IN HER MAJESTY'S CORONER'S COURT
BEFORE THE CHIEF CORONER HHJ LUCRAFT QC

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

SUBMISSIONS ON BEHALF OF THE PARENTS AND PARTNER OF
XAVIER THOMAS
AS TO DETERMINATIONS TO BE MADE BY THE CORONER

Introduction

1. These submissions concern the conclusion of the inquest into the death of Xavier Thomas. The parents and partner of Xavier Thomas wish to thank the Coroner, Counsel and Solicitors to the Inquest for the detailed enquiry that they have conducted and facilitated.

2. For ease, these submissions will be separated into five sections.

   (1) The Law
   (2) Investigation of Butt, appreciation and prevention of the attack
   (3) Protective Security on the Bridge
   (4) The Search and Rescue Effort
   (5) Conclusion as to Determinations

3. With respect to the investigation of Butt it is submitted that it is arguable that MI5 and/or MPS violated article 2 rights by failing to take reasonable steps to protect him from a real and immediate risk to life.

4. With respect to protective security on the bridge it is submitted that it is arguable that:-

(a) Collectively and individually the Secretary of State for the Home Department, the City of London Police (CoLP), City of London Corporation (CoLC) and/or Transport for London (TFL) violated the general duty imposed by article 2 by failing to have adequate systems in place for the protection of life by establishing and maintaining adequate security arrangements on London Bridge.

(b) The City of London Police and the Corporation of London breached the operational duty imposed by article 2 by failing to take reasonable steps to protect him from a real and immediate risk to life from a vehicular attack on London Bridge.

5. It is not suggested that the general duty imposed by article 2 was arguably breached in relation to the search and rescue effort on behalf of Xavier. However, it will, in due course be submitted that there are obvious areas of potential improvement.

6. The Coroner should produce a narrative conclusion which must be directed to the issues which are 'central' to the cause of death (see *R (Allen) v HM Coroner for Inner London North [2009] EWCA Civ 623*) or to the 'disputed factual issues at the heart of the case' or 'core issues which the inquest raised': (see *R (Cash) v HM Coroner for Northamptonshire [2007] EWHC 1354 (Admin)* at 49) or the important issues (see *Smith v Assistant Deputy Coroner for Oxfordshire* [*2006] EWHC 694 (Admin)*). It is submitted that the this will necessarily involve the Coroner addressing whose matters identified in paragraph 2 above.

Section 1: The Law

7. CTI's summary of the law is generally agreed.

Article 2: the Investigative Duty

8. Article 2 of the ECHR (the right to life) imposes a positive procedural obligation which includes a requirement to establish effective and independent investigations into the deaths in certain circumstances. The circumstances of this case do not give rise to that obligation being automatically engaged. The obligation to establish such an investigation is also engaged where it is arguable that the state has committed a breach

of the article 2 substantive duties (the general and operational duties – as to which see below).

9. The threshold for an arguable breach of article 2 is low and for these purposes is anything more than fanciful (*R v (AP) HM Coroner for Worcestershire [2011] EWHC 1453 (Admin)* at [60]).

The General Duty

10. Article 2 imposes a positive general duty on the state to establish "*a framework of laws, precautions, procedures and means of enforcement*" to protect life. The distinguishing feature of the any general duty is that of a systemic failure as opposed to individual negligence. The general duty can extend beyond written procedures and can included the planning and control of operations.

11. A determination of whether the general duty has been satisfied involves assessing the adequacy of – inter alia – the procedures and systems taking into account their overall effect and the resources available to support them.

12. The principle is clear: a breach of Art 2 can only be established where there were insufficient regulations or insufficient control, rather than isolated instances of negligence or a '*concatenation of unfortunate events*'. *Stoyanovi* concerned an army skydiving training exercise. In that case the ECtHR found there had been no breach – there had been a prompt investigation which concluded that the accident was caused by the aircraft's inappropriate speed and poor communication between the crew and paratroopers (see [64]-[68]). Article 2 does not arise when personnel are exposed to ordinary occupational risk even if inherently dangerous, but it may be engaged if death was caused by insufficient state systems or control.

13. The need for more than individual negligence was emphasised in *R (Long) v Secretary of State for Defence [2015] EWCA Civ 770* at [13]:

> *"… Thirdly, a case which involves no more than an allegation of "negligent conduct of an individual or the concatenation of unfortunate events" (see the Stoyanovi case, para 61) will not engage article 2. But a case involving dangerous activities undertaken, organised or authorised by the state and which falls within the middle ground may engage article 2 if it is arguable that the death was caused by insufficient state systems, regulations or control."*

14. It is clear that routine acceptance of unsafe practice will engage article 2: see ***Long*** at [27]-[29].

15. Breaches of article 2 have been found in respect of broader State actions in respect of the general / systemic duty. For example, in ***Öneryildiz v Turkey*** *(2005) 41 EHRR 20*, the ECtHR emphasised that the positive, general obligations under Art 2 required a legislative and administrative framework aimed at deterring threats to the right to life in respect of dangerous activities. The applicant and his family lived near a municipal rubbish tip. In 1993 a methane explosion caused a landslide that killed a number of people. Two years earlier, the authorities had been warned of the risks of the explosion, however, even though the operation of household refuse tips and domestic areas were subject to regulations, they were not enforced by the State. The ECtHR stated at [71]:

> "*Art. 2 does not solely concern deaths resulting from the use of force by its agents of the state but also … lays down a positive obligation on states to take appropriate steps to safeguard the lives of those within their jurisdiction. The Court considers that this obligation must be construed as applying in the context of any activity, whether public or not, in which the right to life may be at stake, and a fortiori in the case of industrial activities, which, by their very nature, are dangerous…".*

16. The Court went on to say at:

> "[89] *The positive obligation to take all appropriate steps to safeguard life for the purposes of Article 2 entails above all a primary duty on the State to put in*

place a legislative and administrative framework designed to provide effective deterrence against threats to the right to life …

[90] This obligation indisputably applies in the particular context of dangerous activities, where, in addition, special emphasis must be placed on regulations geared to the special features of the activity in question, particularly with regard to the level of the potential risk to human lives. They must govern the licensing, setting up, operation, security and supervision of the activity and must make it compulsory for all those concerned to take practical measures to ensure the effective protection of citizens whose lives might be endangered by the inherent risks."

The Operational Duty

17. The 'operational duty' requires the state to take reasonable steps to prevent a '*real and immediate risk to life*': see *Osman v United Kingdom (2000) 29 EHRR 245* at [116]*:*

> *"…bearing in mind the difficulties involved in policing modern societies, the unpredictability of human conduct, and the operation choices which must be made in terms of priorities and resources, such an obligation [under Art 2] must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities… [W]here there is an allegation that the authorities have violated their positive obligation to protect the right to life in the context of their above-mentioned duty to prevent and suppress offences against the person, it must be established to its satisfaction that the authorities* ***knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.****"*

18. This approach was confirmed in *Van Colle v Chief Constable of Hertfordshire Police [2008] UKHL 50* [31]:

> *[32] The Strasbourg court laid emphasis on what the authorities knew or ought to have known 'at the time'. This is a crucial part of the test, since where (as here) a tragic killing has occurred it is all too easy to interpret the events which preceded it in the light of that knowledge and not as they appeared at the time … The Court should endeavour to place itself in the chair of DC Ridley and assess events as they unfolded through his eyes.* ***But the application of the test depends not only on what the authorities knew, but what they ought to have known. Thus stupidity, lack of imagination and inertia do not afford an excuse to a national authority which reasonably ought, in the light of what it knew or was told, to make further inquiries or investigations …****".*

19. For further comment on the threshold test see also *In re Officer L and Ors [2007] UKHL 36* per Lord Carswell at [20]:

> "*…this positive obligation arises only when the risk is 'real and immediate'. The wording of this test has been the subject of some critical discussion, but its meaning has been aptly summarised in Northern Island by Weatherup J in In re W's Application [2004] NIQV 67 at [17] where he said that '****a real risk is one that is objectively verified and an immediate risk is one that is present and continuing****'. It is in my opinion clear that the criterion is and should be one that is not readily satisfied: in other words, the threshold is high."*

20. Where there was a real and immediate risk to life, for a duty of care on the police to arise it is not necessary that the identity of the victim should be known. It was sufficient that the police knew or ought to have known of a real and immediate risk to the life of the victim of violence, and whether they had done all that they reasonably could to prevent the risk occurring (see *Sarjantson v Chief Constable of Humberside [2013] EWCA Civ 1252* at [22]-[25]).

21. In summary: -

(a) What amounts to "a real and immediate risk" is fact specific. As a matter of law, the risk merely has to be real not, of course, a probability (*Rabone* at [73]).

(b) Where there is a risk of serious violence, then it will be easy reasonably to foresee a risk to life; but the relevant risk of which the authority has to have actual or constructive knowledge is to the individual's life, not merely of some harm. Where the threat is of terrorism – this will be easily overcome.

(c) In determining whether there was such a risk, guard must be taken against hindsight: what matters is what the authorities knew or ought to have known at the time (see *Osman* at paragraph [116]; and *Van Colle* at [32] per Lord Bingham).

Causation

22. The starting point when considering the issue of causation is the statutory obligation and in particular the matters to be ascertained by the Coroner's investigation. That is set out in s.5. Section 5(1)(b) Coroners and Justice Act provides that the inquest must determine in what circumstances the deceased came by his death. Where necessary to avoid breach of a convention right this must be read as including the purpose of ascertaining in what circumstances the deceased came by his death (s.5(2) of the Act).

23. This has further been explored in *R (Lewis) v Mid and North Shropshire Coroner [2010] 1 WLR 1836* in which the Claimant sought a judicial review of the Coroner's decision not to put questions to the jury addressing alleged failings arising in the immediate aftermath of a death. The Court of Appeal held there was no duty on a coroner to leave to the jury facts or circumstances which were possible but not probable causes of death, although he had a power to do so. In *R (Tainton) v HM Senior Coroner for Preston and West Lancashire [2016] 4 WLR 157* the Divisional Court indicated held that serious (admitted) failings ought to have formed part of a narrative conclusion given that they formed part of the circumstances of the death even though the jury could not find them to be causative.

24. Finally, in *Van Colle v Chief Constable of Hertfordshire Police [2008] UKHL 50,* the House of Lords held, in respect of causation in Article 2 claims, the Claimant need only show a substantial chance of survival as a result of the state's actions. See [138] of *Van Colle:*

> "*It also seems to me to explain why a looser approach to causation is adopted under the Convention than in English tort law. Whereas the latter requires the claimant to establish on the balance of probabilities that, but for the defendant's negligence, he would not have suffered his claimed loss—and so establish under Lord Bingham's proposed liability principle that appropriate police action would probably have kept the victim safe—**under the Convention it appears sufficient generally to establish merely that he lost a substantial chance of this**".* See also *Osman v United Kingdom (23452/94) [1999] 1 F.L.R. 193* and *Opuz v Turkey (33401/02) (2010) 50 E.H.R.R. 28.*

As to Conclusions

25. There is no limit on the length of any conclusion (see e.g. the conclusions in the Inquests into the deaths of the 96 victims of the Hillsborough Stadium Disaster). It submitted that the length any narrative must fit the needs and demands of the case.

26. A narrative conclusion should avoid being 'bland' or 'anodyne', in the sense that it adds 'nothing of significance to anyone's knowledge of the circumstances' surrounding the death: *R (Cash) v HM Coroner for Northamptonshire [2007] EWHC 1354* (Admin) at [49]; [2007] 4 All ER 903. The conclusion ought to address '*disputed factual issues at the heart of the case*' or '*core issues which the inquest raised*'**.**

27. These inquests are now into their eighth week. The public interest in these inquests has been enormous. Any conclusion which fails to grapple properly with the issues would be deficient. The narrative must be appropriately detailed.

Section 2:The Investigation of Butt, Appreciation and Prevention of the Attack

The Operational Duty: MI5/MPS

28. MI5's mission is to keep the country safe[1]. MPS (SO15) carries out counter-terrorist police work. It works in partnership with MI5 to develop intelligence, to apprehend those who seek to perpetrate acts of terror and to bring them to justice. On this occasion, they failed.

29. This attack was not unstoppable. M rejected any suggestion that it was. Both M and L referred to numerous successful disruptions of terrorist plots. The real issue for the Court to consider is why this attack was not stopped? The investigation has exposed failings in the investigation and a failure, on the part of the MI5 and/or MPS to take steps to protect life.

30. MI5 and MPS had suspected that Butt might conduct an attack in the UK. Butt was not a closed Subject of Interest such as Masood; the perpetrator of the Westminster attack. He was the subject of an ongoing investigation but his attack planning – and his nefarious association with Redouanne and Zagbha – eluded both organisations in their joint endeavours.

31. Realistically, the planning of these attacks must have been ongoing for many months. It is probable that the suspicious meeting on 7 March 2017 attended by Butt, and possibly Zaghba, involved planning. Butt was displaying operational security in relation to that meeting. The operational phone used on the day of the attack was purchased in early March 2017 and was not used at all from 27 March 2017. Redouanne purchased the knives used in the attack on 15 May 2017. The attack planning must have commenced before this phone was purchased.

32. The attack must have been discussed on many occasions: on the phone, in person, at the Ummah fitness gym, at Butt's home, and quite possibly at the Ad-Deen school. It is submitted that there would have been many opportunities for it to be picked up. And yet it was not.

[1] https://www.mi5.gov.uk/

33. It is necessary in the failure to identify the attack planning in the context of what was known and what was ought to have been known.

34. The following was known:-

(a) The detailed investigation into Butt commenced in mid-2015. He was considered to be a threat to national security. It was categorised as P2H (see L para 104) which indicated that Butt was involved in high risk extremist activity linked to attack planning. It is understood that this was because aspired to carry out an attack in the UK. A potential lone actor triage assessment in September 2015 of Butt had concluded that he had strong intent (L para 106). These early assessments of the threat Butt posed indicate a dangerous mindset.

(b) Meanwhile Butt's confidence in expressing his extremism both in word and deed grew. He attended the Regent's Park demonstration on 31 July 2015. On the same day he was praying in front of the black flag associated with ISIS (see L day 25, p 38). His behaviour at this time was no secret to the authorities. The police were present and intervened on that day. Butt must have known that he was being filmed for a Channel 4 documentary. This must have been known by the authorities.

(c) Butt routinely mixed with known extremists. Hiss associates on 31 July 2015 ought to have given the authorities no cause for comfort. L acknowledged that this indicated that he was willing to associate with extremists publicly (day 25, p.42). He regularly associated with Anjem Choudhury (and – in all probability – rather longer).

(d) Butt was using anti-surveillance measures to evade detection. L agreed that this suggested that he was hiding something and added to concerns relating to him (see day 25, 35).

(e) In the following year the Regent's Park demonstration, Butt's activities ought to have heightened concern. He explored employment within the security industry and thereafter to seek and obtain employment on the London Underground. This

was a benign assessment of a troubling development. These were forms of employment which potentially placed the public at risk and yet they were viewed as potentially stabilising influences.

(f) Butt was engaged in fraudulent activities. As HM Government's ACT Campaign observes "*Like other criminals, terrorists need to plan. They need to prepare, buy and store materials, and find ways to fund their activities.*"[2] Whilst Butt's exact motivation for this fraudulent activity will never be known, this behaviour was a continued source of concern and one which is recognised as a risk factor with respect to terror suspects.

(g) It is acknowledged that Butt's fraudulent activity was not ignored. Butt was arrested in October 2016. The raid on Butt's home resulted in seizure of his phone and computer. DS Ager has explained in detail what was discovered from these devices at that time. There was graphic and brutal imagery (e.g. the picture of the man with a spade buried into his face) and evidence of routine access to ISIS propaganda concerning martyrdom. DS Ager agreed that the material on these devices indicated that Butt's mindset was both disturbed and dangerous.

(h) There was no positive evidence that L had abandoned an aspiration to carry out an attack in the United Kingdom: which was the reason why the investigation into him had been opened.

35. Everything which was known and ought to have been known about Butt ought to have led to the conclusion that he was dangerous and required the closest possible scrutiny.

36. Xavier's parents and partner inevitably face a disadvantage. Unlike L & M they do not know the true scope and scale of the investigation into Butt, the nature of any surveillance techniques used or not used, the identity of any sources that may or may not have been utilised. However, the evidence does indicate that there were significant failures in their investigation:-

[2] https://act.campaign.gov.uk/ - it notes that cheque and credit card fraud are ways of generating cash.

(a) By September 2015 relevant information had been lost to the MI5 and MPS investigations into Butt. An unknown source had reported Butt to MI5 directly at some point prior to mid-2015. This was not communicated to the relevant team at MI5. Usman Darr reported Butt to the anti-terror hotline on 30 September 2015. This was not reported to either of the investigatory teams at SO15 or MI5. This was an acknowledged operational failing on the part of the police and MI5 (see M, day 19 p 159-160 and L day 25, p 28). Both L and M contended that the information supplied by the unidentified caller and Usman Darr did not provide any new information. This is misconceived. It indicated that those who knew Butt were sufficiently concerned about his behaviour that they felt it necessary to report. It is submitted that this information would have influenced the teams investigating him and provided potential investigatory opportunities[3].

(b) MI5/SO15 attached little or no significance to Butt's attendance at the Ummah Fitness Gym.

i. The mere fact that Butt was attending this gym ought to have triggered alarm given that it was set up by Sajeel Shahid who had an historical extremist pedigree. He is alleged links to Al-Qaeda, ALM and the perpetrator of the 7/7 bombings[4]. Although the investigative teams became aware that Butt was attending the Ummah fitness gym (L day 24, p126-131) they attached no significance to this. This ought to have raised alarm bells.[5] It ought to have resulted in significantly increased coverage.

[3] The opportunity to follow up on the report by Usman Darr was lost. This could have led to the discovery that Butt had gone further than merely expressing a desire to travel to Syria but had in fact gone as far as to book a ticket to Turkey and both the wider Butt and Rehman families had intervened. This evidence that his aspirations had transformed into action.

[4] Press reports [DC8254] and [DC8253] state that Shaheed was running or was involved in the management of Ummah Fitness Centre ("the gym"). The same reports state that Shahid is a member of Anjem Choudhary's network, that Shahid created the Pakistani branch of Al-Muhajiroun and that he established an Al-Qaeda training camp in Pakistan that was attended by the leader of the 7 July 2005 attacks, Mohammad Sidique Khan.

[5] DCI Jolley accepted that it was a possibility, given evidence that the attackers had an agreed stabbing method, that the attackers had trained for the attack at the gym and could not suggest any other realistic possible locations (see p.161)

ii. L accepted (day 24 p.130) that the gym could have been subject of greater coverage than it was. L accepted that had it been subject to additional surveillance that it was possible that Redouanne and Zaghba would have been identified as regular associates of Butt (day 24, p.130).

iii. In the event we know that MI5's enquiries into the gym – the nature of which was not capable of being explained – were unsuccessful (see L day 25, p.80). It is not known whether any follow-up was planned.

(c) MI5 and SO15 failed to establish that Butt was teaching at the Ad-Deen school:-

i. This represented a serious safeguarding concern because of the potential for Butt to seek radicalise children. One of the strategic aims of SO15's investigation was to protect those whom Butt might attempt to influence (see day 19, 64-5).

ii. The 'uncorroborated intelligence' that Butt was teaching in a school was inadequately explored. Only the schools specifically identified in the intelligence were considered (see M day 19 108-111) but, when that drew a blank, no further investigation was pursued.

iii. The school could and should have been identified. It was less than 1 mile from Butt's home address. It had been the subject of adverse media publicity given the link between the school and Shahid. An open source google search could have unearthed this information. Whilst it is accepted that there are likely to be many schools in the Barking/Ilford area, it is highly unlikely that many of them were set up by a person with Shahid's extremist pedigree.

iv. Moreover, Butt was attending almost every day (see Zahrah Rehman; see also L day 24, p.132). Surveillance on Butt was not used to establish the school.

v. The failure to properly investigate and identify the school meant that a further opportunity to appreciate the significance of Butt's attendance at the gym was lost given that the gym and the school were closely linked:

Shahid had set up both. Butt attended and worked at both. Moreover, a further opportunity to identify the association between Butt and Zaghba.

(d) The investigation into Butt was suspended on two occasions without consultation of SO15 (in itself a significant systemic failing). The latter suspension took place between in the potentially important period between 21 March 2017 until 5 May 2017 (see L statement para 125).

37. MI5 and MPS had no awareness of Redouanne or Zaghba. L accepted that both could have been identified (day 25 p.102). Had they been identified then efforts could have been made to investigate their background. That would have identified, for example, that Zaghba had been the subject of an alert on the Schengen Information System and, with that, the possibility that the further enquiries might have led to the fact that he had previously attempted to travel Turkey for extreme purposes.

38. Once the investigation into Butt was resumed, MI5 was drawing up a closure plan in respect of their investigation into Butt (L statement para 126) at the very time that he and the other attackers were have been continuing their preparations for and finalising the plans for the attack.

39. Doubtless it will be suggested that it would have required substantial resource for the attack planning to have been picked up '*in real time*': see e.g. questioning of L on day 25, p.147-149 regarding the so called 'walk and talk' meeting on 29 May 2017[6]; see also the observation at p.153 that based on what was known about Butt on 3 June 2017 there was no realistic case for continual surveillance.

40. It is submitted that the Court should approach that evidence with caution. L agreed that it is possible that more intensive monitoring could have led to the discovery of the van hire and the purchase of the gravel (see day 24, p 173).

[6] It was pointed out that the CCTV footage of Redouanne putting down his phone was observed on private CCTV cameras and L stated that was no realistic possibility of having access to this material and that the resource to review it would have been so demanding as to be unrealistic.

41. On day 19 p.131-2 M gave the following evidence:-

Q. And just to be clear –

A. And in the context of the overarching threat picture as well.

*Q. -- **if you get a reliable piece of evidence that Khuram Butt on that Saturday afternoon was attempting to hire vans or trucks***

A. Mm.

Q. No reason to assume that the information is inaccurate

A. No.

Q. -- but no surrounding intelligence to say it's particularly significant, what do you say you would have done?

*A. So I'd like ... **if I think about it logically** then I'm being told this for a reason, **I would think about the overarching threat picture at that time**, the fact there's been **a number of attacks, Berlin, Nice as well, the fact that he's an extremist**. **I would have been inclined to have had him stopped in that vehicle** purely because it would just be **the right side of caution** and there would be **nothing to lose by doing that activity**, and that's **even without the benefit of hindsight**, I think that would be consistent across our operational picture.*

42. The candid admission by M that had he known of the hire, given the threat picture and the fact that Butt was a known extremist, he would have been inclined to have had him stopped demonstrates that it is arguable that the authorities could have stopped this attack if their investigation had not been flawed in the manner described above.

43. In the circumstances, it is submitted that the conclusion should refer to the possibility that the attacks could have been prevented.

Section 3: Protective Security on the Bridge

44. Had efforts been taken to provide some form of protection for pedestrians on the bridge Xavier would, in all probability, be alive today.

45. There were no effective protective security measures on the bridge as a of systemic and operational failings by the state. There was collective and individual failure across a range of state organisations.

The General Duty

46. No witness disputed PS Hone's analysis of attractiveness of London Bridge as a terrorist target which was prepared on or before 16 May 2017 or his observation that it represented the area of "*most concern*" within the City of London Police's jurisdiction (WS5014/33). It was a potent and compelling argument in favour of hostile vehicle mitigation (see e.g. D'Orsi (day 28, p.160), Isaac (day 30, p.18), Woolford, Hayward (day 13 p28), Nacey day 31, p.157)).

47. Despite this all concerned contended that the location ought not to be viewed in isolation and sought to justify the absence of any physical protective security in this wider context. There were many other locations with similar characteristics (see e.g. D'Orsi day 28, p.160). This assertion does not stand up to scrutiny:-

    (a) This was a specific location which had been highlighted by PS Hone and one which he 'HIGHLY RECOMMENDED' serious consideration be given too (see WS5014/34). No other location was specifically singled out PS Hone in this manner.
    (b) PS Hone correctly identified that London Bridge was materially different to other streetscapes in that there is no escape route for pedestrians.
    (c) Ms Hayward's evidence was that following the work performed on London's bridges after the attack on 3 June 2017, no similar barriers have been erected anywhere else on streetscapes for which TFL is the responsible Highway Authority (see day 31 p.29) which undermines the suggestion that there were areas of equal or greater risk.

48. Before PC Hone's involvement, no person had identified London Bridge as an area of concern. It is likely that this had occurred of because of the deficiencies in the approach

to assessment of places of risk. The work of Counter-Terrorism Security Advisers focussed on 'Crowded Places' as opposed to crowded spaces. According to PS Hone CTSAs would 'not apply their mind' to locations which did not qualify as crowded places (see Hone day 29, p.198).

49. The process for the identification of Crowded Places was deficient:-

(a) The definition of what was a Crowded Place was unnecessarily complex (see examination of Nacey day 31 p.164) and had remained the same since at least 2012.

(b) The definition was the subject of justified criticism. It was too rigid (see Gyford para 29 & WS5015/39). It focussed too heavily on defined geographical locations.

(c) The analysis of whether a place was a crowded place operated in such a way that unless there was a specific point of contact at a relevant location with whom a Counter Terrorism Security Adviser could liaise, there was a high probability that the location concerned would not be considered (see Hone para 16 WS5014/4). These characteristics meant that places such as London Bridge and Westminster Bridge would be at significant risk of not being considered at all (as in fact occurred prior to the Westminster attack).

(d) The introduction of the tiering system did not improve the system for determining whether a location was a crowded place – it served only to determine the level of CTSA advisory and other resource allocated to those locations which fell within the scope of the definition of crowded places.

(e) Although there was the potential for a crowded place which did not meet the definition and satisfy the relevant density criteria to be categorised as a tier 3 site such an approach was inevitably going to be a hit and miss.

50. The threat picture was clear: the attacks in Nice and Berlin had demonstrated the clear and present danger of low sophistication attacks. The attack on Westminster Bridge reinforced that view. It is submitted that the definition had not adapted to the changing nature of the terrorist threat (see examination of Nacey day 31 p.174).

51. The evidence of Ms Hayward was to the effect that TFL did not consider that it was their obligation to risk assess stretches of the highway proactively for the purpose of identifying counter-terrorism security measures and that CTSA's were not providing them with that specific advice in relation to locations such as London Bridge.

52. The cumulative effective of these deficiencies in the systems and procedures for assessing locations such as meant that for years the threat to those on London Bridge (and Westminster Bridge) was not properly assessed and no effective measures were taken to protect pedestrians on the bridge.

The Operational Duty

53. It is submitted that the assessments available to the authorities in the period from 22 March to 24 May 2017

54. It is notable that when individuals applied their mind to the location they concluded that the area presented a significant risk: see e.g. Cerastes, PC Hone, and Mark Haddon. It was identified as location within the top 5 locations at which an attack might occur within the City of London.

55. The prevailing attitude within the CoLP (and the MPS) at the time was that a 'fast time solution' to the problems identified by PS Hone could not be achieved in terms of providing barriers. He stated:-

> "*I would love to have been for there to have been a route then and now for a fast-time solution in terms of my fears and concerns around that bridge, or any other locations where we could have a fast-time solution to putting in hostile vehicle mitigation but I know, as of then and as it is now, in terms of business as usual away from events or where direct intelligence is there to suggest there's going to be an attack, there isn't that option.*"

56. PS Hone indicated that implementing HVM would be '*a long-term project*' (see day 29, p.183).

57. On analysis PC Hone clearly did regard London Bridge as an urgent problem: '*if there was a way to have done it fast-time, I would have pursued it and I would have been banging on the door and banging the drum about that.*' (Day 29 p.213). He did not bang the drum because he thought it was impossible to make rapid progress. However, he plainly regarded the problem as an urgent (see also e-mailed dated 24 May 2017).

58. The 'can't do' attitude with respect to fast time solution was pervasive within CoLP. Commander Gyford (as she then was) indicated that barriers could be implemented only '*in extremis*' (see Gyford day 28, p.173). She understood that the National Barrier Asset was unavailable unless there was an event or intelligence demonstrated that there was a specific risk (day 29 p.34). Supt Isaac stated that it was '*unlikely*' that anything could be done regarding HVM '*quick-time*' (day 30 p. 16).

59. Events after 3 June 2017 amply demonstrate, that this was not correct. Commander Gyford, Supt Isaac and, indeed, PC Hone were demonstrably wrong. Temporary barriers could be and were installed rapidly. That decision was taken by DACSO (D'Orsi).

60. In fact there was a mechanism which would have enabled to the Mr Woolford explained that he could have arranged a 'Gold Group' meeting with all relevant stakeholders being present had he known of PS Hone's views (day 30 p.73). Ms Hayward agreed that such a mechanism was available. She made clear that a fast-time solution was possible. Steps could have been taken to improve physical bridge security within a short time (whilst she was keen not to provide a precise estimate, it was plainly a period measured in weeks not months).

Section 4: The Search & Rescue Effort

61. It is not suggested that there was a breach of the article 2 duties in relation to the search and rescue effort for Xavier. He entered the water at 22.07. It was not until after 22.14 that the Marine Police Units arrived on scene. It was not until 22.25 that a structured line search began. Whilst there were significant flaws in the search effort (for example

there was a inadequate communication between the MPU commander and the coastguard as to their involvement in warding civilians on the banks of the river away from the danger area. In doing this they would not have been focussed on the search for Xavier. Moreover, the search was called off at a time, when, theoretically, he might still have been on the surface, possibly even alive. However, it is acknowledged that the evidence of Mr Savage and Mr Lockyer indicates that Xavier probably died at or very shortly after entering the water. The parents and partner of Xavier will in due course make submissions that there are opportunities for improvement so as to prevent future deaths.

Section 5: Conclusion as to Determination

62. It is submitted that for Xavier there should be a conclusion of unlawful killing together with a narrative.

63. As to the proposed wording at paragraph 59(a) of CTI's submissions the parents and partner of Xavier endorse the approach. However, for the avoidance of doubt, they specifically request that the conclusion contains a specific finding that there was an impact between the vehicle and the Xavier. It is not anticipated that this will be controversial given that no interested person has suggested that there was no such impact. There is clear evidence that Xavier was struck by the vehicle was clear and consistent.

64. It is agreed that the Conclusion ought to record that Butt's family were aware of his extreme views and behaviour and these concerns were not reported to the authorities (paragraph 61 CTI).

65. It is agreed that the narrative conclusion should record the fact that one of the attackers was under active investigation by the security services at the time of the attack. However, for the reasons identified above, it is submitted that the conclusion should be critical of the investigation into Butt (albeit it Is acknowledged that he cannot be named). We propose the following form of words to supplement those of CTI at paragraph 62:-

> Relevant information regarding one of the attackers was not supplied to the teams investigating the Subject of Interest including the fact that he had been reported to the Anti-Terror Hotline. The failure to ensure that such information was communicated to the appropriate investigative teams deprived them of opportunities to further investigate. The planning of the attack must have been ongoing for many months and yet the investigative teams had an incomplete and inadequate understanding of daily activities of the attacker who was the Subject of Interest. This meant that it is possible that opportunities to identify his accomplices and the planning of the attack were lost.

66. It is agreed the narrative conclusion in relation to the issue of bridge security ought to record that there was a failure to implement hostile mitigation measures on London Bridge due to the lack of adequate systems for assessing the need for such measures on the bridge and for implementing them promptly (see paragraph 63 CTI). However, it is submitted that the wording proposed by CTI should be amplified as follows:

> The systems in place to identify vulnerable locations and for ensuring that there was comprehensive communication as between the relevant agencies with responsibility for the bridge and its security were deficient with the result that when concerns were belatedly identified no action was taken. There was a widespread misconception that a solution would take time to implement when in fact barriers could have been introduced within a very short space of time.

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