INQUESTS ARISING FROM THE DEATHS IN THE LONDON BRIDGE AND BOROUGH MARKET TERROR ATTACK OF 3 JUNE 2017

SUBMISSIONS ON DETERMINATIONS MADE ON BEHALF OF THE LONDON AMBULANCE SERVICE

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1. The London Ambulance Service ("LAS") makes the following submissions in line with the directions given in the email sent by the Solicitors to the Inquests on 13 June 2019. The submissions concern legal issues about the determinations open to the Chief Coroner and reference to the underlying facts is made only in order to support the legal analysis and argument.

Conclusions available to the Chief Coroner

2. The LAS agrees with Counsel to the Inquests **[CTI submissions ("CTI"), §3]** that the conclusions open to the Chief Coroner on the evidence, and in respect of all of the deaths, are (i) the short-form conclusion of unlawful killing and (ii) a narrative verdict. The latter may incorporate or conclude with the former. The choice between the two is a matter for the Chief Coroner.

Article 2 ECHR

3. There is no evidence of any breach of article 2 ECHR by the LAS or its staff.

4. No general or systemic failing has in fact been identified by the evidence: see *Savage v South Essex Partnership NHS Foundation Trust* [2009] AC 681 [§45,§§68-70 per Lord Rodger of Earlsferry], *Lopes de Sousa Fernandes v Portugal* (2018) 66 E.H.R.R. 28 [§§185-196], *R (Parkinson) v HM Senior Coroner for Kent and others* [2018] EWHC 1501 (Admin) [§§82-92], and the submissions of Counsel to the Inquests **[CTI §§48 to 53]**.

5. The LAS supports and adopts the analysis of CTI in submissions at §§48 to 53 in relation to the response of the LAS and its staff particularly related to those deceased who died in the Boro Bistro courtyard.

6. In relation to paragraph 50 CTI submissions, the LAS has addressed the salient features of the medical evidence in relation to the four deceased and its relevance to causation in detail at §§19-26, and in particular in relation to Sebastien Belanger at §24-26 below. The LAS also notes that the submissions on behalf of the six families ["**Sobo6F**"] accept that the injuries suffered were such that "failures" by the LAS did not cause or contribute to the deaths [Sobo6F §13].

7. In relation to CTI §§52 and 53 the LAS respectfully agrees with and adopts CTI's submissions.

8. The LAS does not accept that there is evidence sufficient to regard any of the actions or omissions of the LAS as "failures". The LAS further submits (contrary to Sobo6F at §4) that it is not purely on the grounds of causation that it is not arguable that any act or omission by the London Ambulance Service constitutes a breach of a substantive Article 2 obligation (although for full submissions on causation see below at §§19-26).

9. There were appropriate acknowledgements from Mr Woodrow, LAS Director of Operations, in his evidence as to difficulties in the operation of systems and procedures and the challenges with which all the emergency services were faced on the night and subsequently as to lessons to be learned for the future (for example, he acknowledged communication issues [D27/144] and said that future consideration would be given to what more could be done to communicate between emergency services as to the location of LAS resources [D27/159] and also as to how specialist resources such as HART and TRU teams could be deployed in a more timely manner

[D27/81-83]). However, this does not amount to evidence of any "failures" on the part of the LAS nor of a systemic defect or absence of systems or procedures so as to breach article 2.

10. It is of significance that Supt McKibbin, MPS, Head of Counter Terrorism and Specialist Operations, who was in overall command of the policing response to the terror attacks on the night of 3 June 2017 made no criticism of the LAS and its response in his evidence. On a number of occasions, in common with Mr Woodrow, he was at pains to explain the challenges and difficulties the emergency response faced on that night [D23/65-68 and 130-131] and how imposing order, in the form of a command structure, on the chaos, gathering accurate information and making decisions about deployment of resources always takes time [D23/61-62, 94-96 and 134-135].

11. Sight should not be lost of the fact that the evidence is that those who were stabbed and died had unsurvivable injuries (even in relation to Sebastien Belanger the evidence was that he could not have been saved by 8 mins after he was attacked as he was in cardiac arrest by that time – see below at §§24-26). All others who were injured, including a significant number who were very seriously injured / whose injuries were life threatening, were evacuated to hospital[1] and survived despite the chaos, the challenges facing the emergency services, the dynamic nature of the scene, the systems and procedures in place and how those determined the actions of those individuals on the ground [D27/137 and 138]. That only those with unsurvivable injuries died is not a picture of "failures" on the part of the LAS, nor an absence of systems and procedures to deal with such a terrorist attack or such significant defects in those systems as to be a breach of article 2. That improvements could be considered to systems and procedures and lessons learned from this attack and the emergency response to it for the future is equally not evidence of such a breach on the part of the LAS.

[1] The LAS conveyed 48 casualties to hospital, 19 of whom were critically injured [D27/138]

12. Nor is there any evidence of a breach of the *Osman* operational duty, which does not apply to clinical decisions made by medical (or paramedical) personnel dealing with acute crises such as those faced by LAS staff on 3 June 2017: see *Powell v United Kingdom* (2000) 30 EHRR CD 362, *Rabone and anr v Pennine Care NHS Trust* [2012] UKSC 2, [2012] 2 A.C. 72 [§§15-19], and *Lopes de Sousa Fernandes* [§187].

13. The LAS makes no submissions on whether the enhanced investigative duty under article 2 is engaged as a result of the acts or omissions by other emanations of the state.

Judgemental conclusions and causation - Relevant law

14. If the enhanced investigative duty is not engaged, the Chief Coroner is bound by the jurisprudence of *R v North Humberside Coroner, ex parte Jamieson* [1995] Q.B. 1 (CA) to limit any narrative verdict to a brief, neutral statement of facts to answer the question of how (by what means) the victims of the terror attacks came by their deaths. [See also §34 Chief Coroner's Guidance No. 17 and **CTI, §6c]**

15. If the enhanced investigative duty is engaged, such that s.5(2) of the Coroners and Justice Act 2009 ("the 2009 Act") applies, the Chief Coroner must address the question of how (by what means and in what circumstances) the victims of the terror attacks came by their deaths. In such circumstances the Chief Coroner is required to exercise judgment to identify and address the central issue or issues in the case. In so doing, he may *"make judgmental conclusions of a factual nature,"* including on *"defects in the system* ***which contributed to the death.****"* See: *R (Middleton) v West Somerset Coroner and another* [2004] UKHL 10, [2004] 2 A.C. 182, [§§35-37] [emphasis added], and the submissions of Counsel to the Inquests **[CTI §9a]**.

16. The Chief Coroner is not, however, conducting a public inquiry. Any conclusions, including those involving qualitative judgments, must be directed to answering the statutory questions, in particular the question of *how* an individual died. The Chief Coroner is prohibited by s.5(3) of the 2009 Act from expressing any view on wider matters. It follows that his determination must, in law, be

limited to matters that were causative of death. Recent Court of Appeal authority has reiterated the importance of a coroner directing his or her attention to the central issues of the case and not straying beyond the coronial jurisdiction: see *Coroner for the Birmingham Inquests (1974) v Hambleton and ors* [2018] EWCA Civ 2081, [§§46-57].

17. The case of *R (Lewis) v Mid and North Shropshire Coroner* [2009] EWCA Civ 1403, [2010] 1 WLR 1836, is authority for the proposition that a coroner has a power but not a duty to include within his or her determinations circumstances that were possibly causative of death, as well as those that were probably causative [§§28-29, per Sedley LJ; see also **CTI §9f**]. The facts of *Lewis* are instructive as to when it may be appropriate for a coroner to exercise this power, which has the effect of loosening the standard of proof. The case concerned a prison death to which the most anxious scrutiny is applied, article 2 was engaged, there was clear evidence of a failure to provide training and equipment that could have prevented the death, and a report on these matters under (then) rule 43 of the Coroners Rules 1984 (SI 1984/552) was mandatory.

18. It is plain that the Court of Appeal was not suggesting that the usual civil standard of proof should be abandoned in all inquests. Nor was it inviting excessive speculation in coronial determinations. The *Lewis* discretion, it is submitted, should be exercised with caution and only where it would assist a coroner in discharging his or her statutory duties, in particular the duty to establish the salient, central facts that answer the question of how an individual died.

Application to the present Inquests

19. No evidence heard at the Inquests would support any criticism of the care provided by staff of the LAS to any of those that died as a result of the attacks. No expert evidence has been adduced that is critical of any of that care, nor have applicable guidelines or other materials on which criticism may properly be founded been put to LAS witnesses such as to support any negative assessment of the care that they provided.

20. The evidence of Dr Fenella Wrigley, LAS Medical Director was supportive of the care given by all LAS staff who attended the deceased and of the decisions they made **[D27/172** (Christine Archibald)**, D27/178** (Sebastien Belanger)**, D27/180** (Kirsty Boden)**, D27/181** (Alexandre Pigeard)**, D27/182** (James McMullan)**, D27/183 and 184** (Sara Zelenak)**, D27/184 and 185** (Ignacio Echeverria)**]**.

21. Dr Wrigley fully acknowledged that the decision of David Armstrong to perform a procedure on Christine Archibald (a needle chest decompression) was outside his clinical scope of competence **[D27/167-168]**. He was not qualified to perform such a procedure being Emergency Ambulance Crew and not a registered paramedic (as he accepted in evidence **[D4/170-172]**) although he had received training to do so (albeit not by the LAS) and did so given the exceptional circumstances he was facing at the time. Dr Wrigley noted in her evidence that the LAS does not support any clinician working outside their scope of practice.

22. Dr Wrigley was, however, clear in her view that Mr Armstrong's performance of such a procedure would have made no difference to Christine Archibald's condition or outcome as she had, sadly, already died prior to it being performed. She gave her opinion that the injuries were unsurvivable **[D27/172]**. The pathology evidence supports her opinion as Dr Fegan-Earl gave evidence that Christine Archibald died near instantaneously **[D14/14]**.

23. The pathology evidence is clear that the injuries of Sara Zelenak, James McMullan, Alexandre Pigeard, Kirsty Boden and Ignacio Echeverria were, sadly, unsurvivable regardless of any medical care that was or may have been provided and further that collapse followed very rapidly after the attacks happened with death occurring quickly thereafter (within only a few minutes) (Sara Zelenak) **D14/33]**; James McMullan **[D19/13 and 20]** Alexandre Pigeard **[D19/27-29]**; Kirsty Boden **[D17/79-80]** and Ignacio Echeverria **[D17/65-66]**.

24. In respect of Sebastien Belanger, hypothetical lines of questioning were pursued as to whether any difference in outcome may have been achieved had medical attention reached him earlier. The responses of the relevant medical and pathology witnesses were as follows:

a. In response to questions posed by Mr Hough Q.C. (CTI), Dr Benjamin Swift, Consultant Pathologist, stated: "*It is difficult for me to say whether it's more than possible that a more rapid response would have had a positive outcome in this case*" **[D17/14-16 ref]**

b. Dr Swift heavily caveated his answers on this and related subsidiary issues with the limits of his expertise (as a pathologist) or could not answer the question at all **[D17/15/4-8 and 23 and D17/16/17-18]**. That is not to criticise Dr Swift, it simply reflects his area of relevant expertise; this issue is essentially a clinical one and is not capable of determination on the basis of pathology evidence alone;

c. In response to questions posed by Ms Ailes, Dr Swift stated that there would have been surgical interventions that would have been performed at hospital and that some of them can be performed at the scene as well **[D17/17/6-9]** but when asked about these interventions previously had been unable to give a timescale within which they would have had to have been performed to be effective **[D17/16/15-18]**;

d. When pressed on whether Dr Swift was open to the possibility that such intervention could have saved his life he stated "*There is that possibility*". **[D17/22/5]**. When providing such responses it is not only the limit of Dr Swift's expertise to comment that is significant but also that the initial premise of the line of questions answered assumed that Sebastien Belanger could have been transported "*instantly*" to hospital in the moments after he was attacked **[D17/17/1-5]**. The Chief Coroner should not only be wary of the benefits of applying hindsight to the determination of this issue but should also be careful not to apply completely unrealistic and purely

hypothetical circumstances to his conclusions. If he were to do so those conclusions would become meaningless. We live in the real world and the Chief Coroner should base his conclusions on what actually happened and / or on what could or should have been done in the reality of the circumstances eventuating on the night;

e. Dr Swift had not viewed the body worn camera footage showing the resuscitation attempts on Sebastien Belanger **[D17/25]**;

f. Dr Swift described "*agonal breathing*" as "*a form of gasping that a person does in the last moments of their life*" **[D17/26/1-2]**. PC Orr's body worn camera footage records comment that Sebastien Belanger was "gasping" at 22.18.30 hours **[AV0296]** PC Kerr described in evidence that she heard Sebastien Belanger "gasping" when she first checked his condition **[D7/19/7]**;

g. Dr Fenella Wrigley, LAS Medical Director and Consultant in Emergency Medicine, said that "*at the point that the police arrived, the combination of the blood loss externally from his arm wounds and from his neck and internally from the two significant chest injuries to his lung and one lower in his right lung and through into his liver, which would have been bleeding both internally and externally, meant that he was in a hypovolemic and hypoxic cardiac arrest, so a combination of having lost a huge amount of blood and having not enough blood pumping round the body to be able to take oxygen round, and the injury to his lung*" **[D27/174]**;

h. Dr Wrigley stated that Sebastien Belanger received extremely good care from the people that were at the scene who did everything they could, but at the point that he went into cardiac arrest, which was around 22.16 hours, the blood loss had resulted in him having an unsalvageable situation. She explained: "*The reason that I've drawn that conclusion is that I have watched the body-worn footage from the police who were there and the extent of the blood that was seen around Sébastien suggests that he had had a massive blood loss*" **[D27/174]**;

i. Dr Wrigley had reviewed her opinion following listening to Dr Swift's evidence in court **[D27/175]**;
j. Dr Wrigley was asked about Dr Swift's evidence that it might have been possible to save Sebastien Belanger. She stated: "*So I fully respect that Dr Swift has a vast range of experience of doing post mortems on these type of patient. When patients reach a situation where the body's response to losing blood has been overwhelmed, so the increase in your heart rate, the tightening up of all of your peripheral blood vessels to try and pump back the blood to your heart and to your brain, and the clotting cascade, which is there to be able to help the blood loss reduce by forming clots, has been overwhelmed, that is when a patient becomes unsalvageable.*"
k. Dr Wrigley again reiterated that by 22.16 he was in cardiac arrest and had suffered significant blood loss and that he was not salvageable at that point. In her opinion there was no medical intervention at all from that point, 22.16, which could have saved his life **[D27/176]**.
l. Dr Wrigley was asked if before that, between the time that he was attacked at around 7 or 8 minutes past, and 16 minutes past, there was anything that could have been done for Sebastien Belanger, in any context, even in an emergency room, that could have saved him. She stated: "*So if Sébastien had been in an emergency room or been an isolated patient in an isolated incident, then trying to stop the bleeding by putting a tourniquet on his arm, packing his bleeding wound from his neck, establishing a definitive airway, so passing a tube down his trachea, into his lungs to take over his breathing to be able to provide oxygen for him and giving fluid could have been done.*
If London's Air Ambulance team had been able to get to him as an isolated patient, there are then additional things that they bring because they carry blood and they are able to do more advanced procedures such as opening the chest in order to be able to try to get control of the bleeding by then pressing [sic] [should read "compressing"] the aorta, the big vessel."
m. She said that the survivors that HEMS have reported from haemorrhagic cardiac arrests remain very low, but it is

certainly an area that they continue to work really hard on in order to try to save people with these injuries in the future.

n. Dr Wrigley gave a concluding opinion that even had Sebastien Belanger received dedicated treatment at some point between 22.07 and 22.16, it is possible that he might have survived but the chances of surviving such injuries were nevertheless not very optimistic. She stated: "*… on the balance of probabilities the extent of his injuries and the extent and speed of his blood loss would have almost certainly meant that he sadly would not have survived, but more would have been able to have been done.*" **[D27/177]**

25. At its height, this evidence amounts to a pathologist accepting a lawyer's proposition that there was a possibility of survival had there been earlier significant medical interventions provided which were not practicably available in the circumstances (see below).

26. In terms of factual causation:

a. In order to make any difference in the chances of survival of Sebastien Belanger, HEMS staff would have had to reach him some minutes prior to his cardiac arrest which had occurred by 22.16 hours (to allow for assessment of the situation, assessment of his condition, a decision to be made as to the medical interventions available and necessary, equipment prepared and then those medical interventions to have actually been carried out - applying a tourniquet to his arm, compression to his neck and chest wounds, giving blood and opening his chest in order to compress his aorta) i.e. by 22.13 hours or 22.14 hours, some 5 or 6 minutes after he was attacked. To try to control blood loss, LAS clinicians would only have been able to apply a tourniquet and direct pressure to the wounds. They do not carry blood and would not perform a thoracotomy (open a patient's chest) to compress his aorta;

b. The first LAS staff to reach the general area in which Sebastien Belanger was being attended to by members of the public and police officers were Gary Edwards, Jacob Carlson and Keir Rutherford. The evidence from the body worn camera footage

is that they first reached the area at the top of the steps to Green Dragon Court at some time between 22.23 and 22.24 hours **[AV0307 and AV0308]**. By this time Sebastien Belanger had been in cardiac arrest and therefore unsalvageable for between 7 and 8 minutes (since 22.16) and probably dead for around 5 minutes (since moments after 22.18.30 hours when an agonal breath / gasp was reported);

c. Further, the evidence was that had any LAS staff or HEMS staff attended Sebastien Belanger after 22.16 he would have been triaged dead in accordance with the triage sieve algorithm which applies during a major incident **[D5/151, D6/201, D10/155, WS5037/12]**;
d. In relation to the availability of a HEMS team to give such an intervention: Dr Lambert's team was the single HEMS team on duty overnight at the Royal London Hospital **[D10/124]** and was dispatched at 22.14 hours and en route at 22.15 hours **[DC5139/1 and D10/128]**. They arrived at the east end of Tooley Street at some time between 22.22 hours and 22.25 hours **[DC5138/1 and D10/128]**. The team waited for instruction and then moved to the north side of London Bridge to the Casualty Clearing Station at Adelaide House where they assisted in triaging, treating and evacuating patients to hospital **[D10/128]**;
e. Therefore, according to the evidence they would have needed to reach Sebastien Belanger and to have provided the various necessary medical interventions including giving blood and opening his chest to compress his aorta within 2 minutes of being dispatched and within 1 minute of being en route from the Royal London Hospital for him to have had a chance of survival, which even then was only a possibility and not a probability **[D27/177]**. By the time they had arrived in Tooley Street, Sebastien Belanger had been in cardiac arrest and therefore unsalvageable for 9 minutes (since 22.16) and probably dead for around 7 minutes (since moments after 22.18.30 hours when agonal breathing / gasping was heard);
f. The LAS submit that any conclusion on what may have happened, hypothetically, had a HEMS team been deployed in

sufficient time to Sebastien Belanger, would be entirely speculative given the relevant timings set out above. Even allowing for the *Lewis* exception to the usual rules of causation it is submitted that no informative or safe determination could be returned on this matter. Nor would such speculation assist the Chief Coroner in discharging his statutory duty to address the central facts in providing an answer to how Sebastien Belanger died.

Observations on the narrative verdicts proposed by Counsel to the Inquests

27. The following submissions are made on the basis that the Chief Coroner accepts the analysis put forward by Counsel to the Inquests concerning the engagement of the enhanced investigative duty under article 2.

28. In such circumstances, the LAS agrees with the form and substance of the proposed narrative conclusions, with the following minor suggestions made for the consideration of the Chief Coroner:

    a. Christine Archibald: delete "paramedics" from the penultimate sentence and instead insert "… Emergency Ambulance Crew, a student paramedic …" to reflect the fact that Keely Whale and David Armstrong, who attended Christine Archibald, were Emergency Ambulance Crew and William Brown was a student paramedic.

29. In relation to the suggestion in Sobo6F at §18 and §19 concerning Sebastien Belanger and James McMullan the LAS submits that the amendment suggested that those who remained in the courtyard, continuing to provide the treatment, did so at a time when they were unaware that ambulances were close by is unnecessary and inappropriate in the circumstances. This is the case particularly as this individual circumstance selected holds no causative relevance to the deaths.

30. Whilst it is permissible to return findings in relation to non-causative circumstances the Chief Coroner should exercise this

power with caution and only where it would assist in discharging his statutory duties, in particular the duty to establish the salient, central facts that answer the question of how an individual died. The amendment suggested does not do so here.

31. Further, as drafted the amendment does not accurately reflect the reality of the timeline. Ambulances were moved forward from a police designated RVP towards Borough High Street arriving around 22.30 hours and in the minutes thereafter. Members of the public and PC's Kerr and Orr were providing assistance to Sebastien Belanger from 22.15.48 hours **[AV0296].** PC Miah was attending to James McMullan at around 22.20 hours **[D7/155]** and was joined by PC Attwood by around 22.23 hours **[D8/169]**). Therefore prior to 22.30 they could not have been aware of ambulances close by because the ambulances had not been authorised to move forward from the designated RVP at that time.

32. Further and of far greater significance, this one narrowly defined circumstance selected does not give the whole context of the situation and therefore risks giving undue significance to this one circumstance over and above a number of other relevant circumstances not mentioned which are equally significant.

33. The circumstances that pertained on the ground in Borough High Street at that time were that it remained a warm zone [WS1370/37] and was considered to be unsafe, that on declaration of Operation Plato ambulances would be dispatched to RVP's and would only usually be called forward once a zone had been designated as cold and a casualty clearing station established [D27/115, 144, 153-154]. PC Attwood also gave evidence that he was aware the location he was in was a hot zone and that therefore the LAS would not be attending his location in the courtyard at that time [D8/182-183]. Further, from around 22.30 hours the ambulances which started to arrive in Borough High Street were dealing with patients presented to them there who were all a category P1 and in need of urgent treatment and evacuation to hospital (Plamen Raychev, Grant Merrall, Robert Piersant, Antonio Filis and Joyce Piersant). We also

know that the ambulance that dealt with Sebastien Belanger was then used to transport Marine Vincent to hospital [D27/138, 157 and 178].

34. Secondly, the context of the circumstances of officers being unaware of ambulances in Borough High Street from 22.30 hours up until 22.45 hours when they came up on to street level is that there was no ability at the time for the Metropolitan Police Service (or other police force) to see directly where LAS resources were at any time [D23/65-68] and [D27/60-65]. Evidence was given of consideration for the future as to what more could be done to assist first responders in this regard.

35. The LAS therefore supports the formulation as drafted by CTI.

Reports on the prevention of future deaths

36. The LAS respectfully agrees with the approach proposed by Counsel to the Inquests in relation to submissions in relation to reports on the prevention of future deaths subject to the following procedural point **[CTI §72]**. The LAS suggests a slightly longer timetable for service of the first and second tranches of submissions (2 August and 6 September with the third tranche then on 6 September) due to the deadlines suggested falling during the holiday season.

SARAH SIMCOCK[2]
Serjeants' Inn Chambers
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25 June 2019

[2] These written submissions have had the benefit of the written submissions on behalf of the LAS in the Westminster Terror Attack authored by Matthew Hill.