

MANCHESTER ARENA INQUIRY PUBLICATION**REPORT OF THE CHIEF FIRE OFFICER****For Information****1. PURPOSE OF REPORT**

- 1.1 To inform Members of the publication of Manchester Arena Inquiry Volume 2: Emergency Response, Report of the Public Inquiry into the Attack on the Manchester Arena on 22 May 2017; and
- 1.2 To inform Members of the Hon Sir John Saunders, Chairman of the Manchester Arena Public Inquiry, summary of findings and recommendations arising from the inquiry into the response of the emergency services to the Attack on the Manchester Arena

2. RECOMMENDATIONS

- 2.1 Members note:
 - the publication of Manchester Arena Inquiry Volume 2: Emergency Response Report November 2022
 - the Inquiry's summary of findings and the 149 recommendations attached as Appendix 1.
 - the Chief Fire Officer will review the Report and its recommendations in detail and look to implement improvements to the local arrangements, where appropriate.
 - further reports will be provided as necessary

3. MANCHESTER ARENA INQUIRY VOLUME 2: EMERGENCY RESPONSE, REPORT OF THE PUBLIC INQUIRY INTO THE ATTACK ON THE MANCHESTER ARENA ON 22 MAY 2017

- 3.1 The Manchester Arena Inquiry, a statutory public inquiry, was established by the then Home Secretary in 2019 to investigate the deaths of the victims of the attack on the Arena on 22 May 2017. It is chaired by the Hon Sir John Saunders.

- 3.2 The Hon Sir John Saunders, Chairman of the Manchester Arena Public Inquiry has published Volume Two of his report into the death of the 22 victims of the attack on 22nd May 2017. This report, Volume Two: Emergency Response, is the second of three and examines the emergency response following the attack at the Manchester Arena and sets out the chair's findings and recommendations on the emergency response to the attack. This report has been laid before Parliament and is available at: <https://manchesterarenainquiry.org.uk/report-volume-two#2>
- 3.3 The Public Inquiry Volume 2 Report is divided into two sub-volumes, Volume 2-I, comprising Parts 9 to 16, and Volume 2-II, comprising Parts 17 to 21 and the Appendices. It is laid out as follows.
- 3.4 Part 9 remembers each of those who died. They are at the heart of the Inquiry and it is appropriate that Volume 2, which deals with their deaths, begins by remembering who they were.
- 3.5 Part 10 is a narrative summary of the emergency response and what went wrong with it. It does not set out my reasoning, which comes in later Parts. So far as is possible, it sets out events in a chronological order.
- 3.6 Part 11 considers the overarching framework in place in 2017 for an emergency response. This includes the relevant legal provisions and the guidance documents that applied on 22nd May 2017.
- 3.7 Part 12 addresses the preparedness of a number of organisations: the Greater Manchester Resilience Forum; BTP; GMP; NWAS; North West Fire Control (NWFC); and GMFRS.
- Part 12 also deals with two particular areas of preparedness, which apply across the emergency services in Greater Manchester: the setting up of a multi-agency control room talk group; and multi-agency exercising, in particular one called Exercise Winchester Accord, which took place almost exactly a year before the Attack.
- 3.8 Part 13 considers the police services emergency response to the Attack: that of BTP, GMP and Counter Terrorism Policing Headquarters. Along with the ambulance and fire and rescue services discussed in Parts 14 and 15, these organisations represented the state's immediate response to the Attack. This Part also summarises the help BTP and GMP police officers sought to provide to those who died.
- 3.9 Part 14 considers the ambulance service emergency response to the Attack from NWAS. This Part includes a record the help NWAS personnel sought to provide to those who died.
- 3.10 Part 15 considers the fire and rescue service emergency response to the Attack from NWFC and GMFRS.

- 3.11 Part 16 deals with a number of other organisations that were present on the night of the Attack and whose staff went to help. The principal focus is on SMG, the Arena operator, and on the organisation that SMG contracted to provide healthcare services, Emergency Training UK (ETUK).

Part 16 also considers the response of: Showsec, the crowd management and security company retained by SMG; employees of TravelSafe, which provided security to parts of the railway network; and Network Rail.

Part 16 concludes with a section that sets out the important contribution that members of the public made to the response. This Part identifies the members of the public and staff working in the Victoria Exchange Complex who tried to help those who died.

- 3.12 Part 17 sets out the effect of the explosion. It includes a record of the accounts that some of those who survived gave.
- 3.13 Part 18 is focused on the twenty-two who died. It sets out in relation to each of them, in summary form, what happened from the point of the explosion. This Part deals with the question of whether any of those who died might have been able to survive had the emergency response been better.
- 3.14 Part 19 reviews the stages and investigations that have preceded this Inquiry and draw out ways in which investigations following mass casualty incidents may be improved in the future.
- 3.15 Part 20 is concerned with a period that, during the course of the Inquiry, was termed 'the Care Gap'. This is the inevitable period of time between an incident that causes injury and the arrival of the emergency services, particularly the ambulance service. The Chair explain why change needs to occur in order to both narrow and fill that Care Gap. Recommendations are made that seek to achieve this.
- 3.16 Part 21 sets out my conclusions, lists the recommendations made across the course of this Volume and specifies those recommendations that the Inquiry shall monitor.

4. NEXT STEPS

- 4.1 The Chief Fire Officer will review the Report's findings and recommendations and work with the other emergency services and wider public sector partners to ensure that any learning is captured and areas for improvement are development into prioritised local action plans.
- 4.2 In line with current arrangements the Chief Fire Officer will continue to provide the Fire Authority with update reports as necessary.

IAN HAYTON
CHIEF FIRE OFFICER

KAREN WINTER
ASSISTANT CHIEF FIRE OFFICER
STRATEGIC PLANNING AND RESOURCES