaneous suicide bombing and marauding terrorist firearm attack (MTFA) at Manchester Airport resulting in 187 adult and paediatric casualties.

- 56 Ambulances and seven Rapid Response Vehicles
- Six Advanced Paramedics and three Consultant Paramedics
- Nine Volunteer Ambulance Services
- Two Hazardous Area Response Teams (Manchester and Liverpool) plus two staff and one Manager self-mobilised (fifteen in total)
- Two Medical Emergency Incident Response Team Doctors
- Three British Association for Immediate Medical Care North West Doctors
- Six Managers on scene supporting roles
- East Midlands Ambulance Service Hazardous Area Response Team on standby in NWS region
- Major Incident Cells from three surrounding ambulance services
- Yorkshire Ambulance Service and West Midlands Ambulance Service also provided mutual aid vehicles to cover NWS core business in Lancashire and Cheshire/Mersey. The NWS assets were drawn from across the entire North West as crews were moved around to maintain cover.

### North West Ambulance Service: JESIP 'Huddles' at the Force Command Module

- 3.134.** Whereas JESIP meetings at the operational level were referred to as 'scrums', within the Force Command Module these were called 'huddles'. However, there was surprise that even after NWS Gold and Silver Commanders both enquired as to whether respective Strategic and Tactical 'huddles' were going to be held, to define and agree the multi-agency strategic response and the preferred tactical solutions to be employed, no such meetings were held until 04:15hrs. The preference of the Police Gold Commander was holding 'around the room' updates, which the NWS officers stated to have occurred at least twice in the initial hours.

### North West Ambulance Service: Debriefing and Welfare

- 3.135.** After the final casualties had been placed onto transport, the Gold Level Trained Manager requested that the 80 staff at the Casualty Clearing Station re-group at a designated NWS facility in order to check and replace used equipment. His

intention was that staff should also use this opportunity away from the scene in order to start to defuse and to call home.

- 3.136.** Later sessions included the formal debrief workshops organised by Greater Manchester Resilience Forum and a NWAS focused structured debrief, facilitated by the National Ambulance Resilience Unit, which was held at the Etihad Stadium. There was also a dedicated NWAS 'shared awareness' event where staff were able to hear 'the story' of the incident through the different perspectives of people who had been there. This event drew over 300 attendees, with one important outcome being the offer by medical staff to discuss the treatment of specific casualties on the night with concerned NWAS staff who had been directly involved in their treatment at the Casualty Clearing Station.

## **The Response of Greater Manchester Fire and Rescue Service to the Arena Attack**

### **Greater Manchester Fire and Rescue Service Notification of the Arena Attack**

- 3.137.** Following the explosion, numerous calls and radio communications were made to control rooms across Greater Manchester and beyond. Emergency calls were, however, made predominantly to the GMP and NWAS control rooms.
- 3.138.** To illustrate the relevance of this factor in building, or constraining, the development of single-agency and inter-agency situational awareness of the attack, it is important to note that in the first hour following detonation, GMP received 240 calls into its call management and resolution system whereas over the course of the night North West Fire Control received three directly incident-related calls. These calls were from the ambulance service and the police and one from a member of the public. In effect, this meant that North West Fire Control and GMFRS had to be more reliant for their own situational awareness on their interpretation of information passed to them by partner organisations (GMP, NWAS) because no information was coming directly to them from the scene.
- 3.139.** Initially, the control operators situated at the North West Fire Control facility in Warrington learnt about the incident in the midst of an unrelated conversation with

an operator at GMP control room. However, as details became clearer to the GMP operator, substantive notification of an explosion in the Arena foyer was passed to the North West Fire Control operator at 22:36hrs.

- 3.140.** The basis of the information was that GMP was receiving information about an 'explosion' or 'bomb' and later, possible 'gunfire' at the Arena. With this information, the North West Fire Control operator commenced a standard operating procedure by using an action plan which dictates the actions that GMFRS should take in response to an incident of this type.

### Greater Manchester Fire and Rescue Service Response Practice: Standard Operating Procedures and Specialist Capabilities

- 3.141.** The first stage of a normal deployment process for GMFRS is the receipt of a call into North West Fire Control. This can either come from a partner agency's control room (e.g. GMP), or from a member of the public via the 999 system. If the call is received via the 999 system, then this activates an automated 'pre-alert'. The pre-alert system is GPS-based and has been developed to give GMFRS assets in the vicinity of the 999 caller an immediate indication that they may be called out to deal with an incident. This gives crews time to, for example, put on their protective work wear and to open the station doors, i.e. actions that will reduce the length of time it takes for the crews to deploy.
- 3.142.** The pre-alert takes the form of a tone which is transmitted through the GMFRS radio system directly to the nearby assets (e.g. the nearest station or the nearest fire tender if it is mobile, to the 999 caller). Pre-alerts do not always involve a deployment, however, so if the North West Fire Control operator does not trigger a full activation within five minutes, then the crews know they can stand down. In effect, pre-alerts are not cancelled, they simply expire after five minutes.
- 3.143.** If on receipt of a call to North West Fire Control a full activation is warranted, then GMFRS, as with all other Fire and Rescue Services, will respond to incidents using the concept known as Pre-Determined Attendance. A Pre-Determined Attendance relates to the number and type of assets that have been previously calculated and risk-assessed to be appropriate to send to any specific type of

reported incident (e.g. a dwelling fire in which persons are reported; a road-traffic collision; an automatic fire alarm; an explosion). Predominantly, Pre-Determined Attendances tend to encompass the deployment of a 'command structure' and sufficient resources to deal with the initial actions of an incident. It is then expected that the first arriving officer will do a dynamic risk assessment at the scene and order the deployment of any further resources needed.

**3.144.** Deploying a command structure, in simplified terms, means that a Pre-Determined Attendance of, for example, 'two pumps' comprises the deployment of two fully equipped fire tenders and eight firefighters. One of the firefighters on each 'pump' will hold a more senior rank of which the most senior of them will automatically become the Incident Commander.

**3.145.** If the scale or type of incident dictates it, the Incident Commander will then request further resources. If a more senior officer is deployed to the scene then the role of Incident Commander would be formally taken by this officer, i.e. it is an operating principle within GMFRS that the most senior officer at an incident will always take the role of Incident Commander or leave the scene.

**3.146.** If specialist advice or capabilities are required, then the Incident Commander can access the expertise of a range of subject matter specialists (e.g. Technical Rescue; Fire Investigation; Wildfire; Command Support). These officers are referred to as Tactical Advisors.

**3.147.** One specialism within GMFRS tactical command is the National Inter-Agency Liaison Officer. The National Inter-Agency Liaison Officer role is defined as:

"A trained and qualified officer who can advise and support Incident Commanders from the police, health, military and other Government agencies on the Fire and Rescue Services operational capacity and capability to reduce risk and to safely resolve incidents at which a Fire and Rescue Service attendance may be required."<sup>21</sup>

**3.148.** National Inter-Agency Liaison Officers have been fully integrated into Greater Manchester's multi-agency planning, training and exercising regime for Marauding

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<sup>21</sup> CFOA (2014) National Inter-Agency Liaison Officer Guidance

Terrorist Firearms Attack and other terror-related responses. Accordingly, they have worked closely in developing contingencies for terrorist attacks alongside the GMP Counter-Terrorism Unit, the NWS Ambulance Intervention Team Commander cadre and Hazardous Area Response Team and other partners.

- 3.149.** Additionally, as part of the specialist terrorism-response capability of GMFRS, the service also operates three Special Response Teams, who have been similarly trained, equipped and practised in terrorist-incident response. Special Response Teams equipment includes ballistic protection and basic casualty portage capabilities.
- 3.150.** All these terrorist-attack capabilities and multi-agency responses have been regularly trained for and exercised and were, for example, tested in Exercise ‘Winchester Accord’, which took place at the Trafford Centre in May 2016.
- 3.151.** GMFRS also operates a number of Technical Rescue Units, which have an enhanced capability to risk assess and carry out any particularly challenging rescues in physically (rather than maliciously) dangerous environments. They also have a Marauding Terrorist Firearms Attack capability.

### Greater Manchester Fire and Rescue Service: Operational Deployment to the Arena

- 3.152.** On being told on the telephone by GMP at 22:35hrs that ‘there had been an explosion and that a bomb has exploded’, the North West Fire Control operator initially acted in accordance with the action plan for ‘EXPLOSION’ and created an incident log. Following the plan’s instructions, they then opened the action plan for ‘BOMB’. Instructions on this plan were to:

“**INFORM**” – Duty National Inter-Agency Liaison Officer, request guidance on actions to be carried out before proceeding further.

“**ACTION**” – Obtain a rendezvous point from the National Inter-Agency Liaison officer.

- 3.153.** The on-duty National Inter-Agency Liaison Officer was notified of the incident at 22:40hrs. This notification was done over the telephone and the Duty National Inter-Agency Liaison Officer, who was situated 22 miles from the Arena, was informed of the reported explosion and the current uncertainty about what it involved (i.e. the possibility of it being an explosion or bomb). The National Inter-Agency Liaison Officer was also informed that GMP had nominated the Cathedral car park as their incident rendezvous point.
- 3.154.** Acting on the information available at that time, suspecting the potential for an escalating Marauding Terrorist Firearms Attack, and assessing the risk of sending firefighters toward such an incident without sufficient protection, the National Inter-Agency Liaison Officer gave an initial instruction to North West Fire Control to group four pumps (fire engines) at Philips Park Fire Station, which he nominated as the GMFRS rendezvous point. This choice of rendezvous point required two pumps to relocate from the Manchester Central Fire Station, on Thompson Street, which is the nearest to the Arena but which was considered by the National Inter-Agency Liaison Officer as being within the Marauding Terrorist Firearms Attacks Joint Operating Principles defined 500m scene-exclusion zone. It should be noted that even though the Duty National Inter-Agency Liaison Officer suspected a Marauding Terrorist Firearms Attack at this stage, GMP had not shared the fact that Operation PLATO had been declared. This led the Duty National Inter-Agency Liaison Officer to doubt that the Cathedral car park was a sufficiently secure forward control point. Therefore, he tried to speak to the Force Duty Officer to clarify details of the incident and obtain a secure forward control point chosen by someone in full knowledge that PLATO had been declared but could not get through to him on the phone.
- 3.155.** Concurrent to the initial conversation between the National Inter-Agency Liaison Officer and North West Fire Control Operator, a member of the public telephoned 999 from the Arena area to request the Ambulance Service but was accidentally directed to the Fire Service. This call activated an automated pre-alert to be sent out to Manchester Central Fire Station, where it prompted firefighters, some of whom had heard the sound of the explosion, to prepare for mobilisation. However, because North West Fire Control were mobilising resources in accordance with the 'BOMB' action plan, these crews were not activated within five minutes and the pre-alert expired.



- 3.156.** Following their initial conversation, North West Fire Control rang the National Inter-Agency Liaison Officer back and left a message on his phone to notify him of reports of an 'active shooter' that had been passed to North West Fire Control by NWAS. GMP did advise North West Fire Control a minute later that the wounds initially believed to be bullet wounds were in fact shrapnel wounds and, therefore, were not suggestive of a firearms attack. This update was passed to the Duty Group Manager, but this information was not passed directly to the Duty National Inter-Agency Liaison Officer. The National Inter-Agency Liaison Officer then made his own way to the GMFRS rendezvous point from his home (arrived 23:40hrs).
- 3.157.** In addition to the four pumps initially held at the Philips Park rendezvous point (including the two pumps that had been deployed from Manchester Central, thus moving them further away from the scene), a Special Response Team (specially trained and equipped to deal with terrorist incidents), which had been deployed to an unrelated road traffic collision, also deployed to the rendezvous point at Philips Park Fire Station after hearing about the explosion from GMP officers at the road traffic collision scene. This was followed by a second Special Response Team, which was deployed by North West Fire Control from its home station.
- 3.158.** In addition to the Duty National Inter-Agency Liaison Officer, two further National Inter-Agency Liaison Officers were activated, and were directed to the rendezvous point at Philips Park (arrived 23:23hrs & 23:36hrs) and a further National Inter-Agency Liaison Officer booked himself on-duty and self-deployed to the GMP Force Command Module (arrived at 00:04hrs) after a telephone call to a more senior officer.
- 3.159.** At this time, the GMFRS airwave-based radio channel was reported as 'quiet', as was the National Inter-Agency Liaison Officers' national inter-agency liaison channel. This is contrary to other services' channels which were already needing to be boosted to improve their capacity to handle the growing magnitude of radio traffic. At this point North West Fire Control were monitoring the GMP major-incident and other channels, but as no information was being transmitted on those channels there was nothing useful to be relayed to the National Inter-Agency Liaison Officers.

- 3.160.** By 23:40hrs at the rendezvous point at Philips Park Fire Station, there were four fire engines, two Special Response Teams and three National Inter-Agency Liaison Officers. One of the National Inter-Agency Liaison Officers nominated himself as Officer in Charge to give clarity and control at the rendezvous point. However, North West Fire Control were not informed of this until 00:15hrs. At 23:53hrs the National Inter-Agency Liaison Officer, who had now become the Officer-in-Charge, telephoned the Chief Fire Officer, who as Duty Principal Officer, had chosen to position himself in the Command Support Room at Fire Headquarters in Swinton (approximately five miles away from the Arena), with other senior officers. As a result of this call, at 23:58hrs the pumps, Special Response Teams and the three National Inter-Agency Liaison Officers left Philips Park to relocate at Manchester Central Fire Station, on Thompson Street (arrived 00:04hrs), where they joined numerous NWAS vehicles who were rotating between their rendezvous point at the Fire Station, the Arena, the hospitals and back.
- 3.161.** At 00:12hrs, knowing no fire service resources were at the incident yet, the Chief Fire Officer, situated in the Command Support Room at Fire Service Headquarters, telephoned a senior officer in the NWAS that he knew well and who was NWAS Bronze Commander on Victoria Train station concourse. They discussed which GMFRS assets the NWAS Bronze Commander required. Following this conversation and a subsequent discussion between the Chief Fire Officer and the Officer in Charge at the rendezvous point, three pumps and the Duty National Inter-Agency Liaison Officer left the rendezvous point to go to Corporation Street, which was not a declared forward rendezvous point but was 'where they were being asked to go' (arrive 00:27hrs). From there the four vehicles then drove to Victoria station entrance (arrive 00:37hrs).
- 3.162.** The elapsed time between North West Fire Control creating the initial incident log and the arrival of these assets at the scene was 1 hour 59 minutes.
- 3.163.** Following their arrival, further delays occurred before the GMFRS crews entered the concourse to provide assistance in the operation of the Casualty Clearing Station. The firefighters assisted with the remaining casualties until the last one was transported at 02:46hrs and then they assisted NWAS staff to clear their equipment from the Casualty Clearing Station.

- 3.164.** GMFRS stood down from the scene and returned to Manchester Central Fire Station on Thompson Street at 03:08hrs.

### Greater Manchester Fire and Rescue Service: Command Support Room

- 3.165.** Concurrent to the National Inter-Agency Liaison Officer and other GMFRS assets' deployment to Philips Park, GMFRS personnel were initiating a command and control support structure located at their Command Support Room. This became fully operational at 23:30hrs.
- 3.166.** The group deploying to the Command Support Room comprised senior officers including the Chief Fire Officer, who had deployed from his home address in his role as Duty Principal Officer (arrived 23:49hrs), and an Area Manager deployed as Duty Assistant Principal Officer (arrived 23:46hrs), the Duty Group Manager, the GMFRS Resilience Manager and others. In effect, in the early stages of the incident, the on-duty senior officer cadre of GMFRS deployed, almost in its entirety, to the Service's own command and control supporting facility, rather than deploying Silver and Gold Officers to the GMP Force Command Module as other agencies had.
- 3.167.** The GMFRS timeline indicates that senior officers arrived at their Command Support Room from about 23:45hrs onwards, with only the single GMFRS National Inter-Agency Liaison Officer (a Station Manager) self-deploying to the Multi-Agency Force Command Module at GMP Force Headquarters (arrived 00:04hrs).

### Greater Manchester Fire and Rescue Service: Follow-up Operations

- 3.168.** Once GMFRS was represented within the Force Command Module, their role became more effective. After the initially deployed crews were relieved from their duties on the concourse or rendezvous point, some went on to complete their shifts.

- 3.169.** Later that day, a Group Manager was instrumental in assessing the structural safety of the foyer area and as a result GMFRS provided crucial support by ensuring safety provisions were met during the systematic process of removing the deceased from the scene.
- 3.170.** Throughout the week that followed, National Inter-Agency Liaison Officers were also embedded within the GMP Counter-Terrorism Unit to provide specialist tactical advice during the raids and arrests. GMFRS crews were deployed across Greater Manchester to provide public reassurance and to assist the ongoing multi-agency searches, arrests and operations. The GMFRS Volunteers cadre was also a key agency in providing volunteers to help coordinate the public tributes and commemorations in St. Ann's Square.

### Greater Manchester Fire and Rescue Service: Incident Debriefing and Welfare

- 3.171.** Following the stand down of crews from the scene and their return to Manchester Central Fire Station, a senior officer met the crews on the Fire Station apron to conduct a 'hot debrief'.
- 3.172.** Subsequent to this, at 08:30hrs the next morning the on-duty crews went on their four-day-off rotation, returning to work on Saturday 27<sup>th</sup> May. The Panel was informed by GMFRS that upon the crews' return to work on that next shift, arrangements had been put in place for Trauma Risk Management de-fuser sessions to be held with crews and for a follow-on discussion with relevant crews with the Deputy Chief Fire Officer, who had been re-called from his annual leave abroad to do this. There was an expressed desire by fire-crews to hold an immediate debrief with all the officers who had been on duty on the night of 22<sup>nd</sup> May, however, particularly as it was a school half term, several key officers were on holiday and out of the country that week.
- 3.173.** A tactical debrief was subsequently held, led by an independent facilitator and involving the on-duty officers and the junior officers of each of the fire engines involved on the night, the intention being that these officers would represent the firefighters' opinions. Written feedback was also requested from all involved to feed into the debrief.

- 3.174.** Occupational Health Services, the Brigade Chaplaincy Services and the Employee Assistance Programme, in addition to Trauma Risk Management sessions, were provided to those who requested that support. A follow-on offer was also made to all crews, that if they wished, a senior officer from the team exploring the events of the night would specifically visit any watch/crew who so requested.
- 3.175.** GMFRS officers who had been part of that internal debrief process also took part in the structured debriefing that was run later by Greater Manchester Resilience Forum, which contributed to the wider partnership learning.

### **Military Assistance to the Civil Authorities During the Response to the Arena Attack**

- 3.176.** The Government has established plans to provide an effective response to all types of emergencies and major crises at national, regional and local level. This involves pre-planned and coordinated responses from the Ministry of Defence. If there is an emergency in the United Kingdom, local emergency services provide the first response; Government departments or civil authorities may then request military assistance from the Ministry of Defence.
- 3.177.** Military Assistance to the Civil Authorities can be requested to increase the capacity of civil authorities' response efforts, or to expand their capabilities.
- 3.178.** Following an assessment of initial media coverage of the attack, one Military Liaison Officer was already 'en route' to GMP Force Control Room prior to being contacted by the Force Duty Officer as part of Operation PLATO protocol. His deployment meant that the Military Liaison Officer was able to stand alongside the Force Duty Officer and gain crucial situational awareness at an early stage, which informed the development of GMP's request to the Ministry of Defence for specific military assistance. Other Military Liaison Officers had also made their way to the Force Command Module.
- 3.179.** In response to the attack GMP Command initiated the Military Assistance to Civil Authorities (MACA) to request appropriate support from the military. This is a well-

planned-for and rehearsed for process utilised in response to a range of relevant incidents.

- 3.180.** Over the following days, additional assistance from the military was also provided. This included medical expertise provided by staff at the specialist trauma unit at Queen Elizabeth Hospital, Birmingham which directly assisted the attending staff's understanding and treatment of blast injuries. Also, at the request of the Coroner, a team of specialist forensic radiologists assisted with the post-mortem process. During the week, military facilities were seconded for use as local accommodation by personnel operating in the city region under the various Military Assistance to the Civil Authorities arrangements and civil mutual aid agreements.
- 3.181.** When the COBR meeting raised the national security state to 'Critical' from 23<sup>rd</sup> to 27<sup>th</sup> May, the Ministry of Defence also provided armed soldiers to 'augment Armed Police Officers engaged in protective security duties' around the country. However, as sufficient mutual aid and military resources were already present in Greater Manchester, no additional armed military resources were deployed to the city region.

## **Chapter 4 – The Response of the Community, Businesses, Non-‘Blue Light’ Responders and Partner Organisations.**

### **The Civic Response – Manchester City Council**

- 4.1.** Manchester City Council has a fundamental role in responding to and providing civic leadership for major incidents in the city. A wide range of its services were involved on the night and in the nine days of the response phase. The Council quickly enacted its own contingency plans and Greater Manchester’s multi-agency emergency plans which included: the Manchester City Council Emergency Management Framework, the Manchester City Council Multi-Agency Sheltering Evacuees (Reception Centre) Plan, the Greater Manchester Generic Response Plan, the Greater Manchester Strategic Mass Casualties Plan and the Greater Manchester Mass Fatalities Plan.
- 4.2.** Council officers and elected members, including the Leader of the Council, were activated early. The Council’s civil contingency duty rota includes Gold and Silver leadership roles plus a Forward Incident Officer. All were activated smoothly together with communications support. The Chief Executive Officer took a key role outside of the command structure liaising with the Mayor of Greater Manchester, advising and supporting elected members, ensuring resources, including financial, were available and leading on planning for civic and VIP arrangements. Council officers were deployed to three key locations:
- GMP Force Command Module, where the Council Gold Officer arrived by 23:30hrs
  - Manchester City Council Emergency Control Centre, which was operational from 23:40hrs
  - The Etihad Stadium, which was opened as a reception centre for humanitarian assistance from 02:30hrs on Tuesday 23<sup>rd</sup> May with 30 staff from the Council’s Children’s and Adults’ Social Care services.
- 4.3.** The establishment of the Directors’ Suite at the Etihad Stadium as a prospective rest centre was activated through the multi-agency tactical command structure and established by Council staff using a trained and rehearsed process. A clear

chain of command with all staff being aware of which officer was 'in charge' at the centre worked well. The lead officer had relevant experience, training and contacts and was a Suitably Qualified Experienced and Empowered Person for this role. The transition from the envisaged 'reception centre' for children to be reunited with their families to a 'Family and Friends' Reception Centre' happened at 06:30hrs as it was recognised that those in attendance at the centre were the families of those who were missing. About fourteen families, some 150 people, came to the centre and were told that information would be provided to them at that location. Supporting and providing assistance to those directly affected was a priority within the Council's response.

## **Leadership and Community Reassurance**

- 4.4.** The Leader of the Council gave a joint press conference with the Mayor of Greater Manchester from the Town Hall steps at 07:30hrs. It was quickly decided to hold a vigil on the evening of 23<sup>rd</sup> May in front of the Town Hall. Monitoring of social media had shown that there were likely to be large numbers of people coming into Manchester. The vigil provided a managed focal point and allowed for promotion of the key messages of respect and resilience. The vigil was attended by thousands of people comprising the wide range of ethnicity and religious groups which make up Manchester. Attendees held banners and placards proclaiming 'Love not Hate' and 'We stand together'. The vigil was a powerful outpouring of emotion captured by news channels across the world. Whilst national politicians, including the Prime Minister, had arrived in the city that day, the vigil did not include political speeches. The Bishop of Manchester spoke for all faiths and poet Tony Walsh was invited to perform his poem about the city, 'This is the Place'.
- 4.5.** Council officers and elected members held meetings with community and faith groups in the first few days to share information and listen to concerns. These meetings built upon significant relationships that had developed in the city over the last few years, for example through the delivery of the RADEQUAL campaign. Tension monitoring was put in place across Greater Manchester with daily analysis and information sharing. Advice and reassurance was provided to city centre businesses and those within the cordon were contacted to provide support and business continuity advice. The first meeting for the business community,



attended by over 200 businesses, was called by the Council the next day and was also attended by a senior GMP officer.

- 4.6.** The attack occurred during the week in which the Great Manchester Run and City Games were due to take place. The Council Leader told the Panel of his experience visiting a deserted Paris two weeks after the terrorist attack in that city and his determination that the run should go ahead to provide the message that Manchester was open for business. The Chief Constable was in agreement and these significant events in Manchester's calendar proceeded successfully.
- 4.7.** In recognition of the young age of many of the audience at the concert, all Manchester schools were contacted by Council staff within two days of the attack. Many schools reported that staff and learners had been present at the Arena. Head teachers and college principals were kept aware of events, particularly where there was police activity in the vicinity as part of the investigation. Information was provided about how to access employee support and educational psychology support.

## **Managing Public Response and Tributes**

- 4.8.** In addition to the vigil on the 23<sup>rd</sup>, the Council also assisted with the management of a further vigil in St Ann's Square on Thursday 25<sup>th</sup> May to coincide with the national vigil and two minutes' silence. Around 4,000 people gathered to mark the silence.
- 4.9.** In the time between the two vigils, the Council had organised the sensitive movement of the flowers and other tributes which had been placed in Albert Square in front of the Town Hall. The Leader led council volunteers moving each tribute by hand. St. Ann's Square remained a focal point over the next two weeks with an increasing carpet of flowers, balloons, candles and messages. Council volunteers were briefed and prepared for the emotional role of supporting the activity in St. Ann's Square, maintaining a visible presence from 08:00hrs to 22:00hrs each day. Overnight security staff were also put in place to ensure the space was maintained safely and respectfully. A book of condolence was opened at the Town Hall, receiving over 1,000 messages. The Council liaised with bereaved families through GMP and Family Liaison Officers to seek their

preferences regarding the management of tributes and to ensure that items of sentimental value were retrieved.

## **Support to the Investigation**

- 4.10.** The fast-moving police investigations provided a challenge to Manchester City Council and partner agencies. A series of arrests, raids, controlled explosions and evacuations occurred in the response phase. The Council set up reception centres for residents displaced by the police activity, sometimes with only fifteen minutes' notice. Council staff also assisted with the collection of potential evidence and with supporting the response to disruption on road and travel networks. During the nine days of the response phase, the Council continued their presence at the GMP Force Command Module.

## **Establishing the 'We Love Manchester' Fund**

- 4.11.** The Council's previous experience with relief funds had taught them the importance of setting up a legitimate emergency fund swiftly. The Deputy Leader of the Council was involved in setting up the 'We Love Manchester' fund and is Chair of the Board of Trustees. Key organisations who supported establishment of the fund included Victim Support and the Manchester Evening News as trustees, with Barclays Bank and the British Red Cross providing key logistical support.
- 4.12.** The fund was established on 23<sup>rd</sup> May and made its first payments in the same week. There are three wide categories of beneficiaries: those bereaved, those with injuries causing long-term difficulties and those with injuries causing short-term difficulties. A flat-rate award for each category was agreed and initial payments made quickly. The trustees received pro bono legal and financial advice, together with audit arrangements. Manchester's financial community was described as incredibly helpful.

## **Management of Media and Communications**

- 4.13.** There was immediate national and international media interest in the incident. The Council's approach to communications and media was both proactive and responsive, supporting reporting which was seen to be in the public interest whilst

seeking to prevent and mitigate anything detrimental to this. The response included monitoring and responding to all social media, website and press activity and enquiries.

- 4.14.** The Council website received 200,000 visits on 23<sup>rd</sup> May, an increase from around 80,000 per day. Business continuity measures were implemented when capacity issues became a problem. Manchester City Council direct messages via social media platforms increased from 80 per day to over 1,000. Council tweets were retweeted 2.8 million times in one day compared to an average daily rate of 50,000. Following the vigil on 23<sup>rd</sup> May, there were over 30 satellite trucks outside the Town Hall. The response to this was supported via mutual aid from other Greater Manchester local authorities.

## **Manchester Arena**

- 4.15.** The Arena is operated by SMG Europe, a United States-based global entertainment business.
- 4.16.** SMG described to the Panel how each event at the Arena is assessed in advance of being held and a decision made about the level of security and medical cover required. This assessment is based largely on the risk factors associated with the type and size of audience anticipated. Once complete, these risk assessments are sent directly to the venue's multi-agency partners in advance of the event.
- 4.17.** SMG managers also explained to the Panel that they had been involved in multi-agency exercises for a terrorist attack and as a result knew there would be a period of time before the emergency services arrived. Accordingly, this knowledge had been built into their risk assessment process.
- 4.18.** At the time of the bomb detonation, there were five SMG staff members from merchandising in the foyer and some 140 security staff on duty, of which 30 were full-time security staff and the remainder were stewards. The security staff were employed by Showsec, a crowd management, venue and event security specialist company.

- 4.19.** On 22<sup>nd</sup> May, SMG's General Manager was at home and was notified within a couple of minutes about the explosion by the on-site duty manager. The duty manager made the decision to allow the audience exit from the Arena to continue, believing that, as people had already started leaving, this was the safest option. Someone from the performer's team made announcements telling people to stay calm, which is part of the plan covered in the pre-show briefing. For some time, there was also an automated evacuation message sounding in the building.
- 4.20.** Within the first few minutes after the explosion, the duty manager instructed Showsec stewards in the Arena bowl to close the aisles nearest to the foyer exit and for the stewards on the concourse to position themselves to divert concert goers in order, as far as possible, to avoid the public having to witness the scenes in the foyer.
- 4.21.** Staff from Showsec provided an immediate response as the incident was unfolding. They assisted with the management of the crowds exiting the venue and provided care and first aid to those with minor injuries despite being untrained for this role. The duty manager also spoke to the director of Emergency Training UK (who provide first aid services at the Arena during events) to request that he and his team go from where they were in the Arena up to the foyer to assist the victims. The director asked if it was safe to do so but the duty manager could only say that she could see, on CCTV, that there were injured people. Despite not being advised if the area was safe, all thirteen Emergency Training staff, two Emergency Medical Technicians and eleven first aiders either went to the foyer, where the director started a triage process, or otherwise supported those attending to the injured in the foyer. They were soon joined by SMG staff with first aid training, first aid kits and equipment (stretchers and carry chairs) and by BTP officers from the station.
- 4.22.** By 23:00hrs all customers and staff had been evacuated from the Arena other than casualties and those assisting them, together with SMG and Showsec staff in the Arena control room. Armed police had arrived and told staff members they met in different parts of the Arena to leave.
- 4.23.** The SMG General Manager arrived in the Arena control room at 22:55hrs and took over from the duty manager. The duty manager told the Panel that they had

turned off their loud speaker announcements and did not know where the ongoing automated announcement at this time came from. The General Manager provided the Police Bronze Commander with a key allowing access to the entire venue. All personnel in the Arena control room were told to stay there with an armed guard. The Arena was cleared of remaining staff by 03:00hrs with the exception of the senior management, who stayed until 05:40hrs. The following day GMP collected the CCTV servers.

- 4.24.** SMG's senior management relocated to the Bridgewater Hall, from where they were able to instigate disaster recovery plans, liaise with GMP and other relevant parties, liaise with their staff in respect of emotional support interventions and the return of their belongings, and deal with public communications.
- 4.25.** The SMG events staff were left with no work venue, however they met together at a park where they sat on picnic blankets, some held hands, and talked about the night as an informal debrief. About 45 people attended including some staff from Showsec. SMG arranged emotional support for staff very quickly and held group sessions getting the team together to talk. Showsec staff were contacted at home, some within hours, and given information about the Employee Assistance Programme support line which was available to them.

## **Greater Manchester Health and Social Care Partnership**

- 4.26.** Greater Manchester Health and Social Care Partnership delivers health and social care in Greater Manchester via a partnership between NHS England and Greater Manchester local authorities. The Greater Manchester Health and Social Care Partnership strategic duty officer on the night of 22<sup>nd</sup> May was the lead for NHS Emergency Preparedness, Resilience and Response in Greater Manchester, a role he had held for ten years. He liaised early with the Chief Officer and agreed the Chief Officer would take over as Gold Commander the following morning. A recent Greater Manchester exercise had practised the Greater Manchester Strategic Mass Casualty Plan in all hospitals.
- 4.27.** Initially, there was confusion about what had occurred at the Arena. Both Gold and Silver officers deployed to the NWS control centre, a couple of miles south

of Manchester city centre. The Gold Commander then went to GMP Force Command Module.

- 4.28.** The Greater Manchester NHS Incident Control Centre was set up on the morning of 23<sup>rd</sup> May and remained open until the formal handover to the recovery phase on 31<sup>st</sup> May. Members of the on-call teams coordinated the response from the Incident Control Centre in the city centre Greater Manchester Health and Social Care Partnership building. Support was provided in the Incident Control Centre by the Emergency Preparedness, Resilience and Response team and members of the wider partnership team. The Greater Manchester Health and Social Care Partnership Chief Officer took the strategic lead in liaising with NWAS, media, hospitals and NHS England.

## Hospitals

- 4.29.** The Panel met with staff groups from six of the Greater Manchester hospitals. Whilst the experience was different for each location and each staff member, there was consistency in the belief that their recent training exercise (Exercise SOCRATES), based on the scenario of an explosion and active shooter at Manchester Airport, had prepared them well. All were familiar with the plan for specific categories of patient to be taken to specific hospitals and felt the Greater Manchester Strategic Mass Casualty Plan stood up well.

*“I knew what to expect...I had the action plans in my head...didn’t worry about the rest, just my role.”*

- 4.30.** On the night, some hospitals were alerted to a major incident whilst others first found out from social media or when patients arrived in taxis. All the hospitals put into place their plan for increasing bed capacity in preparation. Some described how patients were already getting ready to leave of their own volition having seen the news. However, due to the important time lag before the hospitals started to receive the casualties from the scene as people were triaged and stabilised through the Casualty Clearing Station at Victoria station, doctors were able to focus on treating and clearing patients from the A&E departments in preparation for the main influx of Arena casualties.

**4.31.** All hospitals experienced staff volunteering to come in but there was awareness of the need to maintain cover throughout the week too. Some reported that it was disruptive having staff phoning in and that it would have been better for them to follow procedure and wait to be called.

**4.32.** At midnight, Manchester Royal Infirmary liaised with military surgeons in Birmingham with experience of shrapnel and blast injuries and a team travelled to Manchester the following day. Full-body CT scans were needed for those suffering from blast injuries and this was not initially known by some attending surgeons. One patient reported that this did not happen initially however, the presence of military surgeons together with networking with staff at Birmingham's Queen Elizabeth Hospital, meant that these issues were rapidly overcome. Staff described a steep learning curve on the night, for instance in the need to preserve forensic evidence.

*"I struggled with police coming in during the night...passwords kept changing, I didn't know whether we could give information."*

**4.33.** Staff also told the Review that at first medical teams did not take full account of the need to mitigate the risk of the transfer of infection due to cross-contamination in blood spatter from shrapnel wounds. This risk was identified by Public Health England and NHS staff from the West Midlands. Guidance was issued rapidly to the NHS nationally. Public Health England worked with GPs, acute NHS Trusts and the devolved administrations to follow up relevant patients and offer blood-borne virus testing and Hepatitis B vaccinations at three and six months after exposure. Public Health England also worked with NHS and military staff to develop and share guidance on antibiotic use to prevent bacterial infections in those injured.

**4.34.** Silver command from each hospital coordinated across Greater Manchester so that specialist clinicians moved between hospitals where they were needed rather than transferring patients, with plastic surgeons being one of the surgical teams which used a WhatsApp group to facilitate this.

- 4.35.** Most staff felt that there had been a good health and welfare package for staff subsequently. Many had attended debriefs. Particular mention was made of how helpful sharing experiences and emotions with a senior leader had been.

*“The debrief was helpful...like a group hug.”*

- 4.36.** Mention was made of the benefit gained from the hospital chaplains and of the culture that it was ‘OK to feel bad about something horrible’.

### Arrangements for Mental Health Support

- 4.37.** Greater Manchester Health and Social Care Partnership started work on their strategy and their offer for people experiencing mental health issues as a result of the attack by bringing together clinical experts from across Greater Manchester on a conference call on the 23<sup>rd</sup>. It was recognised that they needed different ‘pathways’ for adults and children and that they needed to get an understanding of the numbers involved and the geographical spread outside Greater Manchester. It was also realised that there was no clear knowledge of the breadth and spread of the mental health network across the voluntary sector.
- 4.38.** The purpose of the call was to develop, coordinate and deliver a recovery offer, including a communication strategy, immediately and over the next few weeks. It was recognised that schools and colleges should be a priority given the makeup of the concert-goers. There were concerns over ‘inappropriate’ assessment, counselling and treatment being offered by ‘pop-ups’ which did not follow the Greater Manchester Health and Social Care Partnership strategy or principles.
- 4.39.** The strategy was to communicate a ‘normalisation’ and support message not only in Greater Manchester but via NHS national networks. The advice given was that directing people into treatment at an early stage was potentially harmful and was an inappropriate response to normal responses which people experience after such an incident. If, after four weeks, people were experiencing difficulty e.g. mood shifts, trouble sleeping, experiencing panic, then they should be pointed to further mental health support. This advice relating to psychological reactions to traumatic experiences was widely circulated within hours of the incident, describing what were normal reactions, when to seek help, and from where to get



help. Efforts were made to circulate these messages through a range of media platforms including digital and broadcast.

- 4.40.** The group of clinicians, mental health policy experts and voluntary sector representatives worked over the first week to draft complementary pathways for adults and children and young people and also recognised the need for family provision. Three phases were identified: phase one covered the first 72 hours and involved 'universal offers of listening for schools, services and general public'; phase two covered the school holiday period and, finally, phase three implemented the screening process. The screening involved completion of a questionnaire so that an assessment could be made of what, if any, support was indicated.
- 4.41.** It was decided to have a central hub to coordinate the screening programme. On 26<sup>th</sup> May, a professionals' helpline was established which subsequently became the number for the Manchester Resilience Hub (outside the timeframe of this Review). It is of note that approximately 80% of the 2,988 individuals currently supported by the Manchester Resilience Hub live outside of Greater Manchester. The Manchester Resilience Hub is supporting individuals from all over the UK (including Scotland, Wales and Ireland), as well as a small number of international victims. Some callers report a perception of a Manchester-centric response when they ring into the Manchester Resilience Hub.
- 4.42.** NHS Mental Health Trusts were supporting many of the wounded and their families in the first few days. In addition to services being offered onsite at the Acute Hospital sites, the phone number and email address of the Manchester Resilience Hub were active within three days of the incident. Initially they were only made available to first responder staff and emergency service staff along with NHS colleagues. The Resilience Hub was supporting other victims within six weeks and officially secured premises seven weeks after the attack.
- 4.43.** The Manchester Resilience Hub was, and continues to be, staffed by clinicians from the regional Military Veterans' Service (hosted by Pennine Care NHS Foundation Trust) due to their expertise in supporting professionals and uniformed services. The clinicians have knowledge and experience of supporting those with trauma following improvised explosive devices and body recovery work.

- 4.44.** A decision was made very early on that as Victim Support had been commissioned by the Mayor of Greater Manchester to provide a 24-hour helpline for all victims, that an additional helpline number for the public to use in relation to the attack may be confusing. Therefore the NHS Mental Health trusts and the Greater Manchester Strategic Clinical Network jointly approached Victim Support, who agreed to act as the front door for everyone needing to access services and to pass on details of those requiring mental health support for the first four weeks. The NHS provided free workshops to the Greater Manchester Victim Support volunteers on dealing with child and young person's psychological trauma.
- 4.45.** The Panel was told that Greater Manchester Health and Social Care Partnership looked at evidence available from previous incidents such as Dunblane and the Tunisian attack, which helped to inform the view that a screening process was necessary.
- 4.46.** The Panel received comments from the NHS Manchester Resilience Hub and the Tim Parry Johnathan Ball Peace Foundation that they have spoken to numerous individuals who felt that a number of well-meaning organisations provided mental health interventions which were damaging. Without any professional affiliation, statutory organisations were powerless to stop this and similar organisations from seeking to get involved.

## Transport and Rail

### Northern

- 4.47.** The buildings and structure at Victoria train station are owned by Network Rail, who subcontract it to Northern. Both organisations played a role in the response to the attack at the Arena.
- 4.48.** Immediately on hearing the detonation, fifteen Northern staff ran to the site of the explosion from Victoria train station. These staff were not medically qualified staff but had received standard first aid at work training. Normal working procedure is for staff to evacuate and stay safe but this was not followed on the night. Once the magnitude of the event was conveyed by the staff in the foyer area to their control

room, more staff were sent with additional medical supplies. The staff were asked to leave for their own safety by police officers but they refused, choosing to stay with the casualties. Once paramedics arrived on scene, the Northern staff assisted with carrying casualties from the foyer to the station concourse, which was the designated Casualty Clearing Station.

- 4.49.** Northern put their three-tier command structure in place with Bronze being the on-call station manager who attended the site. Due to the scale of the incident, the Head of Trains and Stations self-activated on being advised of events at 22:45hrs. She then coordinated the response from home, focusing on which staff were in the vicinity of the site rather than relying simply on the on-call structure. She also had a manager set up a meeting point outside the cordon. The Head of Trains and Stations described her role as ‘taking the lead’ and she worked through the night to rewrite the emergency train plan to bypass Victoria train station. She attended the site at 05:00hrs on Tuesday 23<sup>rd</sup> May. The Bronze Commander liaised with emergency services at their ‘scrum’ meetings, exchanging updates and information.
- 4.50.** On Wednesday 24<sup>th</sup> May, the Northern Head of Trains and Stations along with the Northern Regional Director attended Victoria train station to join a survey of the site to assess its potential to be re-opened as it was no longer classified as a live crime scene. In addition, Northern enacted their crisis management protocols led by the Northern Regional Director, which focused on supporting GMP and BTP on the reopening of Victoria train station.
- 4.51.** In order for the station to become operational as soon as possible, staff from all the agencies worked together. This included a BTP officer who was seconded to Northern, the Head of Trains and Stations and a Network Rail representative co-locating at the station to short-circuit problems and to facilitate contractors’ operations. In addition, Northern attended the GMP Force Command Module on Wednesday 24<sup>th</sup> May, enabling improved communication between transport operators and partner agencies.
- 4.52.** The station was handed back to Northern on 29<sup>th</sup> May, the Bank Holiday Monday. The Head of Trains and Stations then worked with GMP to make arrangements for the visit that evening by bereaved families.

## Network Rail

- 4.53.** Network Rail received reports of an incident at Victoria train station directly into their Manchester control room at just after 22:30hrs. The Mobile Operations Manager for the area was dispatched to the site to gain clearer information. On arrival, the Mobile Operations Manager was appointed Rail Incident Officer. The Rail Incident Officer takes the Silver tactical role in the Network Rail three-tier incident management structure. Once the scale of the incident became apparent a Gold strategic role, Rail Incident Commander, was also activated.
- 4.54.** The Rail Incident Commander assessed the information available at the time including television news reports and established the Network Rail 'Gold Intent' which sets out the incident priorities. As it became known that this was a terrorist incident and that the station would not be operational for at least 24 hours, the Gold Intent was amended to consider the impact on train movements and passenger information the following morning. This involved holding train operator conference calls to update and agree the pre-defined contingency plan for a full closure of the station.
- 4.55.** As soon as access was allowed, Network Rail had a structural and building surveyor on site to make an assessment of the condition of the station including the roof and the block separating the Arena from the platforms. A specialist access team was also on site for hard-to-reach areas. The on-site team worked closely with other agencies such as BTP and GMP to ensure that work was permissible and would not interfere with the criminal investigation. By 23:30hrs on 23<sup>rd</sup> May, the Network Rail structural engineer and building surveyor were satisfied that the integrity of the station building and structure was intact but still considered that work was required to make the station safe.
- 4.56.** On Wednesday 24<sup>th</sup> May, Network Rail were requested by BTP to examine the damage to the Arena's glazed atrium roof. This was undertaken with a Manchester City Council surveyor. The objective was to understand any potential risk from the vibration of train movements. It was found that there was a risk and this information was communicated to Network Rail Gold Commander. A plan was drawn up to provide an understanding of necessary activities to allow the station

to re-open. The outcome of a subsequent conference call was to keep contingency train plans in place, due to the ongoing investigation, with a further decision to be made on Saturday 27<sup>th</sup> May in liaison with Counter Terrorism command. Network Rail Silver Command was on site and so was able to respond rapidly to requests from GMP and Counter Terrorism officers. Network Rail used their existing contractors to swiftly mobilise the necessary specialists.

- 4.57.** The station reopened to train and tram services from 04:00hrs on Tuesday 30<sup>th</sup> May.

### **Transport for Greater Manchester**

- 4.58.** Transport for Greater Manchester is the organisation which delivers the transport policies of the Mayor of Greater Manchester and the Greater Manchester Combined Authority. It works closely with bus and train operators and owns the Metrolink tram system.
- 4.59.** Transport for Greater Manchester is not a designated responder under the Civil Contingencies Act 2004, but is a member of the Greater Manchester Resilience Forum and has been integrated into Greater Manchester's generic response plan through the creation of a 'transport cell'.
- 4.60.** As with all other responders, Transport for Greater Manchester operates an on-call rota. On the night of the incident, GMP had directly notified the Transport for Greater Manchester on-call senior manager. An early discussion between this manager and the Head of Control and Operational Support, based on information available at the time, led to a decision to activate Transport for Greater Manchester's full incident management arrangements. These were live at 23:00hrs with the first full meeting of the Incident Management Team at 23:50hrs. The Gold role was filled by Transport for Greater Manchester's Head of Control and Operational Support, who deployed to GMP Force Command Module where the multi-agency strategic and tactical commanders were based. The Silver role was held by the Business Continuity and Emergency Planning Manager.
- 4.61.** The explosion led to a wider immediate impact on the transport network across the city region. Trains and trams through Victoria train station were suspended or

abandoned and the cordon of road closures impacted on bus and highways services.

- 4.62.** In accordance with the Greater Manchester Generic Response Plan, the Strategic Coordinating Group established its transport cell which was led by Transport for Greater Manchester. This transport cell coordinated the broader transport response, bringing together the key transport partners. Transport for Greater Manchester also took the lead in coordinating Greater Manchester's transport sector social media and acted as the link between the train operating companies, Network Rail, bus operators, emergency services and the Mayor of Greater Manchester's office.
- 4.63.** Transport for Greater Manchester supported NWAS on the night by procuring and mobilising buses and drivers to convey some of the less-seriously injured casualties to hospitals.
- 4.64.** Transport for Greater Manchester stood down their response at 06:00hrs on Tuesday 30<sup>th</sup> May, having maintained a presence in the Force Command Module throughout. Their contribution to the response also included the provision of support to the series of raids which formed part of the police investigation.

## **Manchester Community Groups, Charities and Businesses**

- 4.65.** The Review received some direct responses from charities and businesses but also sought the experiences of others including faith and community group leaders.

### **Community Mobilisation**

- 4.66.** Community mobilisation was rapid. The day following the attack saw hundreds queuing in Manchester to donate blood. Hospitals and police maintaining the cordon received many donations of food from private individuals, community groups and local businesses.
- 4.67.** Numerous people devised initiatives to raise money for the 'We Love Manchester' fund. The Manchester bee symbol gained renewed prominence as hundreds

flocked to take up offers from tattoo artists across Greater Manchester asking for a £50 donation for a bee tattoo. Over 500 people joined the queue at Sacred Art in Chorlton, south Manchester, on the Saturday after the attack. They raised £18,000. The Greater Manchester Tattoo Artists' 'JustGiving' page raised £580,000.

- 4.68.** On Friday evening, hundreds of Muslim children and their families took part in a children's peace walk to the Arena. It was organised by members of a north Manchester mosque to pay their respects.

## Community Engagement

- 4.69.** GMP deployed their lead for Community Engagement, who is also the City of Manchester Territorial Commander, to pick up the community and consequence management element of the strategic response on the morning of 23<sup>rd</sup> May. GMP led the establishment of the multi-agency Consequence Management Cell, which enabled all partners to work together to effectively manage the community and consequence management element of the strategic response.
- 4.70.** GMP deployed high-visibility patrols to areas where smaller black and ethnic minority communities felt vulnerable. The initial period after the attack focused on the investigative arrests and raids. The ability to brief local divisions in advance and provide reassurance was restricted by the need for all GMP communications to be approved by the Counter Terrorism Unit, whereas mainstream media were following police vans and reporting in real time.
- 4.71.** The GMP Chief Constable and Deputy Mayor held a briefing with multi-faith leaders on the 24<sup>th</sup> which focused on listening and reassurance together with building on community strengths.
- 4.72.** The Review received two contributions from members of the Libyan community living in Manchester. Both have been involved in supporting families caught up in the investigation post 22<sup>nd</sup> May. One, a doctor, went to the cordon on the night to offer support. He told the Review that he had met with GMP and the Counter Terrorism Unit at their invitation after the raids. At this meeting he had described the impact of the attack and arrests on families, young people and the community

alongside the damage done to the previously existing trust between GMP and the community, particularly young people.

- 4.73.** The second contributor had also met with GMP and the Counter Terrorism Unit. She told the Panel that whilst GMP, and particularly one Chief Inspector, were ‘brilliant’, she had concerns that the Counter Terrorism Unit were not taking seriously the impact on local people. She was worried that the trust built up over time with GMP would be affected.
- 4.74.** The Lesbian, Gay, Bisexual and Transgender Foundation (LGBTF), based in Manchester, attended briefing meetings with the Council and monitored tensions in the LGBT community. The Foundation was not aware of any increased tension directed at the LGBT community but found that black and ethnic minority members reported an increase in feelings of vulnerability and some hate crime. Support was offered and accepted but this was not an escalating issue.
- 4.75.** The LGBT Foundation also liaised closely with 42<sup>nd</sup> Street (a Manchester-based mental health charity for young people), who were directly involved with those bereaved and injured.

## Charities Involved in the Response

- 4.76.** The Tim Parry Johnathan Ball Peace Foundation, based at The Peace Centre in Warrington, had its first phone call with the Home Office at 05:00hrs on the 23<sup>rd</sup> and agreed to set up an emergency incident room at The Peace Centre which opened at 07:00hrs. A statement was drafted by the Home Office support agencies in the Foundation’s name and released at 08:00hrs. The first people affected by the attack arrived at the Foundation around 12:00hrs. The Centre was visited by the Home Secretary and provided a briefing at 15:00hrs. That day, the Peace Centre issued a message of support on how to talk to children. They produced leaflets with messages of hope and standing together which were distributed at the vigil on 23<sup>rd</sup> May and at the Great Manchester Run at the weekend.
- 4.77.** The Peace Centre told the Review that it was difficult to get its voice heard in Manchester and that the roles of the Council leaders and the Mayor of Greater



Manchester were unclear. It saw a range of ‘advisors’ being utilised by those affected by the attack who were not following the National Institute for Health and Clinical Excellence guidance in relation to mental health after trauma about ‘watchful waiting’. The Peace Centre was also worried about a range of unregulated groups setting up as ‘pop-ups’.

- 4.78.** The day after the attack, the Peace Centre set up a dedicated Yammer (private social network group) site which allows for private communications within a network. The site has one area for the bereaved and one for survivors.
- 4.79.** The Salvation Army deployed three specialist catering vans to the cordon on the night of the attack which fed over 400 people. Salvation Army chaplains visited all Manchester fire stations in the days after the attack as part of their chaplaincy services to GMFRS. As a faith leader, the Salvation Army Senior Officer attended a meeting for faith group leaders with the Mayor of Greater Manchester.
- 4.80.** The British Red Cross psychosocial team provided support to bereaved families at the Friends and Family Reception centre at the Etihad Stadium. British Red Cross worked in conjunction with the Council on the launch of the fundraising appeal and supported the Fund’s trustees. The British Red Cross were also at St. Ann’s Square for the vigil. The British Red Cross launched a support line, operated by 17 staff and volunteers, to provide practical and emotional support. The British Red Cross provided ambulances to a number of hospitals in the area, and ambulance support crews were on standby.
- 4.81.** The Victim Support 24-hour helpline received its first call before 08:00hrs on 23<sup>rd</sup> May. Victim Support’s workers immediately began working with those affected by the attack, providing ‘psychological trauma first aid, emotional wellbeing support, parenting advice and support in accessing specialist support’. Using funding from their contract with the Greater Manchester Combined Authority, Victim Support paid for accommodation and travel for the bereaved across the first weekend. Working with the Mayor of Greater Manchester’s team, the Victim Support helpline was publicised via 20,000 cards and a radio campaign.
- 4.82.** Victim Support participated in a phone conference with the Ministry of Justice, Home Office, Greater Manchester Combined Authority and the Tim Parry

Johnathan Ball Peace Foundation at 09:00hrs on 23<sup>rd</sup> May. Subsequently, Victim Support contacted Police and Crime Commissioners in areas beyond Greater Manchester to promote their phone line. On 26<sup>th</sup> May, Victim Support was contacted by both GMP and Greater Manchester Health and Social Care Partnership wanting to understand Victim Support's role. In the first week Victim Support received more than 241 contacts with the largest number, around a third, being identified as 'struggling to cope'.

- 4.83.** Once Upon a Smile is a small charity which provides emotional, practical and financial support to bereaved families who have lost a child or parent. It is based in Manchester. Within a day of the attack, Once Upon a Smile had set up a 24-hour helpline and launched a social media campaign. Referrals from GMP Family Liaison Officers quickly began to come through using a well-established GMP referral route. In the first week, Once Upon a Smile made attempts to contact a variety of agencies such as Manchester City Council and the Greater Manchester Combined Authority to offer support. The Once Upon a Smile team attended the vigil and maintained a presence at the tribute site in St. Ann's Square. On 30<sup>th</sup> May, Once Upon a Smile were asked to make a support visit to GMP Casualty Bureau staff.

## Businesses

- 4.84.** A small number of businesses participated in the Review. CityCo, the city centre management company for Manchester and Salford, played a key role in sharing information and providing reassurance supported by Manchester City Council. The Chief Executive Officer described spending the night on social media before joining the team in the office at 07:00hrs. The first CityCo meeting was at 10:00hrs, attended by a GMP Chief Inspector, with all businesses in the cordon invited. CityCo attempted to contact all known businesses in the cordon to offer reassurance. They liaised with GMP on behalf of companies who were unable to gain access to their premises. The evacuation of the Arndale Centre, a major city centre shopping complex, on 23<sup>rd</sup> May caused additional disruption and impacted an even higher number of businesses.
- 4.85.** A director of the family-run Street Cars taxi firm participated in the Review. He described how his brother was working on the evening of the attack and saw that

the area around the Arena had been cordoned off. He went back to the office and put a call out to all drivers asking them to help take people to safety. Around forty drivers answered the call and made their way to the Arena. A message was also put on the firm's social media platforms saying that Street Cars were able to give free transport to safe locations. These were mainly the Park Inn and Holiday Inn. The Street Cars' city centre offices were also made available for shelter, phone charging and refreshments. They were able to reunite parents waiting at the Travelodge on Burnley Road with their children. Later other local taxi firms joined in the response.

**4.86.** Selfridges opened on the morning after the attack. It was very quiet but they wanted to send the message that business as usual was going ahead. The police had been clear about the location of the cordon and Selfridges were able to let staff know. They found the business briefings very useful. Selfridges had done a lot of staff training but found the real situation was very different. The Arndale false alarm caused problems due to the lack of communication. Selfridges' staff raised money for the 'We Love Manchester' fund.

**4.87.** The immediate impact on members of the Manchester Hoteliers' Association was for those hotels which were supporting affected families and members of the public. Some hotels provided shelter, use of telephones, food and water, and helped people get back to loved ones. The Association was kept well informed with CityCo briefings every day and was informed of the times at which roads would open. There was a negative impact on customer numbers in the immediate weeks after the attack, partially due directly to the Arena being closed.

*"The emailer's daughter was offered support from a kind lady at Premier Inn."*

*"The caller thought the manager at Park Inn was superb and described his organisational skills as unbelievable."*

**4.88.** The National Football Museum was inside the cordon. The duty manager who responded to the Review had responsibility for security and responding to major incidents for the museum. He had attended training courses to help businesses prepare for terrorist incidents. He was contacted at home on the night of the attack by that night's duty manager advising him that an explosion had been heard and

asking him to check the news. The on-duty manager implemented the museum's major incident plan, which involved locking all external doors and directing all the people inside, who had been attending a product launch, to a designated safe point. The next few hours were spent ensuring the safety and welfare of staff and the 200 guests in the building. At around 02:00hrs, GMP attended the museum to tell them the outside area was now deemed safe and they could leave. Previous training sessions had prepared the staff for exactly these sorts of events.

- 4.89.** The respondee attended the CityCo briefing the next morning having learnt about it via a tweet. Staff were able to regain access to the museum on 24<sup>th</sup> May and opened the cafe facilities to police on the cordon. Staff were all invited to a gathering on Friday 26<sup>th</sup> May in Manchester city centre so that staff could see the building was intact, visit the St. Ann's Square memorial and see that life was continuing in the city. The cordon was lifted on Tuesday 30<sup>th</sup> May and the museum opened the next day.
- 4.90.** Chetham's School of Music is an independent specialist music boarding school directly opposite the Arena. The head teacher lives on site. He was advised of the explosion by the on-site 24-hour security. Pupils in the girls' boarding house heard the explosion. The school has a 'stay put' procedure. Officers on the cordon would not let any staff come into the school and they had no catering team or exam officers to supervise their GCSEs. They were unable to operate as a school so closed early for the half-term holiday, however, most children live overseas and many flights needed to be altered. The head teacher had to plead with police on the cordon to let the children leave and the children were escorted out of the area by police in small groups over the next two days. The head teacher said he was contacted by Manchester City Council's education team, who offered support.
- 4.91.** Trafford College became involved when the bomber's identity was made public as he had been a student at the college at some time in the past. Staff and students were pressed by the media for information. The senior management team spent the days immediately following the attack communicating with parents, staff and students to ensure that none were directly affected and to monitor for any rising tension. The most significant issue for the college was a tweet which erroneously said 'the bomb squad' was on its way to the college. This caused major upset and confusion. Whilst the college put out a correction, nothing was forthcoming from

GMP until much later. At the same time a student known to the Channel team (which works with people seen as being at risk of radicalisation) attended college 'in an agitated state'. Support from the local police was sought and was forthcoming quickly.

- 4.92.** The University of Salford provided information to the Review through their Silver Command and Head of Security, Emergency Planning and Business Continuity. The Silver Command learnt of the attack in the early hours of Tuesday 23<sup>rd</sup> May and initiated Silver Control immediately. His role was to coordinate the internal activation of the university's emergency plan and to manage the public relations' response of the university. The initial priority was to see whether any staff or students had been caught up in the attack. It was not possible to get information from GMP at this time. Using internal systems, within a couple of hours the university had accounted for all students resident in their halls of residence.
- 4.93.** Silver Control included security colleagues from Manchester Metropolitan University and The University of Manchester. This enabled mutual aid between the universities and effective sharing of information from an early stage. However, the university's Silver Control had no obvious way to communicate with GMP's Silver or Gold Control structures.
- 4.94.** The University of Salford learnt the bomber's identity on Tuesday afternoon and, on checking its records, discovered that he had been a student at the university. This information was passed onto GMP as specified in existing communication protocols. There was a significant overt and covert media presence on the campus, with staff and students being pressed for information. These requests were rebuffed robustly and the university's security service escorted press representatives off campus.
- 4.95.** The understanding between the three universities was effective in offering rapid mutual aid when, a few days after the attack, 250 students needed to be evacuated from halls of residence close to a suspect car. The University of Salford was able to offer the shelter required. GMP provided extra patrols on campus, proactively engaging with and assuring students. Staff were asked to come into work to provide extra support and reassurance and the university was inundated by volunteers. The university's social media team was actively engaged in real

time monitoring and they were able to provide effective trusted information and to follow up questions quickly.

## Chapter 5 – Panel Conclusions

- 5.1.** This section covers the findings of the Panel based on the discussions, meetings and other evidence made available which have all been considered in the light of the experiences shared with us by families and those directly affected. Where possible, the specific questions raised by those participating in the Review have been addressed. This chapter draws on all the evidence reported in previous chapters which has been assessed by the Panel and offers their concluding findings of both notable practice and lessons to be learnt. Both identified as recommendations.

### The Emergency Services – Notable Practice and Lessons Identified

#### British Transport Police

- 5.2.** Four British Transport Police (BTP) officers who had been on-duty in Victoria train station and the Arena were the first responders to arrive in the foyer following the detonation of the bomb. Additionally, due to the proximity of the BTP station in Peninsula House, other officers rapidly ran to join their colleagues.
- 5.3.** All of these officers ran toward a completely unknown danger and found a scene of devastation.
- 5.4.** The Panel was impressed to hear of the way in which these officers immediately started to manage the scene and assist Arena staff and members of the public in treating casualties before further assistance arrived.
- 5.5.** The Panel was also aware that, working with Arena staff, rail staff and paramedics, the BTP officers were instrumental in further assisting by initiating the arduous evacuation process that moved casualties in the correct order of priority from the foyer to the Casualty Clearing Station.

- 5.6.** Panel members were particularly impressed by the actions of the BTP Sergeant at the scene. His clear concern had been to take on the initial Bronze Command of the incident, coordinate with his control room and oversee casualty care, but he also reflected genuine anxiety at the time over the safety and welfare of his colleagues.
- 5.7.** It is the Panel's opinion, therefore, that BTP were an integral part of the multi-agency response that night. In addition, it was made clear by several contributors that BTP's work ensured that the re-opening of the station could be conducted efficiently and with sensitivity. This included a supporting and liaison role, in particular that of the officer seconded to the Northern team, who liaised between rail operators and GMP's criminal investigation that week.

## Greater Manchester Police

### Force Control Room Capability and Capacity

- 5.8.** As the attack occurred, GMP Force Control Room was operating on staffing levels for a normal Monday night shift, which were inevitably lower than would be expected on a busier Saturday night, for example.
- 5.9.** This meant that as the incident developed, it rapidly started to consume the capacity of the available staff. In reviewing debrief material, however, the Panel has found that the operation of the Force Control Room and the continued professionalism of the Force Duty Officer, despite the pressure he and his staff were under that night, drew praise from across GMP. However, for the Duty National Inter-Agency Liaison Officer in GMFRS, the demands on the Force Duty Officer created significant difficulties in getting through to talk to him. As we describe later, this contributed to the problems that the Fire and Rescue Service subsequently experienced.
- 5.10.** The Panel has also reviewed GMP's internal debrief material, which makes clear recommendations in relation to mitigating identified weaknesses in the communications systems (i.e. IT, geographic and personnel/training). The Panel, however, felt it necessary to comment on two issues that related specifically to Force Control Room capabilities and capacities.



- 5.11.** In relation to operating on Monday-night staffing levels, the Panel was surprised to learn that 45 minutes into this escalating incident, the Force Duty Officer had to release the Duty Supervisor in order for him to travel a 'ten-minute drive' from the Force Control Room to GMP Headquarters to assist in the activation of the Force Command Module. It is the Panel's opinion that this may have placed additional pressure on the staff in the Force Control Room in terms of continuity, who were needing to coordinate and record details of the movements of, an increasing number of personnel and assets, many of which were in the direct vicinity of a potentially escalating terrorist incident.
- 5.12.** The Panel recognises that the Force Command Module cannot be held in a state of operational readiness at all times and therefore when 'no-notice' incidents occur, on-duty staff will need to be released to activate the command module's various systems.
- 5.13.** Accordingly, the Panel has been reassured to hear that planning is underway to re-site the Force Duty Officer's work station to within the GMP Headquarters building. Not only is that likely to increase the speed and efficiency with which the Force Command Module can be activated during major incidents, but the proximity between the two facilities may also allow more effective links between the Force Duty Officer and Gold and Silver officers in the initial stages of a developing incident.

**Recommendation: Greater Manchester Police should continue with its plans to relocate the Force Duty Officer into the Greater Manchester Police Headquarters building.**

- 5.14.** It is important, however, for business continuity that the capacity to manage all incidents is not condensed into a single control room. Capacity and capabilities need to remain for major incidents to be managed, if necessary, by a dedicated tactical commander in parallel to the Force Duty Officer's operation of 'business as usual'. The fact that the Arena attack occurred on a relatively quiet Monday night should not obscure the possibility that a future terrorist attack may occur at a much busier time.

- 5.15.** A further issue related to Force Control Room capability was revealed during the night as Armed Response Vehicles and other assets started being deployed into the GMP area by neighbouring police forces. This mutual aid provided crucial firearms capacity that was deployed across the city region in response to incidents. However, a notable challenge did occur, whereby the Force Duty Officer could not track the location of these out-of-force assets using the control room mapping systems. Whilst GMP operates an Automatic Resource Location System for its personnel and assets, neighbouring police forces do not use the same IT systems, so their personnel and assets could not be tracked on the GMP system. However, the Force Duty Officer and his support team utilised the national firearms channel to resolve this issue and there was no detriment to operations or public safety.
- 5.16.** Given that, at least initially, some of the additional incidents on the night of the attack appeared to bear the hallmarks of an escalating and distributed terrorist attack, there was a pressing need to be able to deploy armed assets from outside GMP to these incidents. In these instances, it is the Panel's opinion that the Force Duty Officer's inability to monitor the location of responding Armed Response Vehicles and other armed personnel on a national system could easily have introduced avoidable risks to public and responder safety (e.g. because the Force Duty Officer did not know which was the closest asset to deploy).
- 5.17.** GMP have been forthright in reassuring the Panel that the Automatic Resource Location System issue did not detract from the response on the night. However, this issue is not new and the Panel has taken specific note of similar challenges in a police force's ability to monitor firearms assets during the Derek Bird shootings in Cumbria in 2010. Accordingly, the Panel felt it to fall within its prerogative to highlight this as a persisting problem in need of a nationally agreed resolution.

**Recommendation: Greater Manchester Resilience Forum members should clarify their joint operating procedures in relation to the declaration of multi-agency forward control points, rendezvous points and marshalling arrangements during terrorist incidents and suspected terrorist incidents.**

**Recommendation: The Home Office and National Police Chiefs' Council (NPCC) should actively review and enhance the interoperability of Automatic**

**Resource Location Systems between force areas, with precedence being given to improving the nationwide geo-location of Operational Firearms and Counter Terrorism assets.**

**The Role of the Strategic Coordinating Group Chair Following the Arena Attack**

- 5.18.** The coordination of the response to the Arena attack, initially by the GMP Force Duty Officer in the Force Control Room and then by the Strategic and Tactical Coordination Groups in the Force Command Module, worked effectively. In the Panel's opinion, this coordination ensured the provision of an impressive degree of multi-agency support and access to a complex range of capabilities and capacities for those responders on the ground.
- 5.19.** The broad effectiveness of the coordination activity that night is clearly a consequence of the professionalism with which the Greater Manchester Resilience Forum partnership has actively engaged and collaborated in planning, training and exercising contingencies for emergencies as part of their business-as-usual activities. However, whilst it is important to acknowledge this notable success, it is also important to identify where the Panel believes that lessons can be learnt.
- 5.20.** In terms of understanding the complexities of multi-agency coordination, what is clear from the Panel's analysis of the initial response to the Arena attack, is that combining multi-agency coordination with Counter Terrorist operations is an exceptionally hard balancing act to achieve. Furthermore, if the requirement for this coordination falls on a Police Gold Commander (GMP Gold) who is concurrently also managing the responsibilities of the Duty Strategic Firearms Commander, then that individual's effectiveness will be tested.
- 5.21.** On the night of the attack, the GMP Gold role was taken by a senior GMP officer with clearly sufficient seniority, respect, experience and training to carry out this role. This included recent experience as portfolio holder for Counter Terrorism and Serious Crime. She was also the Duty Strategic Firearms Commander on-call in that role that night. Whilst it may be asserted that one person simultaneously adopting both of these demanding roles would bring clarity and simplicity to the

command structure, in reality the huge demands placed on each role by an incident of such magnitude as the Arena attack would have been a challenge for even the most experienced commanders.

**5.22.** The task faced by the GMP Gold in the early stages of the incident was therefore enormous. This was recognised by GMP Gold at an early stage and attempts were made to identify an additional experienced specialist Strategic Firearms Commander. Her duties in coordinating the Police response to the attack, initially by telephone and then through attendance at the Force Command Module, were inevitably complicated by the multiplicity of her roles.

**5.23.** In many ways, it is fortunate that the GMP Gold was so experienced. This meant that this officer had a clear understanding of the right resources, solutions and personnel that would be needed to respond effectively to the attack and to mitigate any on-going threats.

**5.24.** However, by being drawn into command decisions to resolve issues of a more tactical nature related to the Arena attack and a series of other incidents around Greater Manchester, identified in Chapter 3 (The Response of Greater Manchester Police to the Arena Attack), it is the Panel's opinion that two key strategic oversights by the GMP Gold adversely impacted upon the initial coordination of the multi-agency response.

**5.25.** These oversights were:

- Confusion was expressed amongst partners caused by the lack of communication of the declaration of Operation PLATO by GMP
- There was comment by partner agencies that the Strategic Coordinating Group (Gold Group) was not managed in a way that had been anticipated, planned or trained for.

**5.26.** Operation PLATO was declared at 22:47hrs by the GMP Force Duty Officer. Following this declaration, the GMP Strategic Firearms Commander (also the Duty GMP Gold) was informed of the decision as soon as was practicable. His declaration of Operation PLATO gave him, as the GMP Force Duty Officer, the

authority, as Initial Tactical Firearms Commander personally to initiate requests for mutual aid from, for example, other police forces and for military assistance.

**5.27.** What this declaration allowed for was the surging of firearms capability toward Greater Manchester in order to stop a Marauding Terrorist Firearms Attack.

**5.28.** However, this declaration was not explicitly shared with GMP's two principal partners until:

- The GMFRS National Inter-Agency Liaison Officer who attended the Force Command Module to take on a 'Silver' role overheard a conversation about the declaration at 00:15hrs
- The NWAS Gold Commander at the Force Command Module directly asked the GMP 'Silver' for Operation PLATO's status at 00:18hrs.

**5.29.** The considerable delay in GMP sharing this information directly with partners contradicts the Joint Operating Principles, which state:

*"Information on a suspected Marauding Terrorist Firearms Attack should be shared amongst emergency service control rooms immediately. The police are responsible for formally declaring that a Marauding Terrorist Firearms Attack is occurring and that the response, Operation Plato, will be used." (Joint Operating Principles v.3: p.9)*

**5.30.** As was discussed in Chapter 3, on the night of the attack, the expectation rested on the GMP Force Duty Officer to share this information. However, this was not done because of:

- The direct responsibilities that the declaration of Operation PLATO placed on this individual (e.g. requesting Military Assistance to the Civil Authorities; requesting Mutual Aid)
- The intense activity on-going in terms of the Force Duty Officer's need to manage the GMP response to the attack and all other incidents in the GMP area.

- 5.31.** During the Review, the Panel has also become aware of an assumption on the part of GMP in relation to their understanding of the Operation PLATO declaration on the night of the attack. This assumption was built on the perception that because GMP's principal partners were aware of a potential 'active shooter' in the vicinity of the Arena from just after 22:40hrs, this equated to them being aware that the Operation PLATO multi-agency Marauding Terrorist Firearms Attack response had been put in place by GMP. However, what the Panel has discovered is that this assumption is not supported by the experience of GMP's principal partners.
- 5.32.** Following numerous discussions with the Fire and Rescue and Ambulance Service personnel, it has become clear to the Panel that although the 'active shooter' information led to these organisations mobilising preparatory measures for a Marauding Terrorist Firearms Attack response (e.g. GMFRS deploying its Special Rescue Teams to Philips Park), these deployments were conducted in a precautionary manner, i.e. effectively in case Operation PLATO was declared. It was repeatedly stated to Panel members that when it was realised, at past midnight, that Operation PLATO had been declared, Fire and Rescue and Ambulance personnel were surprised to the extent that they perceived the information as 'a game changer' in terms of how they understood their response to that point.
- 5.33.** It was made clear to Panel members that had NWS been aware of the Operation PLATO declaration at 22:47hrs, this may well have influenced their decision to move ambulances and personnel forward, (i.e. it was only after NWS Bronze's receipt of the information at past midnight that he and the Ground-Assigned Tactical Firearms Commander were able to deliberate the 'Operation PLATO is on stand-by' status). Also, as regards the GMFRS National Inter-Agency Liaison Officers, their perception was that if they had known of the declaration at 22:47hrs, rather than learning about it at 00:20hrs, that information would have influenced decisions to deploy the Special Rescue Teams forward earlier, even though they would still have lacked clear situational awareness.
- 5.34.** Whilst these scenarios did not play out, the Panel believes that the experience of GMP's partner agencies on the night illustrates the importance of all resilience

forum members formulating their multi-agency emergency plans using clearly deliberated and shared understandings of procedures.

- 5.35.** Given these conflicting pressures and the assumption-based misunderstanding, the Panel does not feel that it would be appropriate to criticise the Force Duty Officer in regard to his not confirming, categorically, that partners were aware of the Operation PLATO declaration. It is however important to question the level of expectation placed on the Force Duty Officer role during major incidents. GMP have indicated an intention to review the existing control room procedures, particularly the role of the Force Duty Officer and to explore opportunities for accelerating the provision of dedicated incident management support to the Force Duty Officer in the event of a major incident being declared. This is welcomed by the Panel.

**Recommendation: Greater Manchester Police should review its Force Duty Officer protocols to identify ways to reduce the task load placed on the Force Duty Officer during major incidents.**

- 5.36.** In relation to interoperability, the Panel also welcomes the subsequent decision of Greater Manchester Resilience Forum partners to install a dedicated and regularly tested radio talk-group that now operates between the three control rooms. This action will make it significantly easier for the Force Duty Officer to contact partner organisations and is, therefore, likely to reduce pressure on the Force Duty Officer role and improve shared situational awareness during major incidents.
- 5.37.** However, the delay of GMP to actively share the Operation PLATO information to partners within the Force Command Module until after midnight illustrates a different problem. The GMP Gold may have expected the Operation PLATO declaration to have been communicated to other agencies by the Force Duty Officer, for example. However, by choosing not to convene a Strategic Coordinating Group 'Gold Group' at the earliest opportunity, it is the Panel's belief that the GMP Gold missed a critical opportunity to use the Strategic Coordinating Group as a backstop to both tell partners of the declaration, and also to consider and agree actions to offset the potential effects of declaring Operation PLATO on the multi-agency response in a fully informed way.

- 5.38.** Within minutes of declaring Operation PLATO, the Force Duty Officer had been required to make a 'life or death' decision whether to allow responders to remain in the Arena foyer to carry out first aid, when Operation PLATO protocols demanded that all personnel be evacuated. In effect, the Force Duty Officer had been required to decide whether ballistically unprotected responders should be left in what he considered at that time to be a 'hot zone', or whether they should be moved back to the 'cold zone', in accordance with Joint Operating Principles (see Chapter 1). It was the Force Duty Officer's decision to let the responders stay in place. It is the Panel's belief, in terms of protecting saveable lives, that this was one of the most crucial decisions taken on the night, and the Force Duty Officer should be congratulated for this dynamic decision making.
- 5.39.** The Panel, therefore, fully supports the Force Duty Officer's decision to allow responders to remain in the foyer from early in the incident, before the Ground Assigned Tactical Firearms Commander re-designated the area as a 'warm zone' soon after his arrival at 23:23hrs. However, one effect of the Force Duty Officer's decision was that because personnel were not called out and there was no visible retreat of GMP from the foyer, there was also no visible indication to other responders on the ground that Operation PLATO had been declared. Accordingly, nobody at the scene, outside GMP, was asking their commanders for guidance on how they should integrate Operation PLATO protocols into their activities.
- 5.40.** This meant that for around an hour and a half Strategic (Gold) and Tactical (Silver) priorities were being developed by GMP's partners, without their full understanding that their actions should have been, if not dictated by, then at least informed by, Operation PLATO protocols. This may not have made any difference to the way the partners' operations were being conducted. However, as stated above, there was a real possibility that had NWS been notified immediately of the Operation PLATO declaration, then they may have adopted the same procedure as GMFRS and enacted an initial 500m exclusion zone. This would have slowed the process of casualty triage, treatment and transportation markedly. That this did not happen is regarded by the Panel, in hindsight, as fortuitous.
- 5.41.** However, GMP's declaration of Operation PLATO then continued not to be shared with two key partners for an hour and a half. This suggested to the Panel that



GMP, as lead responder and a principal Greater Manchester Resilience Forum member, missed a critical opportunity to deliberate the strategic challenges faced in the coordination of an interdependent, multi-agency Operation PLATO incident response with co-responding partners.

**5.42.** From this perspective, it becomes clear that this secondary failure in the communication of Operation PLATO could be at least partially attributed to the decision by the GMP Gold to delay the formal meeting of the 'Gold Group'/Strategic Coordinating Group. This delay was explained by GMP Gold as being due to her sense that the agencies in the Force Command Module were satisfied with round-the-room updates. Her impression was also that the dynamic nature of the on-going response meant that holding a Strategic Coordination Group meeting would have placed unnecessary additional time pressure on partners' activities.

**5.43.** However, even though 'round the room' updates were reported to have occurred, it remains the Panel's belief that because there were so many people in the room (70–100), this approach to bringing the Gold Group strategic-level partners up to date with critical issues during a major incident (e.g. status of Operation PLATO) was simply inadequate. Had a Strategic Coordinating Group been called, relevant Gold level officers from appropriate organisations would have been requested to attend Force Command Module. Also, relevant agencies would have been able to ensure their tactical and operational plans had been and were being developed and deployed in full recognition of the relevant intelligence GMP held about Operation PLATO. This does not infer that all those agencies would have necessarily changed all or any aspects of their plans but others may have.

**Recommendation: Potential Strategic Coordinating Group Chairs should pursue a clear objective to undertake a Strategic Coordinating Group update briefing (physically or virtually) within two hours of the declaration of a major incident.**

**5.44.** Another concern for the Panel with this approach was that it has become obvious during the Review that Greater Manchester Resilience Forum members and partners have a well-developed and successful planning, training and exercising regime. These activities have prepared the Gold Group personnel across the

partnership for major incidents to be conducted using the Strategic Coordinating Group to develop strategic direction. It was, therefore, troubling for the Panel to hear stated several times that senior officers from other agencies had been surprised when a new, unpractised, approach was adopted by the lead responder (GMP) during this extremely challenging real-time major incident.

- 5.45.** Taking these factors into consideration, the Panel believes that it is important to state that criticism is not being pointed directly at the GMP Gold. As has been explained, the Panel believes that too great an expectation was placed on her following the attack to deliver two high-pressure strategic roles simultaneously for too long (i.e. GMP Gold and Specialist Strategic Firearms Commander). Rather, the Panel wishes to take this opportunity to recommend that GMP review its procedures for nominating strategic commanders and for providing command resilience across capabilities rapidly during major incidents (for example they may choose to separate the roles of Strategic Firearms Commander away from the role of Duty Gold).

**Recommendation: Greater Manchester Police should develop sufficient senior-officer capacity and capability to ensure that single officers are not required to manage multiple strategic roles simultaneously during major incidents.**

## Identification of the Victims and Support for the Bereaved

- 5.46.** Even though the decision to activate a Casualty Bureau was taken by the Police Gold Commander at an early stage, there followed a significant period of time before the necessary arrangements were in place for it to open itself up to receive direct calls from the public. In the interim, at a time when families' anxieties were at their highest, there was no single point of contact for them to report their concerns or for that information to be recorded in a structured way that avoided the need for repetition with each subsequent call. As a result, potential casualty data was held in disparate locations until the Casualty Bureau was in a position to collate it, several hours later. This not only exacerbated families' anxieties at the time but also had the potential to impact adversely on the Disaster Victim Identification process when seeking to reconcile casualty data from the scene.

**Recommendation: In the immediate aftermath of a mass fatalities incident, police forces should consider how they might establish effective arrangements for the collection, collation and retrieval of potential casualty data, during the inevitable period between the event occurring and the Casualty Bureau being fully operational. These arrangements should be made public at the earliest opportunity so that those wishing to report their concerns have absolute clarity about how to do so. The recent establishment of the Public Portal facility for the Casualty Bureau will help to address this issue in the aftermath of a mass fatalities incident.**

**5.47.** The Panel was informed that when the Casualty Bureau manager did attempt to activate the National Mutual Aid Telephony arrangements provided by Vodafone, there was a 'catastrophic failure' in the system which meant that an 0800 number could not be issued to the public. The Panel has been informed by Vodafone that two failures occurred:

- The 0800 number allocated by the Home Office's Police National Computer service team from the bank of numbers they had available had recently been used for another incident in another force, and the recorded message on that 0800 number had not been cleared by the Police National Computer/the other force when the incident closed. This meant the number allocated by the Police National Computer to GMP still carried the message from the previous force's incident.
- As one of the servers on the platform was at capacity, the greeting message could not be recorded over. If an 0800 number had been allocated with no pre-recorded message, then the 0800 number could have been issued and would have routed calls correctly, albeit without a Manchester Arena specific greeting message.

**5.48.** The Casualty Bureau manager made immediate contact with Vodafone in an attempt to rectify the failure and to stress the urgency of having a fully functional Casualty Bureau in place in response to the Arena attack. The Panel was informed that the Vodafone representative had little knowledge of the Casualty Bureau arrangements and referred the Casualty Bureau manager to another company called Content Guru, to whom Vodafone had sub-contracted technical guardianship of the service. Again, the Panel was informed that the Content Guru

representative had little knowledge of the police requirement or the vital role the Casualty Bureau contributed to the response operation.

- 5.49.** It would appear from what the Casualty Bureau manager was told by Content Guru that there had been a major failure of the server in place to deliver the Casualty Bureau capability. A total of eight servers were in place to enable the call taking workload to be spread evenly across them. When a new message is recorded, it is uploaded to each server to ensure consistency. In the event that any of the servers cannot load the new message the system rejects the attempt to upload the message to ensure all servers hold the same message for that incoming line. On 22<sup>nd</sup> May, one server was at capacity as its memory was full. This meant it was unable to accept the new message, leading to the message being rejected across all the servers and, effectively, leading to the service failure.
- 5.50.** By 02:30hrs on Tuesday 23<sup>rd</sup> May, sufficient call takers had been mobilised and were in attendance at the GMP Casualty Bureau, located at Sedgley Park (approximately four miles from GMP Headquarters), to enable it to go live. At this time, the call information received through the other points of entry into GMP was being passed through to the Casualty Bureau team and being collated. However, as a result of the failure of the National Mutual Aid Telephony system, it was not yet possible to activate the usual national arrangements.
- 5.51.** In light of these problems, the Police Silver Commander made the decision for the Casualty Bureau to go live utilising a local (0161) number which although routing calls into the Casualty Bureau, provided significantly less capacity than would have been the case with the national arrangements. At that time, call taking was limited to the twenty operators physically based at Sedgley Park. Due to this limited capacity, the Panel was informed that calls from the public would still have been received in other police control rooms across GMP.
- 5.52.** Operators receiving calls from the public in other police control rooms across GMP or indeed in other parts of the country would not have had access to the Casualty Bureau computer system if the caller was dialling 999 or 101 from a location outside Greater Manchester, and therefore any reference numbers provided would inevitably have been different to what would ordinarily be provided and in fact were subsequently provided to callers speaking directly to the Casualty

Bureau once established. It is the Panel's view that failure to active the National Mutual Aid Telephony arrangements at an early stage was a significant contributing factor to the difficulties experienced by families, outlined in the following paragraph.

- 5.53.** In their conversations with the Panel, families and other members of the public expressed concern about the absence of a cohesive approach to the collection of casualty information and frustration at the need to repeat everything several times over when making further calls relating to their loved ones. Instead of being given a single reference number to quote when calling again, they reported being given multiple different call references which seemed to mean little or nothing to the next person taking their call. This was described as a continuing issue until well into 23<sup>rd</sup> May, with the greatest problems being in the immediate aftermath of the attack when their anxieties and need for information were at their greatest. The Panel was also told of a concerned family being advised by a [unidentified] police officer on a cordon to 'go around the hospitals' in an attempt to find their loved one in the absence of any information being provided to them by the police.
- 5.54.** Aside from the inevitable delay in formally establishing a Casualty Bureau in any circumstances, it is clear that in this case there were further unacceptable delays caused by the failure of the telephony arrangements provided by Vodafone. From the information provided to the Panel, it would appear that the fall-back solution in place in the event of critical server failure did not get activated due to the inability to amend the recorded message and technical difficulties with the server. This suggests there was an inadequate level of knowledge or expertise within Vodafone or its sub-contractor Content Guru.
- 5.55.** Since May 2017, the Home Office has been engaged with Vodafone to explore the reasons for the failure of the National Mutual Aid Telephony system on the night of the attack and to gain reassurance that no such failure will occur again in the future. The Panel has also received written correspondence from Vodafone UK in which their Chief Executive Officer offers formal and personal apologies for the failure and for the impact on those affected by the attack, gives assurance that steps have been taken to avoid a repeat of this failure including migrating the service to a new platform with necessary fall-back, as well as ongoing and rigorous testing and monitoring of the system.

**Recommendation: In order to safeguard the future integrity of the National Mutual Aid Telephony system, the Home Office should urgently secure appropriate guarantees from Vodafone that the necessary fall-back and disaster recovery arrangements are in place to address the failures which occurred on 22<sup>nd</sup> / 23<sup>rd</sup> May 2017.**

- 5.56.** The Panel was informed that no Senior Identification Manager had been appointed at the time when the decision was taken to activate a Casualty Bureau. Opinions differed as to whether this had any material impact upon the setting up of the Casualty Bureau and whether the decision to do so had been taken too soon but it is agreed that establishment of the Casualty Bureau did not take place under the guidance of an appointed Senior Identification Manager. In the absence of such, the Casualty Bureau manager drafted the instructions for the call takers to use when receiving calls from the public.
- 5.57.** Whilst under the national guidelines, the Senior Identification Manager has responsibility for setting the casualty strategy, it would appear that in this case, the impact of not having a Senior Identification Manager appointed at the time of activation did not have a detrimental effect on the effectiveness of the response. The experienced Casualty Bureau manager was involved at an early stage and was capable of producing the general guidelines for call takers to utilise, without the immediate involvement of the Senior Identification Manager. The two spoke on the telephone at around 01:00hrs on the night and the Senior Identification Manager was therefore able to endorse the guidelines and provide strategic oversight of the Casualty Bureau function. The early availability of a Senior Identification Manager will vary in individual circumstances and although every effort should be made to involve her/him in the Casualty Bureau activation, the Panel does not feel that there is a need to make a specific recommendation on this issue.
- 5.58.** The Panel examined the work of the Greater Manchester Mass Fatalities Group, both as a means for establishing agreed policies and procedures through discussion, training and exercising and as a team of professionals coming together as the Mass Fatalities Coordinating Group to deal with the events of 22<sup>nd</sup> May and the days that followed. It was clear that the preparatory work put in place

over many years enabled the response on the night to be timely, effective and efficient. There was considerable praise for the way in which local partners worked together, especially Her Majesty's Coroners and the Police, and for the contribution made by national assets such as the military (provision of medical scanning equipment) and UK Disaster Victim Identification (the provision of national expertise and guidance) amongst others. It is also the Panel's view that the Coroners involved in the response to this incident worked effectively together, as a direct result of their preparatory planning and a shared understanding of roles.

- 5.59.** The Panel heard from families of their frustrations, anxieties and in some cases, anger at the time taken to provide them with information about their loved ones, particularly those who it was reasonable to conclude had died as a result of the attack but no formal confirmation was being given by the Police. One family complained that with no information forthcoming after many hours, it was only when a threat was made to 'go to the media', that they were told their loved one was amongst the deceased. There was a clear demand for information which those affected felt was not being met within an acceptable timescale.
- 5.60.** It was difficult for them to comprehend why they received no information for many hours, when they themselves were convinced that their loved ones were involved and had had no contact with them since the time of the explosion. Differing views were expressed by the families as to why this happened, from the police not actually knowing what was going on, to the Police being fairly sure of the identities of the deceased but being unwilling to say anything for fear of getting it wrong. Whatever the reason, families felt that they were not provided with the information they needed quickly enough.
- 5.61.** In any mass fatalities incident where Disaster Victim Identification procedures are required to establish the identities of the deceased, evidence is required to allow an accurate identification to be made in accordance with the Coroner's directions. This systematic recovery of each victim can only happen once there is an understanding of the incident scene, casualties have been removed and the site is secure, so will therefore inevitably take time. Although this is understood by Disaster Victim Identification practitioners and those involved in the identification process, it is not something which distressed families or the wider public could

reasonably be expected to understand or to accept, when the fate of their loved one(s) is still unclear. The Panel believes there has to be a balance between safeguarding the integrity of the identification process and the provision of early indicative information to families that their relative is likely to be one of the deceased victims.

- 5.62.** The Panel has heard from bereaved families that more could have been done to provide them with clear information about the Disaster Victim Identification process at an early stage, to give families a better understanding of what the process entails and the amount of time needed to secure an accurate identification in every case. It has been suggested that this information could be provided by way of a written document, given to families in conjunction with a personal explanation of the identification process, so that they have a definitive source of information to refer to at each stage. The Panel supports this suggestion and would welcome further consideration by Disaster Victim Identification professionals to produce such a document for use by bereaved families in mass fatality incidents.
- 5.63.** As mentioned above, the process of recovering the bodies of the deceased victims following the Arena attack was conducted one by one, ensuring that the dignity of the deceased was properly balanced with the need for crime scene investigation and forensic retrieval. In practical terms, this meant that it was many hours before the final victim was recovered and transferred to the designated mortuary. As each victim was examined at the scene, pertinent details of their personal belongings and clothing were communicated to the Senior Identification Manager, enabling each family in turn to be informed of the findings. In those conversations with families, the Coroner, Bereavement Nurses and police officers sought to make it clear to them that whilst it would be some time before an official identification would be made through the Identification Commission process, all the indications were that their loved one was among the deceased.
- 5.64.** Although the process of informing families took longer than they were satisfied with, the Panel was advised that all those known to be directly affected were allocated a Family Liaison Officer by 16:00hrs on 23<sup>rd</sup> May at the latest. Family Liaison Officers were deployed as early as possible to any family reasonably



thought to have been bereaved or to families of those critically injured. Of note there were 641 people reported missing to the Casualty Bureau.

- 5.65.** Once appointed, these Family Liaison Officers then provided an essential link between the families and the police – something which many families spoken to regarded as particularly valuable at the time of the incident and for many weeks and months thereafter. The Panel also welcomes the fact that the Family Liaison Officer allocation extended to some of the severely injured and their families and that the provision of this service was clearly valued by those in receipt of it.
- 5.66.** Some concerns were expressed about the consistency of the Family Liaison Officer service, particularly for some families outside Manchester itself. Examples were recounted to the Panel of a differing frequency of contact and the regularity of hospital visits by individual Family Liaison Officers. Some families also expressed concern at having their designated Family Liaison Officer changed, sometimes without prior warning. However, the vast majority of comments received in respect of the service provided by Family Liaison Officers (and the Bereavement Nurses) were very positive and it is clear that they offered valuable support to families in their time of need. In many cases, this valuable support is ongoing as the criminal and coronial investigations continue.

**Recommendation: Whilst having regard to the integrity of the formal identification of the deceased victims in mass fatality incidents, those involved in the Disaster Victim Identification process should continue to take every opportunity to share emerging information with families which would indicate that their loved one is more likely than not to be amongst those who have died.**

**Recommendation: The National Police Chiefs' Council and the College of Policing should explore the production of an appropriate written document to be provided to bereaved families in mass fatality incidents, explaining the Disaster Victim Identification process and the amount of time needed to secure an accurate identification in every case.**

**Recommendation: In order to achieve consistency in the service provided, where Family Liaison Officers from different police forces have been**

**allocated to families directly affected by a mass fatality incident, they must all operate strictly in accordance with the strategy and associated procedures specified by the lead Family Liaison Coordinator.**

**Recommendation: Greater Manchester Police’s practice of extending the deployment of Family Liaison Officers to those who were severely injured should be considered for adoption by other police forces, if such an arrangement is not already in place.**

## The Role of North West Ambulance Service

### Including Broader Comments in Relation to Interoperability During Mass Fatality and Mass Casualty Incidents

- 5.67.** The following comments should not be regarded as a commentary of any type on whether, had certain things been done differently, this would have affected victims’ survivability. This is a question that only the coronial inquests can decide.

### North West Ambulance Service: Interoperability and Role Conflicts

- 5.68.** In relation to the deployment of NWAS personnel and assets to the scene, a consistent reflection by NWAS staff was that as they approached Victoria station there was an expectation by others that the paramedics would immediately assist with casualties who had already made their way out of the foyer and onto the station approach.

*“Specifically it was their opinion that there appeared to be a lack of awareness amongst some of the police officers present about the role of North West Ambulance Service during major incidents and about mass-casualty procedures and priorities. This manifested itself in the paramedics being challenged by police officers to attend to casualties on the station approach who had objectively minor (P3) injuries. Whereas, the North West Ambulance Service officers’ priority at this point was to not be drawn into treating individuals, but to comply with their major incident training by commencing a systematic process of scene assessment and management.”*

- 5.69.** The Panel agrees that these experiences may illustrate a lack of understanding, amongst some of NWAS's partner agencies of NWAS's primary roles in scene assessment and casualty management during major incidents. However, it also probably reveals something of a lack of confidence expressed by those police officers in their own first aid capabilities.
- 5.70.** Either of these interpretations could also be understood as illustrating elements of 'role conflict' for police officers arriving at the scene soon after the explosion. From this perspective, it would be straightforward to understand that police officers would feel that their role should be in securing the scene and/or apprehending offenders, not dealing with casualties, which they would assume would be the role of the paramedics.
- 5.71.** Conversely, the attending paramedics knew that their role in these initial stages was larger than being drawn in to the treatment of individual casualties. As one contributor stated:
- "I bet that police officer hates me now for ignoring him, but I didn't have the time to explain to him what I was doing and why I was leaving him with the casualty."*
- 5.72.** As would be expected, role conflict was managed more effectively by supervisory Bronze-level staff. Officers from both BTP and GMP operating in the foyer described how their priority was not to be drawn into treating casualties themselves but was to maintain an overview of the situation. This allowed them to coordinate the triage and evacuation process more effectively with NWAS staff, whilst also constantly assessing and managing broader risks.
- 5.73.** The Panel does understand the conflict introduced when police officers are drawn away from their primary role to deal with casualties. This is particularly relevant when considering the advanced trauma-care training undertaken by Authorised Firearms Officers and the potential wish for those officers then to be drawn into casualty treatment rather than firearms operations. However, in order to further develop clear mutual understandings of how interoperability needs to work at major incident scenes, there appears to be a requirement to enhance frontline personnel's understanding of partner agencies' procedures and of their expectations of what collaborative working involves.

**Recommendation: Greater Manchester Resilience Forum members should investigate ways to increase their own personnel's understandings of their partner agencies' procedures and operational priorities during the first 30 minutes to one hour of a major incident.**

## North West Ambulance Service: Casualty Portage and Stretchers

- 5.74.** The Panel is aware of the intensive and commendable efforts expended by emergency services responders, Arena and Emergency Training UK staff, rail staff and members of the public in evacuating the casualties from the foyer into the Casualty Clearing Station on the concourse. The Panel is also aware that this evacuation was achieved mostly through the use of improvised rather than purpose-built stretchers and that many people who participated in the Review and had witnessed this operation had expressed their concerns about this.
- 5.75.** Indeed, having witnessed the casualties being carried down the stairs from the foyer to the station on improvised stretchers, the NWAS Bronze described to the Panel his initial concern that this seemed inefficient. However, when the options available were considered (e.g. the use of the spine boards and scoop stretchers on the arriving ambulances) the NWAS Bronze realised it would be more effective to let this process continue than to expect these people to use the NWAS equipment without the necessary training.
- 5.76.** This was due to a pragmatic rather than an overly bureaucratic 'Health and Safety' concern. To be used safely, the NWAS equipment required training in utilising straps to ensure casualty immobilisation. For untrained people to have used the NWAS equipment safely, the NWAS Bronze reasoned, would have delayed the evacuation and redirected NWAS staff toward assisting with portage (i.e. securing straps correctly) and away from providing medical care.
- 5.77.** As there was no GMFRS attendance at this time, the NWAS Bronze made the decision to let the ad hoc evacuation process continue. The NWAS Bronze reasoned that once the decision had been made to use the concourse as the Casualty Clearing Station, the priority was then to extract the casualties as quickly

as possible out of the hazardous foyer area. Needing to use equipment that required training in the delicate movement and immobilisation of casualties before they could be lifted would draw resources into the foyer, and there would be increased risk of turning that devastated and dangerous room into a completely inappropriate casualty treatment area.

- 5.78.** The Panel explored this issue carefully and understands the reasoning behind this decision to allow this method of evacuation to continue, rather than to deploy NWAS staff to lead the operation.
- 5.79.** However, at this point it is important to reflect on the absence of GMFRS assets from the scene during the initial two hours following the explosion. As explained in Chapter 3, GMFRS's three Special Response Teams are equipped with 'Sked' stretchers which are intended for the rapid extraction of casualties from Marauding Terrorist Firearms Attacks 'warm' zones. However, as no Special Response Teams were deployed to the scene on the night, these stretchers were never available for use in the evacuation.
- 5.80.** GMFRS pumps are also equipped with spine boards of the same design used by NWAS, and their crews are trained in their use. However, no pumps arrived at the scene until 00:37hrs, and it is the Panel's understanding that by this time, all casualties had been removed from the foyer using the improvised equipment.
- 5.81.** From this perspective, it is important to note that neither the GMP Ground Assigned Tactical Firearms Commander nor Inspector in the foyer identified the absence of GMFRS as a problem. In fact, the Ground Assigned Tactical Firearms Commander stated to the Panel that by the time of arrival, the GMFRS Special Response Teams were better placed at the Thompson Street rendezvous point as they were providing a rapid reaction capability to other incidents which might occur. In considering this view, the Panel notes that the Ground Assigned Tactical Firearms Commander did not arrive at the Arena until 23:23hrs and then was, at least initially, focused on firearms operations rather than the challenges of moving casualties.

- 5.82.** The initial NWAS Bronze Commander's decision not to use NWAS equipment to support the evacuation and the police officers' opinions are, therefore, all understandable in terms of their situational awareness at the time.
- 5.83.** However, it is the Panel's opinion that had GMFRS assets been deployed directly to the initial police-nominated rendezvous point following the first notification of the incident to North West Fire Control, then firefighters would have been much better placed to support and, potentially, to accelerate the evacuation of casualties from the foyer. It is important here to repeat, however, that the Panel can make no comment on whether the presence of GMFRS crews earlier on the night would have affected any casualty's survivability.
- 5.84.** As an additional point, having viewed the five stretcher types that are available as standard equipment within NWAS and GMFRS vehicles, the Panel is also concerned that none of this equipment would have been ideal in enabling the required rapidity of evacuation that the circumstances on that night dictated.
- 5.85.** As considered by their Bronze, the NWAS equipment required training and/or team leadership to use safely. This issue also, however, applies to the GMFRS spine boards and their Special Response Teams 'Skeds'.
- 5.86.** There will always be a balance between the risk of exacerbating casualties' injuries by moving them and the risk of leaving them in a situation where they are directly exposed to significant additional hazards and/or threats. However, reflecting on the events of the night of 22<sup>nd</sup> May, the Panel is convinced of the need for those responding to terrorist attacks to be able to move casualties in the simplest, most straightforward and fastest way possible. Accordingly, it is the Panel's opinion that what was required in the foyer during that initial period was not the highly technical equipment that is currently carried by responders. Rather, what was needed most quickly were the most basic type of frameless canvas stretcher, onto which casualties could have been rolled by untrained responders and/or by Arena staff or Emergency Training UK staff and the public, before then being carried or dragged by them to the Casualty Clearing Station.
- 5.87.** The evacuation activity had already commenced before NWAS arrived on scene, with people naturally and spontaneously seeking to move casualties away from

the foyer area. When NWAS arrived, the Advance Paramedic started to direct and prioritise the evacuation. However, the Panel believes that in order to have supported initial casualty evacuation it would have been very helpful for basic stretchers to have been available within the major-incident medical packs that were brought to the scene in minutes by the venue medical team and the Northern staff.

- 5.88.** It is important to restate here that it is the Panel's opinion that had GMFRS assets deployed directly to the incident rendezvous points at the earliest opportunity, the evacuation of casualties from the foyer to the Casualty Clearing Station on the concourse could have been achieved more efficiently and possibly more rapidly. This opinion is supported by a contributor to the Review who remarked that Fire and Rescue Services are trained in the safe portage of wheelchair users and, accordingly, had GMFRS arrived on scene sooner then, this type of specialist training would have been utilised.

**Recommendation: All major transport hubs and public venues should possess and provide immediate access to basic frameless canvas stretchers to enable rapid movement and evacuation of casualties during terrorist attacks or other high-threat or dynamic-hazard incidents.**

**Recommendation: All emergency services should consider developing a capability to give their staff rapid access to basic frameless canvas stretchers to enable rapid movement and evacuation of casualties during terrorist attacks or other high-threat or dynamic-hazard incidents.**

### North West Ambulance Service: The Role and Location of the Casualty Clearing Station

- 5.89.** Many contributors to the Review have discussed the NWAS personnel's decision to evacuate the casualties from the foyer to the Casualty Clearing Station that they had set up on the station concourse. It is clear that two principal concerns are involved:

- The concern that casualties could have been treated more effectively (i.e. more quickly) if more medical resources had been brought to them in situ.

- The concern that the operation of the Casualty Clearing Station actively slowed down the evacuation of casualties to hospitals.

**5.90.** In relation to both these issues, the Panel can make no comment on whether the medical outcomes for casualties would have been different if the Casualty Clearing Station had been in the foyer rather than on the concourse.

**5.91.** However, in relation to the first concern, the Panel did consider carefully the clear and logical reasoning that underpinned the Advance Paramedic's decision to set up the Casualty Clearing Station on the concourse and not in the foyer.

**5.92.** His concerns were based on:

- the distance of the Arena foyer from equipment and arriving ambulances
- the dangers present in the foyer (e.g. falling glass)
- the control the firearms officers had of the foyer meaning that the Advanced Paramedic felt the process would be made more difficult for ambulance crews to come up and take away the casualties according to priority, and because the scene had not been declared safe
- the bio-hazard risk presented to people entering the foyer
- his conscious need, from a staff mental health perspective, not to expose too many staff to the shocking scenes in the room.

**5.93.** Whilst discussing his role on the night with the Panel, the Advanced Paramedic admitted that at the time he had been unsure if movement of casualties to a Casualty Clearing Station, rather than setting up a Casualty Clearing Station in situ, was 'part of the plan'. However, he was clear that his listed concerns about the genuine risks involved in keeping seriously injured casualties in situ in such a high-risk environment guided his decision making.

**5.94.** From the perspective of whether it was 'part of the plan', the Advanced Paramedic's decision was clearly supported by Department of Health guidance on the subject, which describes the use of a barn 'near the scene' of the Selby train crash as an example of good practice.



- 5.95.** In relation to the second expressed concern, that the operation of the Casualty Clearing Station unnecessarily slowed the evacuation of casualties to hospital, it is important to acknowledge several points in relation to what the Casualty Clearing Station is designed for.
- 5.96.** Once casualties were on the concourse the NWAS staff worked clearly in accordance with their emergency plans. This meant that the respective priorities (e.g. P1) and types of casualties were stabilised in the Casualty Clearing Station and then dispatched to the receiving hospitals. This operation may appear contrary to usual understandings of ambulance care which may be based on perceptions that the priority is always to get casualties to hospitals as quickly as possible. From this perspective, the Casualty Clearing Station could be perceived as effectively slowing the transfer of casualties from the scene to hospitals.
- 5.97.** The Panel understands that this perception of delay was frustrating and disorientating for the injured and other members of the public that were there. However, the pause that was introduced by the period of casualty stabilisation in the Casualty Clearing Station actually gave the receiving hospitals the vital time they needed to clear and prepare operating theatres and to assemble operating teams. In addition, the Casualty Clearing Station provided a place for essential triage to take place to ensure the best possible onwards care, and provide the means for the most effective utilisation of NWAS resources (ambulance staff) for onward dispersal of patients in the most challenging circumstances. Importantly, it ensured that casualties went to the hospital with the most appropriate specialists and facilities to treat their specific injuries.
- 5.98.** From this perspective, it is important to note that only one patient was subsequently moved from the initial receiving hospital specifically for medical reasons. This fact alone clearly illustrates the success of the on-scene triage and the effectiveness of the implementation of the mass-casualty dispersal plan.
- 5.99.** Taking all these factors into consideration, it is the Panel's opinion that the Advanced Paramedic's early decision to set up the Casualty Clearing Station on the concourse was sound.

## Shared Situational Awareness and Joint Understanding of Risk, Including Operation PLATO

- 5.100.** Throughout the response to the attack, the shared perception amongst those responders in the foyer and around the Casualty Clearing Station on the concourse was that this was not a Marauding Terrorist Firearms Attack. Accordingly, the fact that the declaration of Operation PLATO by GMP (at 22:47hrs) was not clearly communicated to NWAS was suggested by those who had been at the scene to have meant that 'lives were saved'. In effect, their perception was that if attending NWAS staff had been told it was an Operation PLATO incident prior to their arrival they would have followed protocol by going directly to a rendezvous point rather than directly to the scene. In their opinion, this would have undoubtedly delayed the triage, stabilisation, treatment and evacuation of casualties.
- 5.101.** It is the Panel's opinion that the response of NWAS personnel, and of other responders who moved into the station and foyer, illustrated that the success of the operation was based on a willingness to be risk-accepting, rather than being dogmatically risk-averse, even if that meant operating outside normal organisational safety protocols.
- 5.102.** This willingness of responders to move forward into and to then stay within high-risk zones did not, however, manifest itself to the Panel as reckless. Rather, such behaviour was always described as incorporating clear elements of risk assessment, with many individuals discussing their initially cautious approach to scene, to then describing how they had reassessed the risks of staying in the foyer, or of operating the Casualty Clearing Station so close to the foyer, by taking into account dynamic factors such as the presence and continuing arrival of police firearms officers and other responders.
- 5.103.** Responders also spoke about the importance of using the Joint Decision Model described in JESIP to take them through a structured process in making decisions. The model reminds responders to assess risks each time a decision is made, whether on an individual or joint basis. A number of responders commented how useful the Joint Decision Model had been that evening.

## Zero and First Responders to the Scene

- 5.104.** Dr. Chris Cocking (2013) discussed the role of ‘zero-responders’ in relation to the 7/7 London Underground bombings, and identified the public as a potential asset to the emergency services during major incidents:

*“Neglecting the potential spontaneous resilience of crowds in emergencies by the authorities could also be missing out on an opportunity to make use of a positive resource. The ability of people in emergencies to play a leadership role and co-ordinate mutual aid amongst survivors should not be underestimated. Therefore, rather than seeing the public as potential obstructions that need to be moved on, acknowledging and making provision for people’s willingness to help and direct others could provide the emergency services with a large pool of potential volunteers, who can act as ‘force multiplier’” (Cocking, 2013: p.11)*

- 5.105.** During the Review, the Panel has seen evidence that supports Cocking’s proposition and considers that members of the public undoubtedly acted as such a ‘force multiplier’ during the initial response activities in the foyer. The Panel was humbled to view CCTV footage which showed the heroic actions of some members of the public involved in the widespread provision of first aid and reassurance to the casualties as well as assisting in the portage of those casualties from the foyer to the Casualty Clearing Station on the concourse during the initial hour following the explosion.
- 5.106.** In conducting the inquests following the 7/7 London Underground bombings, Lady Justice Hallett explored a public concern that the arrival of the London Fire Brigade on the ground had been unnecessarily delayed following the explosions due to concerns about the safety of the underground tunnels.
- 5.107.** In a similar way, in the Arena attack, some survivors commented to the Panel that their wait for the emergency services to arrive seemed overly long. In the Panel’s opinion, the initial emergency services’ response (notably, BTP, GMP and NWAS) to the Arena foyer was in many ways exceptional in its speed. However, the necessity to operate in that devastated environment, with its genuine risk of additional explosions or attacks, meant that at least the attending firearms officers’ priorities could not be on casualty treatment, but were essentially predicated in

accordance with Marauding Terrorist Firearms Attacks Joint Operating Principles (see Chapter 1) on 'identifying, locating and confronting attackers'.

- 5.108.** What they were confronted with also led NWAS personnel to activate their plan, which meant that only sufficient essential NWAS personnel and resources were deployed directly into the foyer to triage casualties, whilst also encouraging and supporting others (including members of the public) to provide basic first aid on their behalf.
- 5.109.** Unfortunately, this convergence of two essential emergency-response protocols (i.e. firearms/Counter Terrorism and triage) appears to the Panel to have resulted in an impression amongst some of those in the foyer that their pleas for assistance were being ignored. However, having reviewed the information provided, it is the Panel's opinion that the actions and procedures employed by the emergency services present at the scene were appropriate for the circumstances, even though they may have created this perception of unnecessary delay in the minds of others in the foyer.
- 5.110.** This is an important point, because it highlights the fact that during major incidents of this type, the public will likely become a key source of direct assistance for both the injured (by providing first aid and assisting evacuation) and for the emergency services (by enabling them to initiate and manage scene safety and casualty management priorities for all those affected, without being drawn into caring for individuals).
- 5.111.** From this perspective, it is the Panel's opinion that everyone operating in the foyer in the aftermath of the explosion (i.e. the public, the Arena and station staff, the staff from Emergency Training UK and the emergency services) undoubtedly provided essential combined capacity to the medical response, and all of those involved should be immensely proud of their contributions.
- 5.112.** This is not to say that developing terrorist attack plans using the model illustrated in Chapter 1 Figure 2, where there is no apparent place for the public in 'hot' or 'warm zones', is wrong. Rather the events at the Arena illustrate the critical importance of responders being able to conduct dynamic risk assessments and to

manage situations pragmatically rather than in a manner fixed by unrealistic planning scenarios.

- 5.113.** What the selfless actions of the multiple ‘zero’ and first responders in the foyer that night have highlighted so clearly, is that casualty care at, and evacuation from, incident sites should never be planned as something that only fully trained, and expensively equipped personnel should be relied upon to do.
- 5.114.** It is important to add, however, that during the Review, the Panel was made aware by several medically trained responders of their concerns that some members of the public and other responders, whilst trying their very best in genuinely harrowing circumstances, did not appear familiar with first aid principles and/or were attempting to use more complex major-trauma procedures without sufficient knowledge (e.g. applying tourniquets, use of defibrillators).
- 5.115.** The observations made were clearly not intended as criticisms of individuals, who acted with great courage and in good faith. Rather, they point to the fact that, as the response to the attack has illustrated, we should not be over-reliant on public responders in these situations and that, therefore, it would be of great benefit if there was a greater public awareness of basic first aid principles.

**Recommendation: The Government should increase its support for public first-aid training programmes (including those for children and young people).**

**Recommendation: All planning assumptions and training in respect of preparing for and responding to terrorist attacks in public places should include realistic contingencies for public involvement in casualty care, treatment and evacuation within all incident zones.**

### Recommendations in relation to role of Greater Manchester Fire and Rescue Service during the Response to the Arena Attack

- 5.116.** Chapter 3 of this report provides details of the timeline of events which represents the Panel’s understanding of GMFRS’s response to the Arena attack.

- 5.117.** The principal factor that differentiates that timeline from those of the Police and Ambulance services is that no GMFRS personnel or assets arrived at the scene of the blast until 00:37hrs on the morning of Tuesday 23<sup>rd</sup> May, just over two hours after the initial explosion.
- 5.118.** Since the attack, this factor has attracted considerable public and media speculation. Accordingly, it was important for the Panel to consider the reasons that underpinned the delay, which resulted in a principal emergency service failing to contribute effectively to the response to the most significant major incident in the city's recent history.
- 5.119.** For its analysis the Panel has reviewed GMFRS and other multi-agency incident debrief reports and guidance documents and has been granted full access to timelines and incident logs held by North West Fire Control. Panel members have also spent considerable time discussing the events of that night with GMFRS officers and firefighters of all ranks and with North West Fire Control staff. As a result of this activity, the Panel has reached a number of conclusions.
- 5.120.** Principal amongst these conclusions is an understanding that GMFRS and North West Fire Control as organisations both felt that they had let down the people of Greater Manchester and other visitors to the city that night.
- 5.121.** As a direct result of this perceived failure, it was clear to the Panel that the officers and firefighters of GMFRS and staff at North West Fire Control were determined to assist the Panel in ensuring that all relevant lessons from the night of the attack were identified and learnt.
- 5.122.** In response to this, the Panel thanks the GMFRS and North West Fire Control personnel who participated in the Review for their candour and willingness to explore these troubling issues.
- 5.123.** What is important to state here, however, is that in accordance with its terms of reference, the question for the Panel was never 'would the earlier arrival of GMFRS at the scene have made any difference to the medical outcomes of the injured?' This question lies outside the Panel's terms of reference and belongs to the Coroner alone.

- 5.124.** Instead the question pursued was “How can it be that a principal first responder failed to arrive on the scene of a major incident for two hours?”
- 5.125.** Answering this question requires an exploration of a range of complex factors which influenced the way in which GMFRS personnel responded on the night. However, it also demands that these factors be examined against a wider context of interoperability, as it is currently framed within UK civil protection protocols and practice. For this reason, this section of the report has been structured in a way that allows it to stand alone from the other report chapters. This is because in answering the question, the Panel has identified and wishes to raise awareness of a number of inherent conditions, which prescribed the response delay, and yet whose effect and influence spread far beyond any particular decision made by an individual firefighter, fire officer or North West Fire Control operator or manager on the night.
- 5.126.** What has concerned the Panel in considering this issue and the lessons for GMFRS has been the identification of the wider lessons for other responders, whose plans for such an event have not yet been so brutally tested.
- 5.127.** To set the delay in context, it is worth noting that the average response time for all incidents that GMFRS mobilised to in the 3<sup>rd</sup> quarter of 2017/18 **was 5 minutes 41 seconds**.
- 5.128.** In answering the question, the Panel has identified four broad themes of factors which allowed the delayed response to occur:
- The use of the National Inter-Agency Liaison Officer as the initial Pre-Determined Attendance for the Arena attack
  - The role of the National Inter-Agency Liaison Officer: Incident Command and the ‘30-minute’ rule
  - The role of North West Fire Control in supporting a Fire and Rescue Service
  - Leadership and culture within GMFRS.

**5.129.** Before discussing these themes individually, it is important to go back to some key components of the GMFRS response in order that their relevance to the conclusions can be better understood:

- **Action plans:** Action plans are computer-based procedures which lay out a sequence of instructions for the North West Fire Control operators to follow in order to inform specific individuals of an incident and/or to mobilise GMFRS assets to the incident. All action plans are developed by the senior management of GMFRS, just as action plans for each of the other three fire services supplied by North West Fire Control are created to meet their own specified requirements. Once defined by the fire service, North West Fire Control are then instrumental in determining how best to load and format the information into the North West Fire Control Call Management and Resolution system to ensure it is clear to Control Room Operators who have to action them.

**5.130.** The action plans used by North West Fire Control on the night of the attack were ‘EXPLOSION’ and ‘BOMB’. Due to the nature of the information being given to the operator by GMP the North West Fire Control operator opened the ‘EXPLOSION’ action plan but because the word ‘bomb’ had been used in the North West Fire Control operator’s conversation with the GMP operator, this action plan prompted for further actions to be directed using the ‘BOMB’ action plan.

**5.131.** The two key instructions on the ‘BOMB’ plan, which are relevant to the Panel’s conclusions were:

- **INFORM** – Duty National Inter-Agency Liaison Officer, request guidance on actions to be carried out before proceeding further (*Pre-mobilisation*) [emphasis in original]
- **ACTION** – Obtain rendezvous point from National Inter-Agency Liaison Officer (*Pre-mobilisation*) [emphasis in original]

**5.132. GMFRS Command Support Room:** The Command Support Room is a room at GMFRS Headquarters in Swinton, which is used at periods of high or complex operational demand to support the strategic deployment of resources across the county and if necessary from across the country and during major incidents to provide support to the Incident Commander at the scene. The Command Support



Room is not fully operational on a 24-hour basis, so if an incident occurs out of hours then it will need to be brought up to operational readiness. The Command Support Room approach is mirrored across the Greater Manchester Resilience Forum membership, with other responders having their own emergency-operations or coordination centres (e.g. NWS operates a Regional Operations Coordination Centre, which was also activated on the night of the attack).

**5.133. JESIP Interoperability Framework:** The JESIP Interoperability Framework is the agreed multi agency approach for dealing with major emergencies and is underpinned by five key principles. Application of these principles has been shown to enable responders to work together effectively:

- Co-location
- Communication
- Coordination
- Joint Understanding of Risk
- Shared Situational Awareness.

**5.134.** A tool which has also been introduced under the JESIP programme, and which is fundamental to the principle of Shared Situational Awareness, is the multi-agency incident reporting framework. This provides a common structure for responders and their control rooms to share major incident information. This structure is described by the acronym METHANE:

**M** - Major Incident declared?

**E** - Exact Location

**T** - Type of incident

**H** - Hazards present or suspected

**A** - Access routes that are safe to use

**N** - Number, type, severity of casualties

**E** - Emergency services present and those required

**5.135. North West Fire Control:** North West Fire Control is a Local Authority Controlled Company set up exclusively by the Fire Services in the North West to jointly handle all 999 emergency calls and to be responsible for mobilising firefighters

and fire service assets to incidents in Cumbria, Lancashire, Greater Manchester and Cheshire. In effect, North West Fire Control provides a service for the four fire and rescue services, which is delivered by civilian (i.e. non-firefighter) operators.

- 5.136.** Response to incidents that are reported to North West Fire Control is conducted through the **use of action plans**.
- 5.137.** From the Panel's perspective it is important to note that the inter-relationship between GMFRS and North West Fire Control differs from that of GMP and its own Force Control Room. The GMP Force Control Room performs command, control and coordination functions, which are delivered under the oversight of the Force Duty Officer, typically a senior Police Inspector. By contrast, North West Fire Control does not deliver a command function. Once an action plan has been activated, all command decisions (i.e. orders) which impact GMFRS personnel in relation to the management of incidents are made by the designated GMFRS Incident Commander. The North West Fire Control role is to coordinate assets in order that other GMFRS personnel are able to comply with those orders. This relationship between a Fire Service and its Control Centre is common across the UK, as it ensures the primacy of operational decision making remains with the Fire Service, without the need to have a dedicated Fire Service Officer in the control room at all times.
- 5.138. National Inter-Agency Liaison Officer:** A National Inter-Agency Liaison Officer is "a trained and qualified officer who can advise and support incident commanders from the Police, Health, Military and other Government Agencies on the Fire and Rescue Services' operational capacity and capability to reduce risk and to safely resolve incidents at which a Fire and Rescue Service attendance may be required."
- 5.139.** The National Inter-Agency Liaison Officer concept was initially developed by London Fire Brigade who use them as Tactical Advisors, which means that they provide specialist advice to the Incident Commander during certain specifically high-threat incidents. Since their adoption by GMFRS, however, the National Inter-Agency Liaison Officer role has been developed so that, for some incident types, North West Fire Control are required to mobilise a National Inter-Agency Liaison Officer as the initial response in an action plan, with immediate command

decisions in relation to further deployments then bearing on that officer. In May 2017 the action plans for 'BOMB' and Marauding Terrorist Firearms Attack were predicated on North West Fire Control informing the Duty National Inter-Agency Liaison Officer as the initial action, with command decisions relating to further deployments then passing to that officer.

**5.140.** As specialists within the fire service, National Inter-Agency Liaison Officers have their own doctrine in the form of guidance and Standard Operating Procedures. National Inter-Agency Liaison Officers also plan, train and exercise specifically for Marauding Terrorist Firearms Attack response alongside the police and ambulance services. Accordingly, National Inter-Agency Liaison Officers have a detailed understanding of Marauding Terrorist Firearms Attack Joint Operating Principles.

**5.141.** The Panel has reviewed the National Inter-Agency Liaison Officer guidance documents and has two observations:

- i. Firstly, the defined response, once a National Inter-Agency Liaison Officer had been notified of a no-notice incident by GMP (through North West Fire Control), was for the National Inter-Agency Liaison Officer to liaise directly with the GMP Force Duty Officer. The doctrine makes no other directions for the National Inter-Agency Liaison Officer to gain situational awareness from another agency in any other way, before or after s/he requests North West Fire Control to mobilise assets. It appeared odd to the Panel that so much weight was placed in the doctrine on the importance of a single Inter-Agency connection and, therefore potentially, a single point of failure.
- ii. Secondly, both National and GMFRS Standard Operating Procedures for National Inter-Agency Liaison Officers allow a National Inter-Agency Liaison Officer discretion to risk-assess any initial decisions they make immediately following their mobilisation, in respect to *“securing (so far as reasonably practicable) the health, safety and welfare of operational personnel, members of the public or other agencies either at an incident scene or a central briefing location.”* The guidance goes on to state that a National Inter-Agency Liaison Officer should then notify his/her Assistant Principal Officer or Principal Officer of any decisions taken within 30 minutes.

- 5.142.** Given the high-threat nature of incidents that a National Inter-Agency Liaison Officer will be involved in, it is important that the National Inter-Agency Liaison Officer's decisions are themselves assessed and validated by their most senior on-duty officer and that this provides a degree of protection for the more junior officer.
- 5.143. Pre-determined Attendance:** A Pre-determined Attendance relates to the number and type of assets that have been previously calculated and risk-assessed to be appropriate to send to any specific type of reported incident (e.g. a dwelling fire in which persons are reported; a road-traffic collision; an automatic fire alarm; an explosion). Predominantly, Pre-determined Attendances tend to encompass the deployment of a 'command structure' and sufficient resources to deal with the initial actions needed at the incident. It is then expected that the first arriving officer will complete a dynamic risk assessment at the scene and order the deployment of any further resources needed.
- 5.144.** The next section considers each of the four contributory themes identified above in delaying the GMFRS response on the night of the attack.

### The Use of a National Inter-Agency Liaison Officer as the Initial Pre-Determined Attendance

- 5.145.** The Panel believes that the Pre-Determined Attendance protocol that was defined by the action plan for 'BOMB' was used appropriately and followed correctly by North West Fire Control operators. However, this protocol meant that a single GMFRS National Inter-Agency Liaison Officer was initially given full responsibility for the deployment of GMFRS assets to the scene of the incident. The challenge immediately faced by this individual included a lack of situational awareness which was compounded by the fact that at the time of his mobilisation the National Inter-Agency Liaison Officer was physically situated 22 miles (over 40mins' drive) from the Arena.
- 5.146.** Following the action plan, a North West Fire Control operator contacted the National Inter-Agency Liaison Officer at 22:40hrs and informed him of an explosion at the Arena, of reports of 30 casualties and of the location of the GMP-declared

rendezvous point at the Cathedral car park. In strict accordance with the action plan the National Inter-Agency Liaison Officer then nominated Philips Park Fire Station as the provisional rendezvous point for four GMFRS pumps and crews, prior to their being moved forward if necessary. In effect, he chose not to deploy GMFRS assets directly to the scene or to the GMP-declared rendezvous point.

- 5.147.** From examining the information provided to it, the Panel believes that the National Inter-Agency Liaison Officer was acting in accordance with his training and guidance at this point. He had been informed of an explosion at a large public venue and his training dictated the need for him to consider an exclusion zone around the scene. Mobilising four pumps to Philips Park until the National Inter-Agency Liaison Officer had greater situational awareness was a reasonable initial deployment in these circumstances. Specifically so, as it reflects a specialist's concern over the risk of sending assets to an incident scene where there may be secondary explosive devices or other threats. The National Inter-Agency Liaison Officer had no knowledge at this point that other responders were already congregating at the Arena in numbers and acted on the information available to him.
- 5.148.** However, this mobilisation of assets to a separate National Inter-Agency Liaison Officer-declared rendezvous point rather than to the rendezvous point declared by GMP which was nearer the scene immediately introduced problems for the GMFRS response that were subsequently very hard to recover from.
- 5.149.** One of the key benefits that the deployment of an Incident Commander to the scene or to a multi-agency rendezvous point is that it provides an opportunity for individual responders and their organisations to develop shared situational awareness. The decision of the National Inter-Agency Liaison Officer to muster GMFRS assets at a GMFRS station away from the scene and his choice not to mobilise himself or a closer National Inter-Agency Liaison Officer to the GMP-declared multi-agency rendezvous point at the Cathedral car park resulted in the effective denial of situational awareness to both GMFRS and North West Fire Control.
- 5.150.** Once the initial decision to muster pumps and crews at Philips Park was made, the National Inter-Agency Liaison Officer then continued to comply with his

standard operating procedures by attempting to contact the GMP Force Duty Officer by telephone, whilst simultaneously starting the 22-mile drive to the Philips Park rendezvous point.

- 5.151.** Due to the GMP Force Duty Officer's phone system being overwhelmed with call traffic, at this point the National Inter-Agency Liaison Officer's seven attempts to get through all failed. At 22:48hrs the National Inter-Agency Liaison Officer contacted North West Fire Control again to say that he was unable to make contact with the GMP Force Duty Officer. The North West Fire Control operator then informed the National Inter-Agency Liaison Officer of reports of an 'active shooter'. It is clear to the Panel that the National Inter-Agency Liaison Officer would suspect at this point that the initial explosion had been a precursor for a now potentially on-going marauding terrorist firearms attack.
- 5.152.** In receipt of this information he informed the North West Fire Control operator that he had already been contacting other officers to mobilise the GMFRS Marauding Terrorist Firearms Attack-equipped Special Rescue Teams and he took this opportunity to make sure that these actions were recorded on the North West Fire Control incident log. He explained that *"they are going to rendezvous at Philips Park, until we are instructed otherwise and we get some more information about this incident"*<sup>22</sup>.
- 5.153.** Having made his initial decision to rendezvous resources at Philips Park, with the intention of seeking information from the Force Duty Officer to then move forward, and now being unable to get through to the Force Duty Officer, the National Inter-Agency Liaison Officer could have asked North West Fire Control to make contact with GMP Control and ask for a multi-agency rendezvous point or a situation update from GMP.
- 5.154.** It is clear to the Panel that at this point the problems in gaining useful situational awareness presented by the National Inter-Agency Liaison Officer being unable to contact the GMP Force Duty Officer directly were then compounded by his disciplined adherence to the totally unrealistic and inadequate nature of the guidance contained in the National Inter-Agency Liaison Officer standard operating procedures.

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<sup>22</sup> NWFC telephone log: Duty National Inter-Agency Liaison Officer to NWFC

- 5.155.** These procedures predicated the National Inter-Agency Liaison Officer to expect instructions and situational awareness to be provided to him by the GMP Force Duty Officer. However, even though it was obvious to him why he could not make direct contact with the Force Duty Officer<sup>23</sup>, the National Inter-Agency Liaison Officer appears to have acted as though he had no other options available to him through which to gain situational awareness himself or for others to get it for him. It has been disappointing for the Panel to learn that, in this instance, specialist 'Inter-Agency liaison' appeared to count for nothing other than telephoning the GMP Force Duty Officer and when this failed the whole GMFRS response to the scene was effectively brought to a point of paralysis, which was to last until 00:21hrs when pumps were finally deployed forward.
- 5.156.** Notwithstanding this, the National Inter-Agency Liaison Officer did understand there to have been a major explosion with multiple casualties and the likelihood (from the information he had been given) of an on-going Marauding Terrorist Firearms Attack at the location. He understood that lives were at risk. However, he was completely unaware of the fact that by this time the Arena area was being deluged with personnel from other responder organisations, including significant numbers of police firearms officers. Not being aware of this, the National Inter-Agency Liaison Officer continued toward Philips Park.
- 5.157.** It is the Panel's opinion that this situation of apparent risk aversion and unwillingness to deploy immediately forward could in good part be attributed to GMFRS defining different mobilisation protocols for 'BOMB' than for other incident types. Namely, the direct outcome of the National Inter-Agency Liaison Officer being handed initial overall responsibility for GMFRS mobilisations was a situation where no GMFRS personnel were able to provide the critical initial situational awareness from the scene within the first few minutes of the attack. This was not the case for the other responders, whose personnel had been on the scene in minutes, or in some cases, within seconds.
- 5.158.** From this perspective, had a Pre-Determined Attendance of pumps and crews been sent directly to the GMP-declared rendezvous point at the Cathedral car

<sup>23</sup> NWFC telephone log: Duty National Inter-Agency Liaison Officer to North West Fire Control "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".

park, GMFRS and North West Fire Control would have been receiving situational updates from an incident commander on the ground, likely in much less than the average response time of 5 minutes 41 seconds.

- 5.159.** However, the Panel is aware that this suggestion works best when looking backward through time, because we now know that responders going to the scene were only faced with the aftermath of the single initial explosion. It is only the benefit of hindsight that allows the complete discounting of the Marauding Terrorist Firearms Attack risk, because we now know that a Marauding Terrorist Firearms Attack did not materialise.
- 5.160.** This was not knowledge immediately available to North West Fire Control operators or to the Duty National Inter-Agency Liaison Officer on the night. On the contrary, following his first notification by North West Fire Control of the GMP-declared rendezvous point at the Cathedral car park it was a matter of minutes later before the National Inter-Agency Liaison Officer was then informed that an 'active shooter' had been reported. This obviously intensified his concerns about sending GMFRS assets to the Cathedral rendezvous point so close to the Arena, because as far as he knew there was now a possibility that the Cathedral rendezvous point had been compromised.
- 5.161.** Without the knowledge that could have been imparted to them, had any other agency with personnel already at the scene shared a METHANE message with North West Fire Control, the National Inter-Agency Liaison Officer's options were limited. In other words, by now, had the National Inter-Agency Liaison Officer ordered North West Fire Control to deploy assets directly to the scene, the National Inter-Agency Liaison Officer and North West Fire Control would have been bearing the full responsibility for sending personnel effectively into the unknown.
- 5.162.** It is true that when North West Fire Control had been initially contacted by the NWAS control room at 22:37hrs the NWAS operator's initial request to North West Fire Control had been "It's the Ambulance service [...] can we request your assistance?" However, this request occurred very early in the incident before NWAS itself had a clear understanding of what the incident involved. Therefore, it should not be mistaken for a formatted METHANE message and the Panel can understand why North West Fire Control operators did not regard it as a



deployment request, but rather, treated it as an additional incident notification. This interpretation explains why North West Fire Control operators did not, following receipt of this request, change the mobilisation protocols for 'BOMB', which they had already commenced at this point.

- 5.163.** It is worth noting here also, that North West Fire Control had been monitoring the Airwave Interoperability channel since 22:36hrs, with an expectation that partner agencies would be using it to update each other. However, due to the police and ambulance services' need to focus on coordinating their own activities using their own frequencies, this channel remained largely silent throughout the incident and was never used for a multi-agency METHANE update.
- 5.164.** Given the paucity of incoming information, an additional option open to the National Inter-Agency Liaison Officer would have been to accept the Marauding Terrorist Firearms Attack risk to himself and to drive directly to the Cathedral car park (wearing his personal ballistic protection equipment) or to request that North West Fire Control mobilise a nearer National Inter-Agency Liaison Officer or other GMFRS asset. Given what he knew at that point, however, it can be understood why he believed that anyone driving into the Arena area at this time could have been driving directly into an active 'hot zone'. In effect, he did not have the situational awareness to formulate such an action in the 'highly calculated manner'<sup>24</sup> that is required for making life-saving decisions within the Fire and Rescue Service.
- 5.165.** Adding to the National Inter-Agency Liaison Officer's challenges, until his arrival at Philips Park at 23:40hrs he had been trying to manage the incident whilst also engaged in a high-speed 22 mile drive on blue lights, which had involved repeated route changes due to a series of overnight road closures in the area. That he had not informed North West Fire Control of the delays he was experiencing is a factor to keep in mind, because without this knowledge North West Fire Control could only assume best speed was being made.
- 5.166.** At this point it is also important to reflect a different perspective on the distance of GMFRS assets from the scene when the bomb went off. During the Review the

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<sup>24</sup> Dynamic Management of Risk at Operational Incidents A Fire Service Guide Pamphlet (Crown Copyright 1998).

Panel heard from firefighters who had been on-duty at Manchester Central Fire Station and who, due to the station's proximity to the Arena, had actually heard the sound of the explosion. This station had also received, and the crews had responded to, an automated 'pre-alert'. This had been triggered when at 22:41hrs a member of the public had dialled 999 from the NCP car park at the Arena to request the ambulance service but who had been initially put through to North West Fire Control.

**Recommendation: Whilst the Panel acknowledges that Greater Manchester Fire and Rescue Service and North West Fire Control have made alterations to the role of the National Inter-Agency Liaison Officer and Pre-Determined Attendance (PDA) protocols for terrorist-related and suspected terrorist-related incidents, these organisations should test and further review these protocols to ensure they will be effective and always allocate a 'command structure' to the incident and a National Inter-Agency Liaison Officer to act as Tactical Advisor to the incident commander.**

**5.167.** However, as the North West Fire Control operators were by then following the 'BOMB' card, the pre-alert, which required no action to be taken by operators within North West Fire Control anyway, was not followed by an activation of the Manchester Central crews to the scene. Accordingly, after five minutes the pre-alert expired and at about the same time the Manchester Central crews were mobilised to the Philips Park rendezvous point.

**5.168.** As they were turning left out of their own station these crews saw ambulances turning in. Unbeknown to the crews, to the National Inter-Agency Liaison Officer and to North West Fire Control, at the time the National Inter-Agency Liaison Officer was instructing the mustering of GMFRS assets at Philips Park, the NWAS was deploying its own vehicles to Manchester Central Fire Station, which it had declared as its own holding area.

### The Role of the National Inter-Agency Liaison Officer: Incident Command and the '30-minute' Rule

**5.169.** In relation to the Panel's observations in respect to the Chief Fire Officers' Association and GMFRS's standard operating procedures for National

Inter-Agency Liaison Officers, it is important now to discuss activities onward from the point where the mobilised pumps, crews, National Inter-Agency Liaison Officers and other assets arrived at the Philips Park Fire Station rendezvous point.

- 5.170.** As part of his initial response the Duty National Inter-Agency Liaison Officer had mobilised four pumps and crews to the rendezvous point. He later coordinated with other GMFRS officers and North West Fire Control by phone to ensure that a Special Rescue Team, and Marauding Terrorist Firearms Attack-equipped Technical Rescue Unit and two further National Inter-Agency Liaison Officers were also mobilised to Philips Park.
- 5.171.** All these assets were in place at the GMFRS rendezvous point at 23:40hrs, one hour and two minutes after North West Fire Control created the incident log and one hour and seven minutes after the explosion occurred. Upon arrival at the rendezvous point the three National Inter-Agency Liaison Officers were immediately campaigned by the assembled crews, who were viewing social media images and messages that were being transmitted direct from the scene, and who as a result were asking why GMFRS had not been sent forward. This is the first time the National Inter-Agency Liaison Officer's had clear awareness of the nature and scale of the mass casualty incident.
- 5.172.** Apparently as a result of the Duty National Inter-Agency Liaison Officer having mentally discounted the Cathedral car-park rendezvous point as inappropriate, due to its questionable safety and its failure to accord with Marauding Terrorist Firearms Attack Joint Operating Principles exclusion-zone protocols. The Duty National Inter-Agency Liaison Officer did not inform National Inter-Agency Liaison Officers two and three of its existence, even after they all congregated at Philips Park. This meant that National Inter-Agency Liaison Officers two and three were still under the impression that GMP had failed to nominate a multi-agency rendezvous point, as they are required to do by Joint Operating Principles. From the perspective of National Inter-Agency Liaison Officers two and three, therefore, the furthest forward toward the scene that they knew to be currently safe was Manchester Central Fire Station, because they had now been made aware by the crews that NWAS was using that station as a holding area.

**Recommendation: Greater Manchester Resilience Forum members should clarify their joint operating procedures in relation to the declaration of multi-agency forward control point, rendezvous points and marshalling arrangements during terrorist incidents and suspected terrorist incidents.**

- 5.173.** At 23:53hrs National Inter-Agency Liaison Officer three, the most senior of the National Inter-Agency Liaison Officer cadre at the rendezvous point, telephoned his Principal Officer, the Chief Fire Officer, to discuss the incident. This appears to be the first time that a National Inter-Agency Liaison Officer had spoken directly with a Principal Officer since mobilisation. This apparently contradicted the standard operating procedure that all National Inter-Agency Liaison Officer initial decisions should be discussed with a Principal Officer within 30 minutes, in order to provide validation for those decisions.
- 5.174.** It is, however, clear to the Panel that once North West Fire Control had spoken to the Duty Group Manager at 22:52hrs, he then briefed both the Assistant Principal and Principal Officer with his interpretation of the decisions that had been made by the Duty National Inter-Agency Liaison Officer to that point, which is a normal protocol. The Duty Group Manager then also spoke to the Duty National Inter-Agency Liaison Officer on the phone at 23:02hrs and so the Duty National Inter-Agency Liaison Officer was aware that the Assistant Principal and Principal Officer had received an update on actions and decisions to date.
- 5.175.** Following the conversation between National Inter-Agency Liaison Officer three and the Principal Officer, the pumps, crews, Special Response Teams, Technical Response Team and National Inter-Agency Liaison Officers moved forward to Manchester Central Fire Station at 23:58hrs, where they joined the NWS vehicles.
- 5.176.** The Panel has spoken to all the National Inter-Agency Liaison Officers involved and they have stated that, as far as they were concerned, the movement of GMFRS vehicles and crews was effectively the last time they felt in control of the incident. Subsequent to this, from the National Inter-Agency Liaison Officers' perspective, command and control authority was implicitly removed from them and was taken by the Chief Fire Officer (the duty Principal Officer) who was by now at

the GMFRS Command Support Room with the rest of the senior management cadre who had been mobilised.

- 5.177.** On arrival at Manchester Central, with no further information about the incident from North West Fire Control, no knowledge of any major-incident or Operation PLATO declarations or of any METHANE reports from other agencies at the scene, the National Inter-Agency Liaison Officers became concerned when they saw NWS ambulances driving out of the holding area and directly toward the Arena, with the crews wearing no form of ballistic protection. At this point the National Inter-Agency Liaison Officers were all still under the impression that a Marauding Terrorist Firearms Attacks incident could be occurring.
- 5.178.** Although the GMFRS assets and personnel were now co-located at Manchester Central with NWS personnel, this was still not a multi-agency command location, i.e. there were no operational (Bronze) level empowered incident managers there, other than the National Inter-Agency Liaison Officers. Multi-agency coordination was still occurring elsewhere, either on Victoria train station concourse (Bronze) or increasingly at the GMP Force Command Module (Silver, Gold), where there was still no GMFRS presence until National Inter-Agency Liaison Officer four arrived at 00:04hrs after self-deploying<sup>25</sup>. Accordingly, the National Inter-Agency Liaison Officers still lacked the capability to attain substantive multi-agency shared situational awareness.
- 5.179.** The National Inter-Agency Liaison Officers, however, told the Panel that by now they did feel that they had more than enough situational awareness to know that they should be moving forward to provide support at the scene. The social media imagery and the clearly unhindered movement of the ambulances supported that understanding.
- 5.180.** National Inter-Agency Liaison Officer three who, due to his seniority, had by now taken over as Officer in Charge of the incident from the Duty National Inter-Agency Liaison Officer, then started to prepare the Special Response Teams to move forward. This activity was stopped by a command from the Principal Officer, who

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<sup>25</sup> Although off duty, National Inter-Agency Liaison Officer four had become aware of the incident and telephoned two senior officers who coincidentally were also off duty and had suggested he self-deploy to the GMP Force Command Module, which was agreed

ordered three pumps and crews and the Duty National Inter-Agency Liaison Officer to move forward to the scene. This order caused the National Inter-Agency Liaison Officers and Special Response Teams considerable concern because everything they had been able to deduce to that point about the situation at the Arena obviously suggested the need for the specialist equipment and medical-trauma training that the Special Response Teams possessed.

- 5.181.** In effect to the personnel now at Manchester Central this command from their Principal Officer went against normal GMFRS incident-management practice, because in virtually any other situation command would have been retained by the Incident Commander. However, what was presented to the Principal Officer was not a normal situation as he was aware that after this unusually long period of time there were still no Fire Service resources at the scene. Therefore, having spoken to the NWAS Bronze he felt it imperative to intervene. Although the National Inter-Agency Liaison Officer as the senior officer at the rendezvous point considered himself to be the incident commander, he now made the assumption that this status had been taken by the Principal Officer. For these experienced managers at the rendezvous point this realisation caused considerable shock.
- 5.182.** The Panel believes that the Principal Officer, the Chief Fire Officer, was frustrated that he had not been informed about the incident earlier by North West Fire Control and also felt that the 30 minutes described in the National Inter-Agency Liaison Officer guidance, giving autonomy of decisions to National Inter-Agency Liaison Officers, had elapsed. This led him to believe that he should intervene with the tactical decision making at this point. This is not the Panel's interpretation of the National Inter-Agency Liaison Officer guidance and was not the interpretation of the National Inter-Agency Liaison Officers, who by this point had developed a direct-action plan which they now saw being disregarded by their most senior officer. However, a separate explanation is that because by this time the Chief Fire Officer had spoken directly by phone to the NWAS Bronze on the station concourse he was, as a result, in possession of greater shared situational awareness of conditions at the scene than were any of the National Inter-Agency Liaison Officers. He also knew that the NWAS Bronze had only asked him for support from standard crews, not special teams. Accordingly, the Principal Officer's decision to not move the specialist rescue teams forward and instead to deploy three pumps and crews can be understood as him holding those specialist

teams in reserve, in case any further attacks occurred in the city. It should not be forgotten that by the time this happened at 00:20hrs conditions on the station concourse had stabilised considerably and the GMP Ground Assigned Tactical Firearms Commander and NWS Bronze had agreed the 'Operation PLATO is on stand-by' status.

**5.183.** However, the shock experienced by the National Inter-Agency Liaison Officers at having command rescinded from them was then immediately amplified for the National Inter-Agency Liaison Officers at 00:20hrs when information came from National Inter-Agency Liaison Officer four in the GMP Force Command Module that GMP had declared Operation PLATO<sup>26</sup>. Suddenly, from a situation where they had only been operating on an assumption of a Marauding Terrorist Firearms Attacks, this information suggested that the threat was manifest. The National Inter-Agency Liaison Officers immediately tried to renegotiate with the Command Support Room to get the Special Response Teams to move forward to the scene instead of the standard crews. However, this request was denied (because the Principal Officer was now aware of the Operation PLATO stand-by status) and the standard crews and Duty National Inter-Agency Liaison Officer were sent forward, where they arrived at 00:37hrs, two hours and six minutes after the explosion.

**5.184.** Following arrival, it should be noted that the Duty National Inter-Agency Liaison Officer still acted strictly in accordance with his standard operating procedures by not initially allowing firefighters onto the station concourse without first seeking permission from the Chief Fire Officer. Whilst this is completely understandable in a context where the National Inter-Agency Liaison Officers had only minutes before been told Operation PLATO had been declared, it also illustrates the fact that the Chief Fire Officer was indeed now the incident commander and that the Duty National Inter-Agency Liaison Officer now felt unable to make critical decisions, even though he now had the most comprehensive levels of situational awareness of any GMFRS officer in the county.

**5.185.** This situation seemed particularly odd to the Bronze Commanders from the other services who had now been working at the scene for nearly two hours and who could see the immense frustration on the firefighters' faces at their still being

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<sup>26</sup> This was the first time GMFRS officers had been made aware of the Operation PLATO status since it had been declared by the GMP Force Duty Officer at 22:47hrs.

restrained from helping the other responders, who were clearly visible to them all treating the casualties within the station building.

## The Role of North West Fire Control in Supporting a Fire and Rescue Service

- 5.186.** As a Local Authority Controlled Company, North West Fire Control is staffed by civilian (i.e. not operational Fire and Rescue Service personnel) managers and operators, some of whom have worked with or alongside GMFRS for many years.
- 5.187.** It is important to note, however, that North West Fire Control's role is to "handle all 999 emergency calls and be responsible for mobilising firefighters and fire engines to incidents". It is not the role of North West Fire Control operators or managers to 'command' GMFRS personnel. Command of GMFRS assets at the scene is carried out by the Fire and Rescue Service's Incident Commander. North West Fire Control operators support the command decisions made by the Incident Commander, they do not give orders.
- 5.188.** On the night of the attack, North West Fire Control operators acted in accordance with the agreed action plan for 'BOMB' and mobilised the Duty National Inter-Agency Liaison Officer. They then followed his instructions to mobilise four pumps and crews to Philips Park. In effect once the National Inter-Agency Liaison Officer had been mobilised, North West Fire Control took on its designated supportive role. This supportive role involved the active coordination and mobilisation of GMFRS assets, but a much more passive approach to communicating and coordinating directly with other agencies.
- 5.189.** Therefore, in the following minutes other assets were mobilised in response to actions in the action plan and from the additional instructions given by the National Inter-Agency Liaison Officer and Duty Group Manager (i.e. two additional National Inter-Agency Liaison Officers and Marauding Terrorist Firearms Attack specialist rescue teams were also sent to the Philips Park rendezvous point).
- 5.190.** The relationship between North West Fire Control and GMFRS meant, however, that North West Fire Control operators were not authorised, nor trained to question whether the National Inter-Agency Liaison Officer's instructions were



most appropriate or effective from a multi-agency response perspective. These operators, even knowing that the GMP rendezvous point had been nominated as the Cathedral car park, did not and could not question the National Inter-Agency Liaison Officer's instruction to move all mobilising GMFRS assets to Philips Park, or the directions from other officers that the management team should deploy to the Command Support Room.

- 5.191.** The Panel believes that this situation clearly illustrates the limitations of the current service-level agreement between GMFRS and North West Fire Control. This contractually defined lack of agency, which directly affects North West Fire Control operators, meant that the operators were removed from the decision-making. This led to an inability of North West Fire Control operators to fully understand the GMFRS response that they were supporting.
- 5.192.** As the North West Fire Control personnel stated to members of the Panel "We thought there was a multi-agency plan being developed via the National Inter-Agency Liaison Officer network, we thought [the GMFRS Officers] were enacting a plan that we weren't aware of".
- 5.193.** Other than notifying the on-call GMFRS officers, therefore, the majority of deployment commands were given separately from North West Fire Control by other GMFRS officers. Accordingly, North West Fire Control were reliant on their being told by these officers who had been deployed and where to. The Panel finds it surprising that North West Fire Control were not able, apparently due to the restrictive terms of their service-level agreement, to deploy even the GMFRS Duty Gold and/or Silver officers to the Force Command Module. It is the Panel's opinion that this limitation on North West Fire Control operators' ability to deploy GMFRS assets directly to appropriate command locations needs to be removed.
- 5.194.** The Panel believes that North West Fire Control protocols are designed predominantly around the mobilisation of 'ordinary' responses to ordinary incidents. In an ordinary incident (e.g. a house fire; a major fire), North West Fire Control would immediately mobilise a Pre-Determined Attendance of a 'command structure' of pumps and crews and an Incident Commander to the scene. Therefore, North West Fire Control would be getting information directly from the incident commander at the scene, on average, after five minutes and 41 seconds.

This information would directly influence and direct the operators' next actions and/or mobilisations. It is also normal practice that at incidents which are anything other than minor in scale, regular 'informative messages' are sent back from the incident to North West Fire Control, so that they build an information-base about the incident, and which can then be shared upon the request of partner agencies.

- 5.195.** Unfortunately, due to the extraordinary nature of both the Arena attack itself and the Pre-Determined Attendance protocol for 'BOMB', which stipulated the pre-mobilisation deployment of only a National Inter-Agency Liaison Officer, North West Fire Control operators were placed in an information vacuum that they were totally unused to. In effect, the operators did not have information coming to them from GMFRS personnel at the scene for over two hours. Accordingly, the operators and supervisors became totally dependent on the information passed by partner agencies to develop their awareness of conditions and threats at the scene.
- 5.196.** It is, however, quite ordinary for partner agencies' control rooms only to share quite basic information and updates between themselves during incidents, and having viewed the call transcripts, this appears to the Panel to have been the case on the night of the attack. The fact that there were no protocols for an extraordinary incident (i.e. where no information would be coming directly from the scene from a GMFRS incident commander within minutes) meant that North West Fire Control operators could only follow the action plan they had and/or act on requests that came from GMFRS officers, none of whom had substantive situational awareness either.
- 5.197.** This should be seen as a direct challenge to GMFRS's partner agencies for not sharing additional information (including clearly defined METHANE messages and major incident notifications). It is the Panel's opinion that the sharing of these notifications should certainly have been done more effectively by those partners whose on-scene personnel passed such details; communication of such information is after all a key requirement within the JESIP principles. This criticism, however, obviously also encompasses the considerable delay in GMP's notification of the declaration of Operation PLATO to its partners. Importantly, however, identifying this issue and stating this as a criticism of all involved partners also highlights the fact that no contingency had been developed between GMFRS and North West Fire Control, which actively encouraged North West Fire

Control operators to seek situational awareness from GMFRS' partner agencies. It also underlines the fact that the Duty National Inter-Agency Liaison Officer did not think beyond his published procedures to request North West Fire Control operators to gather situational intelligence more actively on his behalf.

**5.198.** In effect, there was no contingency to re-orientate North West Fire Control from its ordinary operation in supporting decisions made by GMFRS officers to one where operators could be empowered actively to seek and request information from other agencies without being asked directly to do so. From this perspective, for example, it is the Panel's opinion that it was insufficient for North West Fire Control to be merely monitoring the Airwave Interoperability channel. Operators should have been actively using the channel to draw METHANE information from other responders.

**5.199.** The Panel is aware that significant changes have already occurred in control room practice in Greater Manchester since the attack, foremost of which is the introduction of the dedicated, regularly tested, inter-control room Airwave Emergency Services channel. The introduction of this measure, whilst clearly overdue, does in the Panel's view now offer genuine opportunities to improve multi-agency working. The Panel is hopeful that the situation of agencies' control rooms not being able effectively to pass critical information between them during major incidents will never happen again.

## Leadership and Culture Within Greater Manchester Fire and Rescue Service

**5.200.** There is an obviously increasing emphasis within the Greater Manchester Resilience Forum membership on the application of the JESIP principles within multi-agency practices. Therefore, the Panel finds it hard to understand why the majority of GMFRS's on-duty officers deployed themselves and/or each other to GMFRS' own Command Support Room, without concurrently deploying appropriate senior officers (not just a single junior Tactical-trained officer) to the GMP Force Command Module. Yet, this is exactly what happened on the night of the attack.

- 5.201.** The Panel found this behaviour by the Service's most senior officers particularly surprising given the substantial leadership role GMFRS has had within the Greater Manchester Resilience Forum over recent years. For example, GMFRS has chaired the Greater Manchester Resilience Forum for the past seven years and has been instrumental in several initiatives through which to support the service's responder partners. Such initiatives include GMFRS having been the first and only Fire and Rescue Service to have trained and equipped all its firefighters and pumps to respond to cardiac arrests for the ambulance service<sup>27</sup>. It has also, undoubtedly, played a key role in supporting the multi-agency response to countless incidents in the city-region, from minor to major.
- 5.202.** However, by focusing his management team within the Command Support Room on the night of the attack, the Chief Fire Officer, in his role as on-call Principal Officer, played a key role in delaying opportunities through which GMFRS capabilities and capacities could be integrated into the multi-agency Strategic and Tactical coordination of the response.
- 5.203.** It is acknowledged by the Panel that at different times, officers who attended the Command Support Room had been in telephone communication with each other and others (e.g. National Inter-Agency Liaison Officers, North West Fire Control and, in the case of the Chief Fire Officer/Principal Officer, with the NWS Chief Executive Officer and by text with the GMP Chief Constable). However, the Panel finds it hard to conclude that such communications between individuals enabled this group of senior officers to establish a shared situational awareness and joint understanding of risk to any substantive degree until they physically arrived at the building. Having spoken to many officers who did attend the Force Command Module it is clear that they obtained or enhanced their tactical and strategic information through face-to-face discussions or through what they heard whilst in the Force Command Module.
- 5.204.** Even then, until after 00:04hrs when the fourth National Inter-Agency Liaison Officer arrived at the Force Command Module, the Command Support Room's principal source of information was effectively via its officers and crews and North West Fire Control, none of whom were either at the scene, co-located with or

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<sup>27</sup> This initiative has, however, now been suspended across the country as a matter of national industrial relations.

directly communicating with any Gold, Silver or Bronze Commanders from other organisations.

- 5.205.** When combined, what the lack of situational awareness within the Command Support Room and the failure to deploy personnel directly to the GMP Force Command Module appears to illustrate to the Panel, is an organisation brought to the point of failure by a reversion, under pressure, to a state of single-agency thinking. It is the Panel's belief that this was underpinned by the Service's culture.
- 5.206.** From this perspective it is important to reflect on the fact that the Fire and Rescue Service culture differs from the other services in important ways. Whereas police officers are granted considerable autonomy to carry out their duties, firefighters are much more defined by their position as part of a team and the adherence to protocol. The Fire and Rescue Service has developed in this way over decades to ensure the safety of firefighters who face extreme hazards.
- 5.207.** Police and ambulance cultures have evolved differently. None of these cultures is intrinsically 'wrong', they are just different. However, what the actions of the senior fire officers on the night of the attack suggest, is that over-reliance on the current GMFRS culture worked against the principles of good interoperability as defined by JESIP.
- 5.208.** For the Panel, such a conflict was clearly illustrated by the Chief Fire Officer/Principal Officer and Assistant Principal Officers' self-deployment and apparent attachment to their own Command Support Room. The negative effect of a hierarchical culture was also illustrated by the Chief Fire Officer effectively taking command of the incident from the Command Support Room and away from the National Inter-Agency Liaison Officer in charge, even if for understandable reasons (i.e. differing situational awareness). Regardless, this was an action that was reported to the Panel by numerous witnesses as something that caused them complete surprise and considerable unease.
- 5.209.** Whereas all other services and Greater Manchester Resilience Forum partners were rapidly deploying senior management team members to the GMP Force Command Module (in accordance with well-rehearsed plans), the Chief Fire Officer felt that it would be sufficient to know that a silver-trained Station Manager

(National Inter-Agency Liaison Officer) was self-deploying to the Force Command Module to act as GMFRS' only asset in that multi-agency environment. During discussion the Chief Fire Officer told Panel members that he had not attended the Force Command Module because he had not been informed of the time of the first Strategic Coordinating Group meeting and that he had been reticent to attend anyway, because his perception of the Force Command Module last time he had gone during an incident is that it had been 'chaos'. By contrast, the Panel has spoken to many officers from a broad spectrum of organisations, including other Gold level officers from other organisations, who are familiar with working in the multi-agency Force Command Module environment. There is broad agreement amongst these officers that the Force Command Module and Silver/Gold environment may be busy, and it certainly was on the night, but it is not chaotic. The Panel believes, therefore, that the Chief Fire Officer's reasons given are insufficient for the Principal Officer not to have attended the Force Command Module immediately following the attack and that there should have been Gold-level GMFRS attendance at the Force Command Module at the earliest opportunity.

**5.210.** The Panel has heard on several occasions from many GMFRS officers and crews that "Whatever they'd [partner services] have asked for they would have got". But this misses the whole point of multi-agency working. In an incident of this magnitude, principal emergency service partners should not have to ask each other to attend. They should go, together.

**5.211.** However, taking this perspective makes it clear to the Panel that its Review of the multi-agency response to the Arena attack has raised important issues in relation to how effective the current levels of multi-agency working can be during the busy stages of initial response and specifically for GMFRS during extraordinary major incidents.

**5.212.** It is clear to the Panel that across different agencies of the sizes and complexities contained within the Greater Manchester Resilience Forum partnership there will be different degrees of experience and expertise across a wide range of matters. Also, all agencies have different cultures, functions and ways of working. It should not be assumed that a desire to work together will always result in smooth Inter-Agency working and especially under the pressure of extreme and complex

situations. Within GMFRS, different officers and staff will have greater or lesser experience in multi-agency working and more specifically in multi-agency command, control and communication. All agencies and specifically GMFRS need to consider this and ensure a suitable level of competence and experience is underpinned by relevant training and preparation for all their relevant staff to ensure effective responses are delivered when ordinary or more extraordinary events happen.

**Recommendation: All Local Resilience Fora should review their planning assumptions and expectations in relation to multi-agency communications during major incidents. Emphasis should be placed on identifying potential single points of failure in communication networks (i.e. technological and command) and building in resilience and/or alternative contingencies to avoid such failures.**

**Recommendation: Greater Manchester Resilience Forum members should develop contingencies to enable METHANE messages to be shared directly between partner agencies' control rooms immediately upon receipt of a message from the incident scene.**

**Recommendation: All Fire and Rescue Services utilising North West Fire Control as their call management and resolution service should review their service-level agreements and build resilient contingencies and capabilities within North West Fire Control to enhance the development of multi-agency shared situational awareness, which can most effectively inform their Fire Service command, control and coordination during no-notice major incidents.**

**Recommendation: All GMFRS firefighters should be sufficiently trained and equipped to attend a nominated multi-agency rendezvous point during terrorist-related and suspected terrorist-related incidents.**

**Recommendation: Greater Manchester Fire and Rescue Service and North West Fire Control should revise their policies and procedures (including action plans) for Bomb, Explosion and Marauding Terrorist Firearms Attack**

**to ensure that greater emphasis is placed on multi-agency co-location, communication and coordination.**

**Recommendation: Greater Manchester Resilience Forum members should adopt the common understanding of specific terms and phrases which impact on multi-agency working that is defined within the Lexicon of UK Civil Protection Terminology (e.g. rendezvous point, forward command point, holding area) .**

**Recommendation: Greater Manchester Police, as lead responder during terrorist incidents and on behalf of the Greater Manchester Resilience Forum, should review the procedures and protocols underpinning the expectations placed on direct communications links between the Greater Manchester Police Force Duty Officer and other partners' control rooms and critical response assets (e.g. Inter-Agency Liaison Officers) .**

**Recommendation: Greater Manchester Police, as lead responder during terrorist incidents and on behalf of the Greater Manchester Resilience Forum, should review the technical capability and capacity of communications links between the Greater Manchester Police Force Duty Officer and other partners' control rooms and critical response assets (e.g. Inter-Agency Liaison Officers) .**

**Recommendation: Greater Manchester Fire and Rescue Service should review the procedures, protocols and expectations that underpin communications links between its Inter-Agency Liaison Officers, the GMP Force Duty Officer and other partners' control rooms and critical response assets (e.g. Hazardous Area Response Teams)**

**Recommendation: The Chief Fire Officers' Association, National Fire Chiefs' Council and Greater Manchester Fire and Rescue Service should revise all policies, procedures and training for National Inter-Agency Liaison Officers and Incident Commanders to ensure that greater emphasis is placed on embedding multi-agency co-location, communication and coordination during major incidents into their standard operating procedures.**



**Recommendation: Greater Manchester Resilience Forum members should conduct a review of their planning assumptions in relation to multi-agency working, up to and including scenarios for all plausible worst-case major incidents.**

**Recommendation: All agencies and specifically GMFRS need to ensure a suitable level of competence and experience is underpinned by relevant training and preparation in multi-agency command, control and communication for all their relevant staff to ensure effective responses are delivered when normal or more extraordinary events happen.**

**Recommendation: The response to the Arena attack provided an extraordinary validation of the on-going work within the UK civil protection sector to embed the JESIP Interoperability Framework into practice. Where responders were able rapidly to co-locate, communicate and coordinate their activities, situational awareness was usefully shared, risks were jointly assessed, and pragmatic solutions were developed to mitigate severe, time-critical, challenges. Where unforeseen limitations in guidance, protocol and circumstance collided to block such close collaboration, the response of the organisation affected was paralysed for a crucial period. Accordingly, it is the Panel's belief that the findings of the Review should provide a critical stimulus for responders nationally to reassess all plans and protocols that include assumptions of interoperability during major incidents, for the response to the Arena attack provides undeniable evidence that such assumptions need to be vigorously tested.**

## **The Role of the Military During the Response to the Arena Attack**

- 5.213.** The military liaison team were on their way to the Force Control Room anticipating the need for the support in advance of any formal activation by the Force Duty Officer. This proved valuable due to pressures experienced by the Force Duty Officer in the initial few hours in their role in activating partner agencies as part of established call-out arrangements. In addition, the military liaison team were contacted by the Force Duty Officer as part of the Operation PLATO declaration whilst they were en-route to the Force Control Room.

**5.214.** It is the Panel's understanding that call-out procedures have already been improved as a direct result of lessons identified from the attack. However, given that the formal call-out procedures had already been recognised as problematic by responders during earlier exercises and shortfalls had obviously still not been fully rectified, it is the Panel's opinion that any new procedures should be robustly tested to ensure their suitability and resilience.

**Recommendation: Greater Manchester Police should initiate a robust testing procedure to ensure the on-going suitability and resilience of its multi-agency emergency call-out procedures to ensure all relevant agencies receive timely notification of and activation in an incident.**

**5.215.** The issues related to the efficacy of call-out of the military were not, however, purely one-sided. The Panel heard from both the Force Duty Officer and the Ground Assigned Tactical Firearms Commander that following the declaration of Operation PLATO, the notification of Military Assets did not happen as effectively as they had hoped.

**5.216.** In accordance with the Operation PLATO protocol, the Force Duty Officer contacted Military Assets direct via telephone directly after its declaration. However, the call was put on hold by the military switchboard for four minutes before he was able to inform their duty commander of the situation. This at a time when, according to the same protocols, the Force Duty Officer was needing to carry out numerous other notifications himself using a single out-going phone line, whilst also remote managing the developing situation at the Arena.

**5.217.** The Panel has also identified that the bureaucratic requirements of maintaining Military Assistance to Civil Authorities support during extended operations should be improved. The military liaison team undoubtedly provided vital support in assisting in the development of the required formal written requests to the Ministry of Defence, yet for some niche capabilities (e.g. Military Assets commitment) this process of developing and making requests needed to be repeated every 24 hours. This placed specific pressure on the military liaison team but also required daily attention in Cabinet Office Briefing Room meetings, thus distracting ministers from other business.

**Recommendation: The Ministry of Defence should review its procedures for authorising Military Assistance to Civil Authorities requests, for operations which will foreseeably require unvarying resources to be in place for durations beyond 24 hours.**

**5.218.** Whilst not directly affecting Greater Manchester (as no additional resources were deployed there as a result), it is the Panel's opinion that the fact that Operation TEMPERER<sup>28</sup> had been the subject of a national exercise four days prior to the attack, meant that the plans were enacted particularly effectively, and provided another illustration for the Panel of the value of the nation's inclusive civil protection training and exercising regime.

**Recommendation: The Panel heard from NHS and Greater Manchester Police (GMP) personnel about the significant contribution from the military: their positive willingness to share both specialist expertise and equipment was valuable and important in, for example, treating the injured and conducting post-mortem examinations. This approach should be considered for replication in other events.**

## **Operation PLATO**

**5.219.** Throughout that part of the Review that has examined the emergency services' response to the Arena attack, the discussion of Operation PLATO has influenced the narrative of all the contributions received. For the Panel, this indicates that the declaration of Operation PLATO and the structure of current Joint Operating Principles for Marauding Terrorist Firearms Attacks (Joint Operating Principles v.4) require specific comment.

**5.220.** What is clear to the Panel is that the decision by the GMP Force Duty Officer to declare Operation PLATO at 22:47hrs on the night of the Arena attack was sound. Indeed, the Panel understands from its discussions with Home Office officials that Operation PLATO has been declared for all significant recent terrorist attacks in the UK, not least because it triggers the deployment of national assets.

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<sup>28</sup> Operation TEMPERER is a British Government plan to deploy troops to support police officers in key locations following a major terrorist attack. Operation TEMPERER provides additional capacity to "augment armed police officers engaged in protective security duties" around the country

- 5.221.** From the information available to the Force Duty Officer at the time, it is clear that the potential existed for the explosion in the Arena foyer to have been the precursor to additional distributed attacks. These attacks could have used Improvised Explosive Devices, and could have been indiscriminate in their use of weapons and/or vehicles against further soft targets in Manchester. These attacks could have taken the form of Marauding Terrorist Firearms Attacks. However, from what the Panel has learnt, it is unlikely that the Police response deployed to any of these types of attacks would have differed from that which was activated in anticipation on the night of Monday 22<sup>nd</sup> May 2017.
- 5.222.** It is the Panel's opinion that the Counter Terrorist response deployed by GMP following the Arena attack was completely proportionate and appropriate. Furthermore, it is the Panel's opinion that in the interests of public safety, the large-scale intensive deployment of firearms capability in response to any sort of terrorist attack is appropriate, particularly so given Europe's recent experience of the risk of cascading attacks occurring.
- 5.223.** However, despite the appropriateness of the Police response to the attack, shortfalls did occur in how the declaration of Operation PLATO was communicated to GMP's emergency services partners. As discussed in earlier sections, the Panel understands why the Force Duty Officer did not actively ensure that partner agencies had been informed and were responding. The Force Duty Officer was already fully committed with activating capabilities in accordance with Operation PLATO protocols as well as managing the wider GMP response to the attack and as supporting GMP's other ongoing 'business as usual'.
- 5.224.** The Panel has also identified where the Force Duty Officer made a 'life or death' decision, to allow responders to remain in the foyer whilst it was still considered a 'hot zone', in order that they could actively protect the lives of those already injured. Although contrary to Joint Operating Principles, it is the Panel's opinion that this key use of discretion by the Force Duty Officer illustrates clearly that flexibility must be allowed in decisions that involve life risk.

- 5.225.** What the Force Duty Officer's decision also illustrates is the critical importance of shared situational awareness and the joint understanding of risk, between the Force Duty Officer and those at the incident scene.
- 5.226.** In relation to shared awareness at the incident scene, the Panel was informed of the valuable role played by the Ground Assigned Tactical Firearms Commander in holding JESIP scrums with other responders. However, GMP officers did suggest that if the firearms threat had moved, the Ground Assigned Tactical Firearms Commander would have moved accordingly. It is clear that had this occurred on the night, partners may have been left without a police command presence and that this would have inhibited further 'scrums' and JESIP information sharing at what had become a consolidated multi-agency coordination facility (i.e. the Casualty Clearing Station). In light of this concern the Panel is minded to suggest that the Bronze-role expectations placed on the Ground Assigned Tactical Firearms Commander should be reviewed in the Joint Operating Principles and PLATO guidance.
- 5.227.** In further consideration of responders' situational awareness at the scene, the Panel has been impressed to hear contributors to the Review describe how they moved toward the scene whilst constantly re-assessing the situation around them. Their focus was on saving lives. These individuals (emergency services, Arena and rail staff and public alike) were risk-accepting in a way that defines courage.
- 5.228.** Knowing what the Joint Operating Principles prescribed responders should do, led to an eventual, somewhat pragmatic, compromise between the GMP and NWSA Bronzes, with them negotiating an on-scene 'PLATO is on stand-by' status: which does not appear in UK doctrine but which, critically, allowed them to continue the evacuation and use of the Casualty Clearing Station in situ. The alternative would have been the enforcement of a whole scene withdrawal of responders and the initiation of a full 'warm zone' casualty evacuation procedure (i.e. allowing only NWSA only Hazardous Area Response Team, and GMFRS and other Marauding Terrorist Firearms Attack-equipped personnel, into the scene).
- 5.229.** Taking all this information into consideration, it is the Panel's opinion that a key recommendation identified as a result of the Arena attack is that any response to terrorist attacks needs to take greater account of the likelihood that responders

may be faced with complex scenes that cannot be understood from distance but require forward movement to investigate.

- 5.230.** Through the actions of those involved, the response to the Arena attack has shown that producing national doctrine that prescribes 'appropriate' responses only in the context of one principal anticipated method of attack (i.e. Marauding Terrorist Firearms Attack) may introduce the real risk that responders will be focused on written protocols when they should be trusting their own judgement and training. The bravery displayed by all the responders who entered that incident scene on the night of 22<sup>nd</sup> May 2017 clearly illustrates that when protocols become too constraining there is immense value in empowering and enabling responders to deal with incidents using situationally aware, informed and risk-assessed initiative.
- 5.231.** The Panel has also identified that Operation PLATO has been deployed to recent terrorist incidents including ones which were not a Marauding Terrorist Firearms Attack. The strict adherence to the relationship between a Marauding Terrorist Firearms Attack and Operation PLATO can lead to confusion, to a lack of common situational awareness or can inhibit the dynamic application of capabilities to deal with the actual situation presented to the responders. The Panel believes that as currently, Operation PLATO is specifically designated as a response to a Marauding Terrorist Firearms Attack, agencies can get confused if the intelligence indicates that firearms are not involved but Operation PLATO has been declared, for example.

**Recommendation: Operation PLATO should be reviewed and modified as deemed necessary to inform the response to any form of terrorist attack and be referred to as the Joint Operating Principles for Responding to a Terrorist Attack, regardless of whether firearms are thought to be involved.**

## **The Response from Network Rail, Northern and Transport for Greater Manchester**

- 5.232.** The Panel notes the swift response to the explosion from staff based at Victoria station and their self-deployment to the scene to provide humanitarian assistance. As with Arena staff, this public spirited and brave response made a positive difference particularly in the period prior to the arrival of the emergency services and subsequently in assisting with the challenge of carrying casualties from the foyer down to the station concourse.
- 5.233.** Transport for Greater Manchester activated their incident management team swiftly and were represented early at GMP Headquarters Forward Command Module along with multi-agency Gold and Silver responders. The early formation of a 'Transport Cell' made liaising and working together more effective for the transport industries and was of direct relevance for responding to this incident given the location.
- 5.234.** The previous experience testing the trauma network's response to mass casualties as part of Operation SOCRATES proved beneficial in meeting the request for buses and drivers to transport P3 casualties on the night. The Panel was informed of the significant contribution to the response by Bus and Metrolink Operators, often at short notice, and were also impressed with the well-equipped setup of the Transport for Greater Manchester Incident Control Room and their connectivity.
- 5.235.** The Panel is also, however, aware that Transport for Greater Manchester do not bear statutory status as a Category 2 responder in the same way that rail operators and other comparable organisations do, such as Transport for London. It is important, therefore, for Greater Manchester Resilience Forum partners to balance any reliance that is placed on Transport for Greater Manchester to facilitate transport contingencies during emergencies, against understanding any implications of this for the separate statutory responsibilities of Transport for Greater Manchester's partners.

**Recommendation: The Transport Cell is a critically important component of the Greater Manchester Resilience Forum’s plan. It provides critical business continuity and recovery support and should be adopted as national good practice.**

## **Navigating Early Practical Guidance and Advice**

**5.236.** The Panel has heard a clear and consistent message from those in need after the attack that they found it hard to find trusted guidance and advice on practical and financial matters. Dealing with these on top of sudden bereavement and suffering significant injury was demanding and added to the other troubles. Survivors of previous terrorist attacks and disasters have said the same. The importance of planning integrated arrangements from the prompt delivery of humanitarian assistance and early, proactive widespread outreach has long been recognised as best practice in addressing people’s needs in major emergencies (Eyre, 2006)<sup>29</sup>. This is also recognised within Greater Manchester’s planning arrangements and, in keeping with its statutory role and contingency arrangements, Manchester City Council established and led a multiagency Welfare and Health Group aimed at coordinating support initiatives.

**5.237.** Notwithstanding this, it is not uncommon for volunteers and charitable organisations to activate their own independent response and offer support, albeit this can result in an unhelpfully fragmented and duplicated range of services which can be hard for those in need to navigate. This appears to have been the case here and may help to explain why the Panel found that some charities offer such guidance, but it is too difficult to find at a time of crisis and too difficult to know whom to trust. The Panel believes that clear objective guidance on early sources of help and advice appropriate to the particular incident that has taken place should be made available and be easily accessible to members of the public, and that this should be widely publicised by the coordinating local authority as well as the Government.

<sup>29</sup> Eyre, A (2006) Identifying People’s needs in Major Emergencies and Best Practice in Humanitarian Response, Independent report commissioned by the Department for Culture, Media and Sport, October 2006  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/61224/ha\\_literatu\\_re\\_review.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61224/ha_literatu_re_review.pdf)



**5.238.** The Panel has heard that this should include information on financial entitlements, dealing with the mainstream media and social media and organising funerals. Many felt there should also be a national helpline to assist with such matters. In fact, several organisations could have helped with such advice and a number established helplines. Such comments may perhaps have reflected a lack of awareness about what was available and reinforces the importance of a more centrally coordinated provision and communication about exactly what kinds of support are available and by whom.

**5.239.** The Home Office has established a Victims of Terrorism Unit to identify and consolidate pathways of support to those affected by terrorist attacks, and the Panel suggests drawing on the experiences from Manchester in informing that work.

**Recommendation: The work being undertaken by the Home Office Victims of Terrorism Unit to identify and consolidate pathways of support to those affected by terrorist attacks draws on the experiences from Manchester in informing their work, and includes producing clear guidance and practical advice. This advice should be made available by the Home Office for victims of terrorism and be widely publicised.**

## **Getting the Right Help from Charities**

**5.240.** Many of the responders to the Review mentioned their contact with charities after the attack. Manchester City Council, in partnership with other responders, had undertaken years of planning with charities in case of such an emergency. Amongst other charities, particular support was offered by the British Red Cross, the Peace Foundation, the Salvation Army and Victim Support. However, many other charities came forward to offer help, although some reported finding it difficult to connect to public agencies.

**5.241.** Whilst many of those contacting the Review had found their interaction with charities very positive, others had felt let down by promises which did not materialise or by 'counselling' which was not helpful.

**5.242.** Review participants from both Manchester City Council and Greater Manchester Health and Social Care Partnership comment on the undefined role and remit of some voluntary groups in the emergency response and the variation in approach and effectiveness. It appears that, for bereaved people and survivors, getting the right help from a charity depends on numerous factors, some of which the Panel believes could be resolved by an accreditation process together with a public information campaign, perhaps led by a professional accreditation body in consultation with organisations such as the Voluntary Sector Civil Protection Forum.

**5.243.** A more comprehensive and longer-term review of the experiences of those affected by the Manchester attack (including where possible those in receipt of service support and those who did not access it) would be especially useful for informing a review of how to better communicate and coordinate offers of help. It may also help with identifying of the kinds of charities, organisations and services which might in future be formally recognised and accredited as appropriate for inclusion in local authority and Local Resilience Forum plans.

**Recommendation: A national review of the possibility of accrediting charities to deliver effective services in the response to an emergency should be undertaken, avoiding the accreditation process becoming too burdensome for the charities concerned but including a requirement to plan with Local Resilience Fora ahead of emergencies.**

**Recommendation: That any national review of voluntary sector engagement in an emergency response consider how to accredit specialist and local charities without making this too burdensome for the charities concerned.**

## **Mental Health and Emotional Wellbeing Support**

### **The Manchester Focus**

**5.244.** During the discussions, many of the organisations, both statutory and voluntary, told the Panel of their initial underestimation of how many people involved in the incident were actually from outside the Greater Manchester area. Whilst the Greater Manchester Health and Social Care Partnership tried to communicate

messages across NHS networks, it is clear from what the Panel has been told by those who were injured that many felt their local health providers were unaware. In addition National Pathway providers reported difficulty in linking in with local structures. Some contributors told the Review that they believed the reason they were not allocated a Family Liaison Officer was because they were out of Manchester and their local Force was uninvolved. Many believed that those in Manchester received preferential services and attention.

**5.245.** Some of the friends and family who participated in the Review felt that there was too much focus on Manchester. Others, particularly those from Greater Manchester, felt supported by the vigils and tributes in the city.

**5.246.** The Panel believes that the sensitive management of the tributes and the St. Ann's Square location worked well in providing a focus for people to pay respects. Responders and some of those directly affected have told the Review that having somewhere to go and the public sharing of grief was important for them.

**Recommendation: Based on good practice reported to the Panel, consideration should be given for a national tribute sites protocol to be developed and incorporated as part of emergency plans.**

**Recommendation: That consideration be given to how National Pathways, commissioned by Government, can support local response.**

## **Community Resilience and Response**

**5.247.** Whilst the majority of people attending the concert at the Arena were from outside Manchester, the impact of the terrorist attack in the city was felt powerfully by Mancunians. Almost all the agency, business and community participants in the Review knew someone who was there on the night and had been there themselves or picked up their children on other occasions. The Panel heard that Mancunians took this attack on their city personally. The determination of the citizens and organisations of Greater Manchester to carry on was linked to the strong civic and community leadership evident immediately and visible in the presence of leaders and members of diverse faith and community groups on the steps of the town hall and filling Albert Square for the first public vigil less than 24

hours after the attack. This vigil on 23<sup>rd</sup> May was supported by over 4,000 people despite the country's threat level having been raised to Critical.

**5.248.** Participants in the Review's community impact conversations were universal in their praise for the response of the emergency services and NHS staff, and the Panel heard that the perception of the wider community in the city-region is that plans were in place and implemented effectively. The Panel was told frequently that the positive engagement of local communities, including those feeling vulnerable after the attack, was built on the established and trusting relationships developed over years of partnership work between communities, faith groups, GMP and the Council. The Panel heard that there was concern that funding pressures due to austerity experienced by the Council and GMP might lead to a deterioration in the relationships between communities and partner agencies.

**5.249.** The high-profile criminal investigations in the nine-day response phase resulted in 22 arrests of people who were subsequently released without charge. The Panel heard of the adverse impact such investigations can have on innocent families and local communities. However, a significant consequence management structure was implemented at an early stage by GMP to try to ensure the confidence and safety of the public over the following weeks.

**Recommendation: The benefits accrued by the long-term investment in local authority and police neighbourhood and community engagement teams should be preserved where possible by consistent partnership resourcing.**

## **Mental Health and Emotional Wellbeing Support**

**5.250.** The need for emotional support after being involved in an incident such as this is almost universal, whether a member of the public or involved professionally. What differs enormously, the Panel was told, is what each individual needs, when, and what is available. Some told the Panel that they received the necessary support from friends and family. Others said they, or their child, needed additional help. In the first nine days, the period covered by this Review, some of the bereaved and injured were able to access support from charities like the British Red Cross, The Peace Foundation and Victim Support. The Peace Foundation reported an unprecedented number of people requesting their support. Those children and

young people in Manchester hospitals were generally visited by the NHS CAMHS (Children and Adolescent Mental Health Service) but this was also inconsistent. The Panel was also told of a family in a hospital being approached by a ‘counsellor’ who was pushy and insensitive. The Panel heard that some schools were understanding and supportive for instance issuing a pass so the pupil could leave lessons if necessary or organising counselling. Some universities were criticised for not offering support.

**5.251.** In the initial response the British Red Cross provided a range of support including the establishment of a rota of a 70-strong psychosocial support team and provision of welfare to hospital staff, FLOs and members of the public including those attending gatherings at St. Ann’s Square.

**5.252.** The impact on an individual’s long-term mental health is not apparent in the first nine days but the Panel heard from many who at the time of contacting the Review, several months later, were living lives severely altered by their ongoing difficulties and that not all had yet been able to access suitable professional support.

**5.253.** Greater Manchester Health and Social Care Partnership participated in the Review and the Panel heard how from the first day after the attack, specialists from NHS and voluntary group provision were brought together to design the right mental health support and to try to identify who had been affected. This culminated in the establishment of the Manchester Resilience Hub which uses a screening tool to assess what each person needs, but this took time and was not operational in the recovery period covered by the Review. The Partnership also used NHS England and Public Health communication networks in the first few days to advise colleagues in other parts of the country, but the Panel deduces that these messages were not always received given the experience of some Review participants.

**5.254.** A further complicating factor is the range of different opinions and approaches about how and when to intervene with counselling, therapies and treatment. The Greater Manchester Health and Social Care Partnership’s ‘normalisation’ message was neither heard by all, nor accepted by others, including providers of mental health support from all sectors. In considering how to improve this situation

for future terrorist incidents, the Panel concludes that widespread communication of clear guidance is necessary from NHS England about the recommended provision, based on learning from similar incidents. The Panel heard that NHS National Institute for Health and Clinical Excellence guidelines (watchful waiting) were not applied consistently by some voluntary groups and charities, but it is not clear whether this was due to them being unaware or consciously opting to operate differently. Some participants in the Review reported that some charities were seen as opportunistic in their approach, for example being unwilling to share their data or appearing to be using this experience to position themselves for future funding opportunities.

**Recommendation: Emergency plans for major incidents should incorporate comprehensive contingencies for the provision of mental health support to adults, children and young people, families and responders.**

## **The Fund and Financial Assistance**

- 5.255.** The Panel found that the partnership between the Council, British Red Cross, Victim Support, Barclays Bank and the Manchester Evening News was created swiftly and effectively to establish an official fund to receive donations from the public, and that being able to make initial payments in the first week was commendable.
- 5.256.** There were many different perspectives on the Fund. Of those who participated in the Review, many felt that they should have been included amongst the beneficiaries or received a larger sum. This was particularly true for those who had suffered relatively minor or no physical injury but felt their mental health had been impacted and their ability to carry on their previous life impaired. The period covered by the Review only encompasses the first week of the Fund. However, some of the comments take a longer view.
- 5.257.** The Panel is aware that a future attack might not attract such a level of public donation and has a concern about support which would then be available. The Panel is mindful that many insurance policies for individuals and businesses exclude acts of terrorism. Many contributors to the Review have painted a bleak

picture of the desperate position some survivors and their families find themselves in.

**Recommendation: Consideration should be given by the Home Secretary as to what support could be made available nationally through statutory funding for those affected directly by a terrorist attack.**

**Recommendation: Standardised contingencies should be developed by all councils to enable an official fund to be established urgently following any future incident that attracts financial donations from the public, as was done in Manchester, to avoid misappropriation of donations and to ensure fair distribution of funds.**

## Media

- 5.258.** The Panel was shocked and dismayed by the accounts of the families of their experience with some of the media. To have experienced such intrusive and overbearing behaviour at a time of enormous vulnerability seemed to us to be completely unacceptable. We were concerned to identify what might be done to prevent this happening again in any future terrorist event.
- 5.259.** In our Progress Report in January, the Panel said that it wished to pursue this matter further. A round table was subsequently held with local and northern-based representatives of the broadcast and print media. The Panel was also contacted by IPSO (Independent Press Standards Organisation), the voluntary regulator of newspapers and magazines in the UK.
- 5.260.** The Independent Press Standards Organisation have produced an Editors' Code of Conduct which contains a set of standards against which they regulate. The Code covers the conduct of journalists in newsgathering as well as articles which are published in print or online. If the journalist in question is a freelance, any of their content used by an Independent Press Standards Organisation publisher must be in line with the Editors' Code and have been gathered in accordance with the Code.

**5.261.** The most relevant clauses of the Editors' Code to the Manchester Arena terrorist attack are:

- **Privacy**
  - i. Everyone is entitled to respect for his or her private and family life, home, health and correspondence, including digital communications.
  - ii. Editors will be expected to justify intrusions into any individual's private life without consent. In considering an individual's reasonable expectation of privacy, account will be taken of the complainant's own public disclosures of information and the extent to which the material complained about is already in the public domain or will become so.
  - iii. It is unacceptable to photograph individuals, without their consent, in public or private places where there is a reasonable expectation of privacy.
  
- **Harassment**
  - i. Journalists must not engage in intimidation, harassment or persistent pursuit.
  - ii. They must not persist in questioning, telephoning, pursuing or photographing individuals once asked to desist; nor remain on property when asked to leave and must not follow them. If requested, they must identify themselves and whom they represent.
  - iii. Editors must ensure these principles are observed by those working for them and take care not to use non-compliant material from other sources.
  
- **Intrusion into grief or shock**
  - i. In cases involving personal grief or shock, enquiries and approaches must be made with sympathy and discretion and publication handled sensitively. These provisions should not restrict the right to report legal proceedings.

**5.262.** From the experiences of the families described above, it is very evident that the behaviour of some of the media covering the Manchester attack fell well short of these standards. It is important to recognise here that there were both national and international media present in Manchester following the attack. Although families referred to reporters saying that they were from individual newspapers, it is not possible to say for certain that they actually were working for that paper – for this reason we have not identified individual media agencies in this report. Our



concern is not in taking individual media agencies to task but to understand how families can be better protected in the future.

**5.263.** The Independent Press Standards Organisation provide a number of services to help families handle press interest that they are finding overwhelming. They work with first responder organisations such as the police and through other routes to increase awareness of what help is available. There is also a 24/7 harassment helpline and the ability to issue industry-wide Private Advisory Notices to make journalists and editors aware of any concerns.

**5.264.** Whilst these services may be effective in individual cases, they will always struggle in the fast moving, confusing and traumatic events following an attack such as occurred in Manchester. The families in particular are extremely traumatised and focused entirely on what has happened to their loved ones. None of the agencies or families we spoke to for example, made reference to the role of the Independent Press Standards Organisation.

**5.265.** In the round table discussion we held, some important points emerged:

- All of the organisations present roundly condemned the reported behaviour and said that they did not recognise it in their own organisations. Few of them used freelancers, and those that were used were well known to the organisations concerned. For those who were locally based, this was a long term relationship with the area and they wanted to do their best by the families.
- The impact of social media was considerable, accelerating the pace at which information on individual families became more widely available.
- There is a positive role that the press can play in communicating on behalf of families and in fundraising. The Manchester Evening News, for example, raised a million pounds for the emergency appeal in 24 hours.
- Strenuous efforts had been made to establish the facts accurately and limit the number of contacts made to individual families. The BBC, for example, prior to this event, had established a central newsgathering team in London and set up a 'round robin' group, establishing and confirming sources but also ensuring that there is a

limit on who can approach a person. All BBC journalists had to go through an agreed process with the London base and a single BBC journalist was assigned to each family so the BBC was not making multiple contacts. This approach had been set up following from learning from other attacks.

- The GMP Press Team played a key role in the process, particularly in providing information on whether or not a family wished to talk to the media. The demands on the press team were intense and the scope for quickly drafting in additional resources should be explored as part of future emergency planning.
- The Family Liaison Officers played an important role in helping families manage contacts with the press, which went beyond the scope of the role they were there to perform. Whilst there are elements of media handling provided as part of the nationally accredited training for Family Liaison Officers, it may be that there are opportunities to increase their skills in this area, without detracting from their primary role.
- The media could be more comprehensively drawn in to future emergency planning events, so that their needs and likely reaction to events could be better anticipated.

**5.266.** The experiences of the families set out above are clear and cannot be denied. This, surely, cannot be as good as it gets. We recognise that there is a wider debate about the conduct of the press which is beyond the scope of this report. The priority for the Panel here is the families, who must be better protected from such intrusive and distressing media interventions. The recommendations below are framed with this in mind.

**Recommendation: The Independent Press Standards Organisation (IPSO) should review the operation of its code in the light of the experiences described by contributors to the Review and consider developing a new code specifically to cover such events.**

**Recommendation: The National Police Chiefs' Council and the College of Policing should review the nationally accredited training programme provided to Family Liaison Officers to explore the opportunities for enhancing their skills in handling media contact with families, without**

**compromising their core role. The potential for collaborative working with the Independent Press Standards Organisation (IPSO) should be considered as part of this review.**

**Recommendation: Statutory Responders should engage with local trusted press and broadcasters as key participants in planning and rehearsing responses to major incidents to anticipate and test out ways in which families and victims can be best protected from inappropriate press approaches, whilst recognising the legitimate desire of journalists to report on the human impact of such events.**

**Recommendation: First response agencies and local authorities should review the resources available to their Press Offices in response to a major incident and consider whether adequate arrangements are in place to flex capacity quickly if further support is needed to deal with the demands of the media. This could be done by mobilising mutual aid from other Police Forces and partner organisations, including academic institutions with particular experience of social network messaging and communication. Consideration should also be given to allocating sufficient dedicated press handlers at key sites such as hospitals and the centre established at the Etihad Stadium.**

## **The Arena**

**5.267.** Based on everything seen and heard, the Panel believes that staff at the Arena made a positive difference and that, without their contributions, the response would have been diminished. The Panel recognises that SMG, Showsec and EMT-UK personnel went above and beyond their roles to provide humanitarian assistance and that many of them attended to casualties in the foyer to the best of their abilities, putting aside concern for their own safety in order to try to save others.

**5.268.** Views were expressed by some participants that there were insufficient police present at the Arena on the night. The Panel has learnt about the joint risk assessment processes in place and believes that the assessment was reasonable, given this was an everyday event of the sort that happens routinely

across the country and that there was nothing that had been revealed during the assessment to indicate a heightened risk on the night.

- 5.269.** The Panel has heard that the experience of leaving the Arena on the night was mixed. Some praised the staff working at the Arena, others felt that more should have been done. The Panel recognises that of the 14,000 people at the concert, the majority exited safely. Some Review participants who are wheelchair users told of the difficulties they had trying to leave the Arena.
- 5.270.** The foyer area where the bomb was detonated is a space with mixed usage, being shared by members of the public using the Arena, station and car park. This type of space is identified by the Review as needing specific consideration for security implications as, whilst not having any evidence that this was significant to outcomes on the 22<sup>nd</sup> May, the Panel believes it has identified a potential risk factor where crowded venues are linked to multi-purpose spaces with the possibility of blurred understanding about ownership and responsibility. This opinion is outside the remit of the Review and does not lead to a formal recommendation but is included as the Panel is of the view that it may be of relevance in the future for other locations.
- 5.271.** Many commented on the relentless voice of the loud announcement on a loop and how this hindered communication. The Panel has heard that this was not an Arena announcement. Nonetheless, the Panel is of the view that emergency announcements can be useful in providing reassurance and clear instructions in crowded places. The Panel have learnt that the Fire Service attend many buildings including the Manchester Arena to deal with alarm activations. Therefore the Fire Service are the most familiar responding agency in dealing with alarms and announcements. They are used to liaising with premises management to determine when best to either silence or reset an alarm.
- 5.272.** The Panel heard that some of those present on the night in the foyer had noticed a man with a large, heavy rucksack and wondered, in hindsight, whether he could have been stopped. The Panel notes that it is normal for people with heavy luggage to be in the vicinity of railway stations and other transport hubs. It is outside the Review's remit to consider this specific issue but, in the light of widespread acknowledgement that the public has a key role to play in being

vigilant, this point is included for the consideration of others, particularly those with a remit to guide and advise the public.

- 5.273.** The Arena operating company, SMG, had previously participated in multi-agency counter-terrorism exercises, and the Panel concludes that this assisted SMG's response on the night.

**Recommendation: Operators of all key/iconic sites should be actively encouraged and enabled to participate in Local Resilience Forum planning, training and exercising.**

### **The Friends and Family Reception Centre**

- 5.274.** The Panel heard from many participants that the support provided at the Etihad worked well and considers that this was largely a result of clear empowered leadership at the venue and the existence of a rehearsed plan. The Panel believes that the role of the Council staff at the Etihad was made more challenging by the length of time families were waiting for news of their loved ones. The Panel notes that initially the role of the centre was not envisaged as a place for friends and family but for those who had been at the Arena but could not be contacted. The care and sensitivity required in these circumstances was outside the Council's experience of providing shelter in emergencies, but the Panel found that the leadership and staff were equal to the task even in changing and challenging circumstances.
- 5.275.** From this perspective, Council staff expressed their concerns that it was only with the arrival of the Bereavement Nurses at the Etihad that they themselves felt reassured that the families and friends were getting the psychological trauma support they needed. This was not to detract from the assistance that had been provided by the Council and its partners to that point. Rather, it highlights the importance of plans for mass-fatality incidents including contingency arrangements for the rapid mobilisation of accredited full-time specialists in bereavement counselling.
- 5.276.** Feedback from one family that should be considered is that the media were able to take photos through the glass of people receiving news of their bereavement

and also that a room used for giving the news was insufficiently sound proofed. Overall the feedback in relation to the Etihad was positive.

**Recommendation: Greater Manchester Resilience Forum’s Mass Fatalities Plan should incorporate clear roles, expectations and activation protocols for specialist staff such as Bereavement Nurses and counsellors to ensure the added benefits of their deployment would be realised in future incidents.**

## VIP Visits and Involvement

- 5.277.** The Arena attack drew attention nationally and internationally. In the first week, Manchester was visited by politicians and members of the royal family which made significant demands on resources in planning and management.
- 5.278.** The visits mentioned most by respondents to the Review who were either in hospital or bereaved, were those made by the Chief Constable and the Mayor of Greater Manchester.
- 5.279.** It was mentioned to the Panel that some of the VIPs from outside Manchester who visited hospitals went only to the children’s wards and this disappointed older patients who were anticipating meeting the awaited VIP.
- 5.280.** Some of the bereaved respondents mentioned receiving personal letters from VIPs such as His Royal Highness Prince Charles and the Prime Minister as a positive experience.
- 5.281.** The Review makes no recommendation but notes that some of those directly affected gained great comfort from the sensitive acknowledgement of their situation.

## Civic Leadership

- 5.282.** The Panel found that civic leadership through the Lord Mayor, Chief Executive, Leader and Deputy Leader of the Council was highly effective. Together with the newly-elected Mayor of Greater Manchester, their swiftly activated visible leadership provided reassurance to the city region’s residents, businesses and

communities. The response successfully promoted the 'we stand together' message. In view of this, the Panel thinks it would make sense to explicitly build in the role of the Greater Manchester Mayor in the future.

**Recommendation: The future role of the Mayor of Greater Manchester in emergencies should be clarified and included in the Greater Manchester Resilience Forum's plans, training and exercises.**

**Recommendation: That civic leaders taking a highly visible role in response to and recovery from major incidents enhances community reassurance and confidence.**

## **Greater Manchester Health and Social Care Partnership**

- 5.283.** Greater Manchester Health and Social Care Partnership was characterised on the night of the attack by clear and calm leadership with relevant experience, expertise and the advantage of long-standing strong multi-agency working relationships. The partnership was represented appropriately at GMP Headquarters Force Command Module and, from early the following morning, the Chief Officer undertook an external facing role dealing with media requests and coordinating the NHS strategic response. The Panel notes that the Greater Manchester response has received praise nationally.
- 5.284.** The responses received by the Review are almost unanimous in their praise and appreciation of the service provided by the hospitals. This is particularly true of those hospitals in Greater Manchester which were part of the rehearsed mass-casualty dispersal plan. Some respondents who attended hospitals outside Greater Manchester found a lack of awareness of the attack and were less happy with the care received and this included the experience of patients, often children, having to return for necessary vaccinations due to potential blood-borne virus risks which didn't take place during initial treatment. In the Panel's view, it is understandable that staff with no previous experience of shrapnel injuries should not immediately be aware of the need to vaccinate.

**Recommendation: Public Health England’s guidance on vaccination as a result of blood-borne virus risks in similar incidents should be recirculated nationally.**

**Recommendation: NHS participants in the Review told the Panel that some colleagues were not aware previously of their role in the collection and preservation of forensic evidence. It is the Panel's supposition that this partial awareness will be similar across the United Kingdom and the Panel recommends that this should be addressed.**

## **Communications**

**5.285.** The Panel heard that almost every organisation found that improvements needed to be made in its ability to communicate within the organisation and externally. This incident highlighted how the ability to communicate effectively is crucial to emergency response and organisations are undertaking urgent work to address gaps identified following the attack, through upgrades to IT, changes to protocol, or amendments to the communications element of emergency plans.

**5.286.** Many agencies found that they needed to increase the capacity of their communications resource during the incident in terms of the number of people and the infrastructure such as number of phones or server capacity. The need to monitor social media, respond to inaccuracies, ‘warn and inform’ and promote their own messages was largely underestimated. Those organisations which had a lengthy approval process experienced particular challenges in issuing timely information, particularly on Twitter.

**5.287.** The Panel also found that, for staff, some official agency communication channels were not user friendly and so unofficial means were commonly utilised such as informal WhatsApp groups. Whilst these served a function, they could not be monitored or managed within organisational processes. An example was some hospital staff telling the Panel that their official pager system bleeps so often with unimportant updates that they do not pay attention to it and were alerted on the night by messages to their mobile phones. Other examples elsewhere were designated ‘red’ phone lines not being used, radios not working and problems with mobile phone network coverage.



**Recommendation: Agencies across Greater Manchester should be minded to explore the use of encrypted social media in improving their internal emergency activation arrangements, together with their internal communication systems for updating staff during an emergency.**

## **Putting Families First**

**5.288.** Throughout its work, the Panel has had in mind the experiences of the bereaved and injured and others directly affected by the attack. It has heard multiple examples of individual acts of kindness and heroism from people doing their job and from members of the public demonstrating great public spiritedness. Significantly, the Panel has also found many examples of organisations consciously aspiring to consider the needs of the individuals affected. Where aspects of the multi-agency response did not go so well, such as the Casualty Bureau phone line, this was not out of any disregard for the bereaved.

## **Contingency Planning**

**5.289.** Throughout the Review, the Panel has been consistently impressed by the professionalism displayed by individuals and teams from across the responder spectrum. What this demonstrates is that Greater Manchester Resilience Forum members have developed a planning, training and exercising regime that works, in ensuring that the emergency response to major incidents is performed as effectively as possible.

**5.290.** This is not to say that there were no identifiable issues and challenges in the response to the Arena attack, however a multitude of capabilities were put into action due to the joint planning and preparation of the Greater Manchester Resilience Forum and its members.

**5.291.** The Panel has also noted the impressive capabilities of so many individual members of staff from across the responder community. For the Panel, the actions of these individuals and the teams they worked in or led provide a clear illustration of the value that the Association of Greater Manchester Authorities, through the Greater Manchester Resilience Forum, places on enabling Suitably Qualified,

Experienced and Empowered Personnel to enact truly multi - agency responses to major incidents.

**Recommendation: The concept of Suitably Qualified Experienced and Empowered Personnel should be integrated into the doctrine, language and training regimes of all Local Resilience Fora.**

## **Chapter 6 – What Went Well and Recommendations**

This final chapter brings together the key points identified by the Panel during this Review. Examples of what went well, together with areas of learning, have been explored throughout this report as the Panel has described its findings. Agencies who may find themselves responding to attacks of a similar nature are invited to consider what went well and the points of learning and to reflect on whether to include them in their planning going forward.

This chapter includes important examples of what went well, albeit this is not an exhaustive list, as well as listing all the recommendations made within the previous chapters where the Panel has identified something which could be improved.

### **What Went Well**

Throughout the Review the Panel has been struck by actions taken both by individuals, whether the public or responders, and by agencies that have stood out as people dealt with the appalling circumstances that everyone faced. In this section, the Panel identifies some areas that worked well that the emergency services and other agencies across the country and beyond could consider when preparing for events of this type.

The Panel welcomed the willingness of all Greater Manchester Resilience Forum partners to participate in the Review in order to record the areas that went well and learn from experience with a commitment to ensuring that important learning is captured and shared.

## Preparedness

Agencies in Greater Manchester have a history of working together to prepare for emergencies. This resulted in some notable practice during the response to the Arena attack and in its immediate aftermath. Although the work of agencies is noted below, the Panel also wishes to expressly acknowledge the courage shown by responders on the night, many of whom were willing to risk their own lives to save others and who demonstrated extraordinary bravery in unimaginably horrific circumstances.

- Agency collaboration through the Greater Manchester Resilience Forum underpinned by a regime of emergency planning and joint rehearsal of plans resulted in partner agencies having a high level of confidence and competence in the response, the vast majority of which was handled well.
- This collective commitment to training and exercising was also reflected in training programmes within individual agencies and demonstrates the importance of supporting the development of Suitably Qualified Experienced and Empowered People within those agencies who are members of a Local Resilience Forum.
- The preplanning that had been undertaken around caring for large numbers of simultaneous casualties and having been agreed through the Greater Manchester Mass Casualty Plan and the Mass Casualty Dispersal Plan, the latter still in draft at the time of the attack, operated effectively, with patients triaged, stabilised and transported to the most appropriate treatment centres.
- The collaborative working arrangements in Greater Manchester enabled Transport for Greater Manchester to establish a 'transport cell' through which activity across the many agencies who own and operate transport systems could be coordinated in the response.
- The combination of strong leadership supported by well-rehearsed plans resulted in a rapid and effective civic response. Visible leadership was demonstrated by the Leader, Deputy Leader and Chief Executive of Manchester City Council, the Mayor of Greater Manchester, the Chief Constable and the Chief Executive of the

Greater Manchester Health and Social Care Partnership. Faith leaders provided strong leadership and community reassurance.

## Response

The response on the night of 22nd May was distinguished by the willingness and readiness of people who were in the vicinity to assist the injured. The Panel found that many unsung heroes played an important role in providing first aid, care and reassurance and in assisting with moving people from the foyer to the Casualty Clearing Station. In addition to members of the public who ran to help, staff with no formal remit in this role selflessly and bravely did their best to provide care and support and undoubtedly made an important contribution to the response. Others also played a part away from the Arena whether providing shelter in local hotels or donating food and drink. Every one of them is owed a debt of gratitude.

- The speed of arrival and deployment of many staff from the emergency services, the Arena and their contractors was admirable as was the readiness of many, including the general public, Arena staff and non-emergency services personnel, to prioritise giving assistance to the injured above concern for their own safety.
- Casualty evacuation from the foyer to the concourse was completed swiftly with many people helping to move casualties including Arena staff, members of the public, British Transport Police and Greater Manchester Police.
- The effective operation of the Casualty Clearing Station enabled those who were injured to be triaged, stabilised and moved to treatment centres where NHS staff worked across specialities and clinical specialists moved between hospitals to ensure their skills could be deployed wherever they were needed.
- The response to the attack, together with the subsequent investigation and arrests, required Greater Manchester Police to coordinate hundreds of officers and assets from across the country. The dynamic and fast-paced criminal investigation covering some twenty addresses, led by Counter Terrorism police and supported by specialists from GMFRS as a dedicated resource for the eight day period, involved over 1,000 people alone. This was a commendable logistical operation.

- Commitment to putting the needs and interests of families and victims first was evidenced throughout the Review, notably at the Etihad reception centre and throughout the Disaster Victim Identification process, for example in the care and sensitivity in the return of belongings to families.
- The response of the Coroner's office, mortuary staff and supporting structures demonstrated successful partnership working with colleagues from NHS, Greater Manchester Police, Manchester City Council, bereavement service and military personnel. In providing support and comfort to many of the families bereaved in the attack, the Family Liaison Officers and Bereavement Nurses offered a vital service.
- The response phase was protracted and challenging but all involved were able to maintain essential services and day to day business simultaneously. In part this was due to effective mutual aid arrangements with other agencies across the country supporting colleagues in Greater Manchester.
- The intensive forensic operation at the scene undertaken with multi-agency cooperation in a difficult and risky environment demonstrated a commitment to securing all relevant evidence. Greater Manchester Police's forensic teams carried out a painstaking search, with the Greater Manchester Fire and Rescue Service actively managing the significant hazard posed from the damaged glass roof. The collaboration between officers leading the criminal investigation and those responsible for the recovery of the bodies of the deceased meant that the process of victim identification was carried out as rapidly as possible.
- The Greater Manchester Health and Social Care Partnership established a group to address mental health needs the day after the attack and included voluntary sector colleagues, both local and national. The resulting mental health strategy and services subsequently offered through the Greater Manchester Resilience Hub recognised the need for specific provision for children and young people and for families, as well as for adults, and used learning from previous international terrorist incidents to inform their response. The Partnership's communication strategy also recognised that many people were from outside the region and were receiving care in their local area.

- In the aftermath of the attack and whilst dealing with the impacts and the investigative process, Manchester City Council and Greater Manchester Police, together with their partners, successfully managed a number of mass participation civic events including vigils and the Great Manchester Run.
- The outpouring of compassion and grief from communities led to tribute sites being established. These were carefully and sensitively managed and the presence of staff and volunteers, from the council, Greater Manchester Fire and Rescue Service and British Red Cross amongst others, provided reassurance to the public.
- This wish from many people to help and support those affected led to numerous donations, including financial donations. Early establishment of the 'We Love Manchester' fund provided an accountable and secure fund into which the public could make donations.
- In the aftermath of the attack, Manchester City Council, Greater Manchester Police and their partners worked swiftly to understand who might have been affected. Meetings with city centre businesses were called rapidly, schools and colleges were contacted to offer advice and support for children and young people who had been affected; community meetings were held by elected members and Greater Manchester Police to listen to wider community concerns; and meetings were held with faith leaders to engage faith communities and address any tensions.

## **Recommendations**

The rationale for each of the recommendations has been described in Chapter 5. The recommendations are listed below and are grouped into themes for ease of reference. Each is cross-referenced to the paragraph under which it is noted in Chapter 5.

## Local Multi-Agency Recommendations

- a. Greater Manchester Resilience Forum members should investigate ways to increase their own personnel's understandings of their partner agencies' procedures and operational priorities during the first 30 minutes to one hour of a major incident (see 5.73).
- b. The future role of the Mayor of Greater Manchester in emergencies should be clarified and included in the Greater Manchester Resilience Forum's plans, training and exercises (see 5.282).
- c. Greater Manchester Resilience Forum members should develop contingencies to enable METHANE messages to be shared directly between partner agencies' control rooms immediately upon receipt of a message from the incident scene (see 5.212).
- d. Greater Manchester Resilience Forum members should adopt the common understanding of specific terms and phrases which impact on multi-agency working that is defined within the Lexicon of UK Civil Protection Terminology (e.g. rendezvous point, forward command point, holding area) (see 5.212).
- e. Greater Manchester Resilience Forum members should clarify their joint operating procedures in relation to the declaration of multi-agency forward control points, rendezvous points and marshalling arrangements during terrorist incidents and suspected terrorist incidents (see 5.17).
- f. Greater Manchester Resilience Forum's Mass Fatalities Plan should incorporate clear roles, expectations and activation protocols for specialist staff such as Bereavement Nurses and counsellors to ensure the added benefits of their deployment would be realised in future incidents (see 5.276).
- g. Agencies across Greater Manchester should be minded to explore the use of encrypted social media in improving their internal emergency activation arrangements, together with their internal communication systems for updating staff during an emergency (see 5.287).



## Recommendations for Emergency Services

### Fire and Rescue Services

- a. All Fire and Rescue Services utilising North West Fire Control as their call management and resolution service should review their service level agreements and build resilient contingencies and capabilities within North West Fire Control to enhance the development of multi-agency shared situational awareness, which can most effectively inform their Fire Service command, control and coordination during no-notice major incidents (see 5.212).
- b. Greater Manchester Fire and Rescue Service and North West Fire Control should revise their policies and procedures (including action plans) for Bomb, Explosion and Marauding Terrorist Firearms Attack to ensure that greater emphasis is placed on multi-agency co-location, communication and coordination (see 5.212).
- c. Greater Manchester Fire and Rescue Service should review the procedures, protocols and expectations that underpin communications links between its Inter-Agency Liaison Officers, the GMP Force Duty Officer and other partners' control rooms and critical response assets (e.g. Hazardous Area Response Teams) (see 5.212).
- d. Whilst the Panel acknowledges that Greater Manchester Fire and Rescue Service and North West Fire Control have made alterations to the role of the National Inter-Agency Liaison Officer and Pre-Determined Attendance (PDA) protocols for terrorist-related and suspected terrorist-related incidents these organisations should test and further review these protocols to ensure they will be effective and always allocate a 'command structure' to the incident and a National Inter-Agency Liaison Officer to act as Tactical Advisor to the incident commander (see 5.166).
- e. The Chief Fire Officers' Association, National Fire Chiefs' Council and Greater Manchester Fire and Rescue Service should revise all policies, procedures and training for National Inter-Agency Liaison Officers and Incident Commanders to ensure that greater emphasis is placed on embedding multi-agency co-location, communication and coordination during major incidents into their standard operating procedures (see 5.212).

## Greater Manchester Police

- f. Greater Manchester Police, as lead responder during terrorist incidents and on behalf of the Greater Manchester Resilience Forum, should review the procedures and protocols underpinning the expectations placed on direct communications links between the Greater Manchester Police Force Duty Officer and other partners' control rooms and critical response assets (e.g. Inter-Agency Liaison Officers) (see 5.212).
- g. Greater Manchester Police, as lead responder during terrorist incidents and on behalf of the Greater Manchester Resilience Forum, should review the technical capability and capacity of communications links between the Greater Manchester Police Force Duty Officer and other partners' control rooms and critical response assets (e.g. Inter-Agency Liaison Officers) (see 5.212).
- h. Greater Manchester Police should initiate a robust testing procedure to ensure the on-going suitability and resilience of its multi-agency emergency call-out procedures to ensure all relevant agencies receive timely notification of and activation in an incident (see 5.214).
- i. Greater Manchester Police should develop sufficient senior-officer capacity and capability to ensure that single officers are not required to manage multiple strategic roles simultaneously during major incidents (see 5.45).
- j. Greater Manchester Police should review its Force Duty Officer protocols to identify ways to reduce the task load placed on the Force Duty Officer during major incidents (see 5.35).
- k. Greater Manchester Police should continue with its plans to relocate the Force Duty Officer into the Greater Manchester Police Headquarters building (see 5.13).

## Recommendations for National Emergency Response Arrangements

### Government

- a. In order to safeguard the future integrity of the National Mutual Aid Telephony system, the Home Office should urgently secure appropriate guarantees from Vodafone that the necessary fall-back and disaster recovery arrangements are in place to address the failures which occurred on 22<sup>nd</sup> / 23<sup>rd</sup> May 2017 (see 5.55).
- b. Operation PLATO should be reviewed and modified as deemed necessary to inform the response to any form of terrorist attack and be referred to as the Joint Operating Principles for Responding to a Terrorist Attack, regardless of whether firearms are thought to be involved (see 5.231).
- c. The Ministry of Defence should review its procedures for authorising Military Assistance to Civil Authorities requests, for operations which will foreseeably require unvarying resources to be in place for durations beyond 24 hours (see 5.217).
- d. The response to the Arena attack provided an extraordinary validation of the on-going work within the UK civil protection sector to embed the JESIP Interoperability Framework into practice. Where responders were able rapidly to co-locate, communicate and coordinate their activities, situational awareness was usefully shared, risks were jointly assessed, and pragmatic solutions were developed to mitigate severe, time-critical, challenges. Where unforeseen limitations in guidance, protocol and circumstance collided to block such close collaboration, the response of the organisation affected was paralysed for a crucial period. Accordingly, it is the Panel's belief that the findings of the Review should provide a critical stimulus for responders nationally to reassess all plans and protocols that include assumptions of interoperability during major incidents; for the response to the Arena attack provides undeniable evidence that such assumptions need to be vigorously tested (see 5.212)
- e. A national review of the possibility of accrediting charities to deliver effective services in the response to an emergency should be undertaken, avoiding the accreditation process becoming too burdensome for the charities concerned but

including a requirement to plan with Local Resilience Fora ahead of emergencies (see 5.243).

- f. The work being undertaken by the Home Office Victims of Terrorism Unit to identify and consolidate pathways of support to those affected by terrorist attacks draws on the experiences from Manchester in informing their work, and includes producing clear guidance and practical advice. This advice should be made available by the Home Office for victims of terrorism and be widely publicised (see 5.239).
- g. Consideration should be given by the Home Secretary as to what support could be made available nationally through statutory funding for those affected directly by a terrorist attack (see 5.257).
- h. Based on good practice reported to the Panel, consideration should be given for a national tribute sites protocol to be developed and incorporated as part of emergency plans (see 5.246).

#### Local Resilience Fora

- a. Potential Strategic Coordinating Group Chairs should pursue a clear objective to undertake a Strategic Coordinating Group update briefing (physically or virtually) within two hours of the declaration of a major incident (see 5.43).
- b. The Transport Cell is a critically important component of the Greater Manchester Resilience Forum's plan. It provides critical business continuity and recovery support and should be adopted as national good practice (see 5.235).
- c. All Local Resilience Fora should review their planning assumptions and expectations in relation to multi-agency communications during major incidents. Emphasis should be placed on identifying potential single points of failure in communication networks (i.e. technological and command) and building in resilience and/or alternative contingencies to avoid such failures (see 5.212).

- d. The concept of Suitably Qualified Experienced and Empowered Personnel should be integrated into the doctrine, language and training regimes of all Local Resilience Fora (see 5.291).
- e. Operators of all key/iconic sites should be actively encouraged and enabled to participate in Local Resilience Forum planning, training and exercising (see 5.273).
- f. The benefits accrued by the long-term investment in local authority and police neighbourhood and community engagement teams should be preserved where possible by consistent partnership resourcing (see 5.249).

#### Health Services

- g. Public Health England's guidance on vaccination as a result of blood-borne virus risks in similar incidents should be recirculated nationally (see 5.284).
- h. NHS participants in the Review told the Panel that some colleagues were not aware previously of their role in the collection and preservation of forensic evidence. It is the Panel's supposition that this partial awareness will be similar across the United Kingdom and the Panel recommends that this should be addressed (see 5.284).
- i. The Panel heard from NHS and Greater Manchester Police (GMP) personnel about the significant contribution from the military: their positive willingness to share both specialist expertise and equipment was valuable and important in, for example, treating the injured and conducting post-mortem examinations. This approach should be considered for replication in other events (see 5.218).
- j. The Government should increase its support for public first-aid training programmes (including those for children and young people) (see 5.115).
- k. All major transport hubs and public venues should possess and provide immediate access to basic frameless canvas stretchers to enable rapid movement and evacuation of casualties during terrorist attacks or other high-threat or dynamic-hazard incidents (see 5.88).

- l. All emergency services should consider developing a capability to give their staff rapid access to basic frameless canvas stretchers to enable rapid movement and evacuation of casualties during terrorist attacks or other high-threat or dynamic-hazard incidents (see 5.88).
- m. Emergency plans for major incidents should incorporate comprehensive contingencies for the provision of mental health support to adults, children and young people, families and responders (see 5.254).

#### Police Service

- n. Whilst having regard to the integrity of the formal identification of the deceased victims in mass fatality incidents, those involved in the Disaster Victim Identification process should continue to take every opportunity to share emerging information with families which would indicate that their loved one is more likely than not to be amongst those who have died (see 5.66).
- o. The National Police Chiefs' Council and the College of Policing should explore the production of an appropriate written document to be provided to bereaved families in mass fatality incidents, explaining the Disaster Victim Identification process and the amount of time needed to secure an accurate identification in every case (see 5.66).
- p. Greater Manchester Police's practice of extending the deployment of Family Liaison Officers to those who were severely injured should be considered for adoption by other Police Forces, if such an arrangement is not already in place (see 5.66).
- q. In order to achieve consistency in the service provided, where Family Liaison Officers from different police forces have been allocated to families directly affected by a mass fatality incident, they must all operate strictly in accordance with the strategy and associated procedures specified by the lead Family Liaison Coordinator (see 5.66).

- r. In the immediate aftermath of a mass fatalities incident, police forces should consider how they might establish effective arrangements for the collection, collation and retrieval of potential casualty data, during the inevitable period between the event occurring and the Casualty Bureau being fully operational. These arrangements should be made public at the earliest opportunity so that those wishing to report their concerns have absolute clarity about how to do so. The recent establishment of the Public Portal facility for the casualty bureau will help to address this issue in the aftermath of a mass fatalities incident (see 5.46).
- s. The Home Office and National Police Chiefs' Council (NPCC) should actively review and enhance the interoperability of Automatic Resource Location Systems between force areas, with precedence being given to improving the nationwide geo-location of Operational Firearms and Counter Terrorism assets (see 5.17).

#### Councils

- t. Standardised contingencies should be developed by all councils to enable an official fund to be established urgently following any future incident that attracts financial donations from the public, as was done in Manchester, to avoid misappropriation of donations and to ensure fair distribution of funds (see 5.257).

#### Recommendations in Relation to Press and Media in Emergencies

- a. The Independent Press Standards Organisation (IPSO) should review the operation of its code in the light of the experiences described by contributors to the Review and consider developing a new code specifically to cover such events (see 5.266).
- b. The National Police Chiefs' Council and the College of Policing should review the nationally accredited training programme provided to Family Liaison Officers to explore the opportunities for enhancing their skills in handling media contact with families, without compromising their core role. The potential for collaborative working with the Independent Press Standards Organisation (IPSO) should be considered as part of this review (see 5.266).

- c. Statutory Responders should engage with local trusted press and broadcasters as key participants in planning and rehearsing responses to major incidents to anticipate and test out ways in which families and victims can be best protected from inappropriate press approaches, whilst recognising the legitimate desire of journalists to report on the human impact of such events (see 5.266).
  
- d. First response agencies and local authorities should review the resources available to their Press Offices in response to a major incident and consider whether adequate arrangements are in place to flex capacity quickly if further support is needed to deal with the demands of the media. This could be done by mobilising mutual aid from other Police Forces and partner organisations, including academic institutions with particular experience of social network messaging and communication. Consideration should also be given to allocating sufficient dedicated press handlers at key sites such as hospitals and the centre established at the Etihad Stadium (see 5.266).



## Glossary

BTP	British Transport Police
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
COBR	Cabinet Office Briefing Room
GMFRS	Greater Manchester Fire and Rescue Service
GMP	Greater Manchester Police
JESIP	Joint Emergency Services Interoperability Programme
LGBT	Lesbian, Gay, Bisexual, and Transgender
NHS	National Health Service
NSPCC	National Society for the Prevention of Cruelty to Children
NWAS	North West Ambulance Service
PTSD	Post Traumatic Stress Disorder

