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

WRITTEN SUBMISSIONS OF COUNSEL TO THE INQUESTS ON DETERMINATIONS TO BE MADE BY THE CORONER

Introduction

1. The purpose of this document is to assist the Coroner in making his determination in respect of each person who died in the London Bridge and Borough Market terror attack. It is structured as follows. First, it summarises the relevant legal principles governing determinations in inquests under the Coroners and Justice Act 2009 ("CJA"). Secondly, it addresses the issue whether the procedural obligation under Article 2, ECHR, is engaged in these Inquests and with what effect. Thirdly, it sets out our provisional submissions on determinations which the Coroner may consider. Finally, it proposes a process whereby representations may be made on the content of any Prevention of Future Deaths Report ("PFD Report").

2. Our submissions at this stage are provisional on those which are yet to be made by Interested Persons. It should also be noted that this document is being prepared and circulated before the conclusion of the evidence, and our comments are therefore necessarily subject to any important features of the remaining witness testimony. We shall address the submissions of others and additional evidence in our oral submissions.

3. In outline, our submissions are as follows:

a. For each of those who died, a short-form conclusion of unlawful killing ought to be given. It is important that the determination for each one should first record the elementary but critical fact that he/she was murdered. On any view, the overwhelming responsibility for these terrible murders rests with the attackers and that should be recorded.

b. For each of those who died, the determination should also include a narrative conclusion. The narrative conclusion in each case should include a paragraph setting out the means and immediate circumstances of death. Furthermore, if the procedural obligation under Article 2, ECHR, is engaged in respect of a particular person, the determination for that person may include an additional section addressing underlying and contributory factors.

c. In our submission, the procedural obligation under Article 2 is engaged in each of the Inquests on the basis that it is arguable that there was a breach of state agents' operational duties to protect life in not taking further steps to prevent the attack. However, while we accept that there is an arguable basis for criticism, we submit that argument ultimately fails and that the narrative conclusions should not criticise the pre-attack investigation.

d. In addition, we submit that the procedural obligation under Article 2 is engaged in the Inquests of Xavier Thomas and Christine Archibald on the basis that it is arguable that there was a breach of the state's general duty to have in place adequate systems for ensuring physical protective security on London Bridge. We do submit that findings about deficiencies in those systems can be made.

e. We do not consider that there is any other basis for Article 2 engagement in any of the Inquests. However, if it is accepted that the procedural obligation is engaged in a particular inquest on any basis, the Court is required for all purposes to take the broad approach to determining how the person died (i.e. addressing the means and circumstances of death).

f. As regards the content of any PFD Report, Interested Persons should be directed to file submissions setting out what (if any) matters they suggest the Coroner might include in such a report. Because of the particular facts of this case, we propose that the Coroner direct two rounds of responses to those suggestions and then consider the responses before deciding whether to produce a report and on what matters.

The Law

Statutory Provisions and Legal Principles concerning Determinations

4. The statutory provisions governing determinations in inquests are contained in sections 5 and 10 of the CJA, which provide as follows:

> **5 Matters to be ascertained**
>
> (1) The purpose of an investigation under this Part into a person's death is to ascertain –
>
> (a) who the deceased was;
>
> (b) how, when and where the deceased came by his or her death;
>
> (c) the particulars (if any) required by the 1953 Act to be registered concerning the death.
>
> (2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.
>
> (3) Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than –
>
> (a) the questions mentioned in subsection (1)(a) and (b) (read with subsection (2) where applicable);
>
> (b) the particulars mentioned in subsection (1)(c).
>
> This is subject to paragraph 7 of Schedule 5 [which addresses PFD Reports].
>
> **10 Determinations and findings to be made**
>
> (1) After hearing the evidence at an inquest into a death, the senior coroner (if there is no jury) or the jury (if there is one) must –

(a) make a determination as to the questions mentioned in section 5(1)(a) and (b) (read with subsection (2) where applicable);

(b) if particulars are required by the 1953 Act to be registered concerning the death, make a finding as to those particulars.

(2) A determination under subsection (1)(a) may not be framed in such a way as to appear to determine any question of –

(a) criminal liability on the part of a named person, or

(b) civil liability.

5. Rule 34 of the Coroners (Inquests) Rules 2013 ("the Rules") provides:

> A coroner or in the case of an inquest heard with a jury, the jury, must make a determination and any findings required under section 10 using Form 2.

Form 2 is headed "Record of an inquest" and it contains the following headings:

> 1. Name of the deceased (if known);
>
> 2. Medical cause of death;
>
> 3. How, when and where, and for investigations where section 5(2) of the [CJA] applies, in what circumstances the deceased came by his or her death (see note(ii);
>
> 4. Conclusion of the coroner / jury as to the death (see notes (i) and (ii));
>
> 5. Further particulars required by the Births and Deaths Registration Act 1953 to be registered concerning the death…

The Notes to that Form identify a number of long-established short-form conclusions, including that of unlawful killing. The Notes correctly state that the standard of proof applicable to most conclusions in an inquest determination is the civil standard (i.e. balance of probabilities). However, on the basis of current authority, the criminal standard of proof (i.e. beyond reasonable doubt) must be applied to an unlawful killing conclusion. See *R (Maughan) v HM Senior Coroner for Oxfordshire* [2019] EWCA Civ 809.

6. The following legal principles have been developed by the higher Courts to guide coroners and juries in conducting inquiries and returning determinations:

a. The primary objective of an inquest is to produce a determination answering the four prescribed factual questions: who the deceased person was; and when, where and how he/she came by his/her death. In that determination, the coroner (or jury) may not express conclusions on any other matters, save for supplying the formal particulars required for death registration (and subject to the coroner's power to make a PFD Report). See the statutory provisions cited above and *R v North Humberside Coroner, Ex Parte Jamieson* [1995] QB 1 at 23 (general conclusion (1)).

b. An inquest will very often cover matters which do not feature in the determination. The scope of inquiry is a matter of broad judgment for the coroner conducting the inquest. In particular, it is a question of judgment (and often a difficult one) how far back to trace chains of events and potential causes. Similarly, the question of which witnesses to call is a matter for the coroner's judgment. Although he/she should conduct a sufficient inquiry to answer the statutory questions, the evidence will commonly cover a wider scope than is necessary for that purpose. See *R v Inner West London Coroner, Ex Parte Dallaglio* [1994] 4 All ER 139 at 155b and 164j. These principles apply across the board (including in Article 2 cases): see *McDonnell v HM Asst Coroner for West London* [2016] EWHC 3078 at [28]; *Coroner for the Birmingham Inquests (1974) v Hambleton* [2019] 1 WLR 3417 at [46]-[50].

c. Before the Human Rights Act 1998 came into force, incorporating the ECHR into domestic law, the question "how" the person died was always to be read as meaning "by what means the deceased came by his/her death". That interpretation focuses attention on the physical means of death. The question was usually answered by the coroner or jury choosing between the recognised short-form conclusions and completing a short entry for the immediate circumstances of death. However, there was no objection to a short-form conclusion being supplemented or replaced with a brief narrative. See *Ex Parte Jamieson* at 24 (general conclusion (6)); *R (Longfield Care Homes) v Blackburn Coroner* [2004] EWHC 2467 (Admin). Today, in cases where the Article 2 procedural obligation is not engaged, the question "how" the person died is still to be regarded as limited to the means of death: see *R (Hurst) v HM Coroner for Northern District of London* [2007] 2 AC 189.

d. Article 2 of the ECHR (the right to life) encompasses positive procedural obligations on member states. These include a requirement, in certain circumstances, to establish

independent investigations into deaths which satisfy Convention standards (including a standard of effectiveness). See *R (Amin) v SSHD* [2004] 1 AC 653 at [20]. Setting aside specific categories of case where the obligation is automatically engaged (e.g. suicides in prison and deliberate killings by state agents), the obligation to establish such an investigation is engaged where on the evidence it is arguable that the state or its agents committed a breach of a substantive Article 2 duty in relation to the death. See: *R (Humberstone) v Legal Services Commission* [2011] 1 WLR 1460 at [52]-[68]; *R (Letts) v Lord Chancellor* [2015] 1 WLR 4497 at [71]-[91]; *R (Parkinson) v Kent Senior Coroner* [2018] 4 WLR 106. The threshold of an "arguable" breach is low; "anything more than fanciful": see *R (AP) v HM Coroner for Worcestershire* [2011] EWHC 1453 (Admin) at [60].

e. In *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182, the House of Lords held that, where the Article 2 obligation to establish an independent investigation into a death is engaged in connection with an inquest, the ordinary approach to inquest conclusions must be modified in one respect to satisfy the Convention standard of effectiveness. The expression "how the deceased came by his/her death" in the statutory provisions is to be interpreted as meaning "by what means and in what circumstances the deceased came by his/her death": see [35]-[38]. In practice, this may require the coroner to return, or elicit from the jury, expanded narrative conclusions (see below). The decision in *Middleton* has now been given statutory force by section 5(2) of the CJA.

f. If it is decided that the procedural obligation under Article 2 is engaged in any inquest on any basis, the statutory provisions are interpreted for all purposes in the manner set out in *Middleton*. Having concluded that Article 2 is engaged by reference to conduct of one state agent, the Court should scrutinise the conduct of all state agents and all others with the same intensiveness. See: *R (Sreedharan) v Manchester City Coroner* [2013] EWCA Civ 181 at [23]. By the same token, the broad interpretation of the "how" question should apply equally to conduct of all state agents and others alike. The statutory "how" question cannot logically be read and applied in different ways within the same inquest determination, and to do so would produce misleading and unbalanced conclusions.

g. The decision as to whether the Article 2 procedural obligation is engaged will have little, if any, effect on the scope of inquiry at an inquest or the conduct of the hearing. That is because any properly conducted inquest will usually consider the circumstances of death sufficiently to enable a proper determination on the broader basis. See: *R (Smith) v Oxfordshire Asst Deputy Coroner* [2011] AC 1 at [152]-[154]; *Sreedharan* (cited above) at [18(vii)].

h. Section 10(2)(a) of the CJA precludes the coroner or jury from making findings which appear to determine any question of criminal liability of a named person. This form of words legitimises a coroner or jury returning in suitable cases the well-established conclusion that a death was due to unlawful killing. That conclusion may be given if it is found that death was due to an offence of murder, manslaughter or infanticide: *R (Wilkinson) v HM Coroner for Greater Manchester South District* [2012] EWHC 2755 (Admin). It will commonly be necessary to consider specifically whether a particular person committed the relevant offence. That person will not be named in the conclusions, although it may be obvious from the circumstances, evidence and/or summing-up who has been identified as responsible. See: *R (Anderson) v HM Coroner for Inner North London* [2004] EWHC 2729 (Admin) at [21]; *R (Evans) v HM Coroner for Cardiff and Glamorgan* [2010] EWHC 3478 (Admin) (upheld on appeal: [2011] EWCA Civ 719).

7. In the recent case of *R v HM Senior Coroner for the County of Cumbria, Ex Parte Worthington* [2018] EWHC 3386 (Admin) at [35], the Divisional Court explained that there is a three-stage process to making a determination at the end of an inquest (whether or not Article 2 is engaged). First, the coroner or jury should make findings of fact on the evidence (which a coroner sitting alone may include in a summing-up and/or a ruling). Secondly, the answer to the question "how" the deceased person came to die should be distilled from those findings (which may be recorded in box 3 of the Record of Inquest and/or within a narrative conclusion). Thirdly, a conclusion should be given as to the death which flows from and is consistent with the findings.

Principles concerning Article 2 Duties

8. The legal principles governing substantive duties of the state under Article 2, ECHR, may be summarised as follows:

a. Article 2 imposes a negative obligation on the state not to take life save in certain specified situations. It also imposes positive obligations to protect life, which fall into two categories: (i) a general duty on the state; and (ii) operational duties which are owed by state agents and agencies in certain types of case.

b. The general duty has been described as requiring the state to –

> "establish a framework of laws, precautions, procedures and means of enforcement which will, to the greatest extent reasonably practicable, protect life."

This general duty arises in a wide range of contexts as diverse as environmental protection, public health and police / military operations. See: *Middleton* at [2]; *Savage v South Essex NHS Foundation Trust* [2009] 1 AC 681 at [18]-[19]; *Oneryildiz v Turkey* (2005) 41 EHRR 20 at [89]-[90]; *Budayeva v Russia* (20.3.08, at [140]-[141]); *Parkinson* (cited above) at [49]-[50] and [82]-[92]. In *Parkinson*, the Court identified the distinguishing feature of any breach of the general duty as being a "systemic failure"; a dysfunction in systems and practices rather than "ordinary negligence" of individuals.

c. The general duty may extend beyond written procedures, to encompass the planning and control of operations (including police operations): see *Kakoulli v Turkey* (2007) 45 EHRR 12 at [106]. It may, for instance, extend to instructions to armed police officers: see *Makaratzis v Greece* (2005) 41 EHRR 49 at [57]-[59].

d. A determination of whether that general duty has been complied with involves assessing the adequacy of legislation, policies, procedures and systems at a relatively high level of generality, taking into account their overall effect and the resources available to support them. See the discussion in *R (AP) v HM Coroner for Worcestershire* (cited above) at [52] and [65]-[74].

e. In certain types of case, it has been held that state agents / agencies may owe an operational duty to protect an individual citizen or group of citizens against specific kinds of danger. This type of duty was first recognised by the ECtHR in *Osman v UK* (2000) 29 EHRR 245, a case concerning the duty of the police to protect individuals against reported threats. The Court formulated the critical test as follows (at [116]):

> "It must be established to [the] satisfaction [of the Court] 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 the 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."

f. In this test, the word "real" is to be interpreted as a risk more than remote or fanciful (a low threshold), and the word "immediate" as "present and continuing" (rather than sudden or topical): see *Rabone v Pennine Care NHS Trust* [2012] 2 AC 72 at [38]-[39]. Breach of Article 2 duties in relation to a death may be established without proof that a relevant failure probably caused the death. It is only necessary to prove that the deceased lost a substantial chance of surviving as a result of the breach: see *Van Colle v Chief Constable of Hertfordshire* [2009] 1 AC 225 at [138].

g. The *Osman* operational duty to take reasonable steps to prevent an appreciable "real and immediate risk to life" has been incrementally extended by the ECtHR to other classes of case. In *Keenan v UK* (2001) 33 EHRR 38 from [88], the Court found that the duty was owed to those in state custody. It has also been held to apply where police operations have given rise to a risk of people being killed or killing themselves (e.g. *Makaratzis* [49]-[72]; *Mammadov v Azerbaijan* (2014) 58 EHRR 18 at [113]-[116]).

h. In *Rabone* (cited above), the Supreme Court extended the *Osman* duty to the situation of a mental patient admitted voluntarily to hospital. Lord Dyson (from [22]) identified indicia which might assist in considering whether the *Osman* duty would exist in a novel situation. These included: (a) assumption of responsibility for welfare of the deceased; (b) vulnerability of the victim; and (c) whether the risk involved is an ordinary one for individuals in a particular category. However, Lord Dyson stressed that these were merely factors which might be relevant, and that they did not provide "a sure guide" to whether the duty should be found to exist.

i. In recent years, specific consideration has been given to the operational duty in the context of the fight against terrorism. The *Osman* duty has been found to apply to the authorities in taking steps to prevent acts of terrorism. In *Tagayeva v Russia* (Application 26562/07, judgment 13.4.17), the ECtHR considered the terrorist attack on a school in Beslan, North Ossetia. At [481]-[492], the Court concluded that the authorities had had sufficient information that there was a terrorist threat to educational

facilities in the district to trigger the obligation to take sufficient protective action (even though the targeted individuals had not been identified with precision – see [486]).

j. The operational duty has been extended over recent years to encompass situations where a threat arises from an identifiable source (e.g. from specific individuals) to the public at large. It has been held by the Strasbourg and domestic Courts that state agents may owe a duty to take reasonable steps to protect the general public in that situation. In considering the case of two prisoners who committed a murderous bank robbery during a short period of prison leave, the ECtHR held that "what is at issue is the obligation to afford general protection to society against the potential acts of one or several persons serving a prison sentence for a violent crime": see *Mastromatteo v Italy* (App. No. 37703/97, 24.10.02) at [69]. That approach has been confirmed in a number of further cases, including *Maiorano v Italy* (App. No. 28634/06, 15.12.09) at [107]; *Choreftakis and Choreftaki v Greece* (App. No. 46846/08, 17.1.12) at [48]; *Guiliani and Gaggio v Italy* (2012] 54 EHRR 10 at [247]; and *Bljakaj v Crotia* (2016) 62 EHRR 4 at [108].

k. In *Griffiths v (1) Chief Constable of Suffolk Police and (2) Norfolk and Suffolk NHS Trust* [2018] EWHC 2538 (QB), Ouseley J considered that line of Convention authority. He concluded as a matter of principle that the operational duty under Article 2 extended to requiring relevant state agents to take reasonable steps to protect society at large where an identifiable individual posed a threat to the public. Addressing the case of *Bljakaj*, Ouseley J (at [499]) identified the breach of duty which had been found by the ECtHR in that case as a failure "to protect the general public". He said that in *Bljakaj* the reasonable steps required to protect the general public would have been to make use of powers for a deranged individual to be committed to hospital.

l. Hallett LJ gave a written ruling following a pre-inquest hearing in the London Bombings Inquests in April 2010,[1] in which argument had been heard regarding the extent of the *Osman* duty (with reference to *Mastromatteo*): see [71]-[83]. At that time, the question whether the operational duty could be owed in respect of the public at large was debatable. Hallett LJ said that she did not need to resolve the issue, but

[1] The ruling is available at:
- https://webarchive.nationalarchives.gov.uk/20120216081134/http://7julyinquests.independent.gov.uk/docs/orders/dec-april-2010.pdf

indicated that she was attracted to a solution construing the duty as covering two situations in the counter-terrorism context: (i) a duty to take reasonable protective action arising from information as to a target; and (ii) a duty to take reasonable preventive action arising from information as to a potential attacker: see [82]. In our submission, subsequent case law has confirmed that the operational duty can be owed to the public at large and has given support to the analysis suggested by Hallett LJ.

Principles concerning Narrative Conclusions in Article 2 Cases

9. Over the years since the *Middleton* case, the Courts have provided the following relevant guidance on the approach of coroners to eliciting and returning narrative conclusions in inquests in which the Article 2 procedural obligation is engaged:

a. The objective of the narrative conclusion is for the coroner or jury to express findings on the key factual issues in the case, which might go beyond the immediate physical means of death. In particular, they may deal with underlying and contributory factors. Lord Bingham gave this further guidance in *Middleton* (at [36], in the context of a jury case):

> "If the coroner invites either a narrative verdict or answers to questions, he may find it helpful to direct the jury with reference to some of the matters to which a sheriff will have regard in making his determination under section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976: where and when the death took place; the cause or causes of such death; the defects in the system which contributed to the death; and any other factors which are relevant to the circumstances of the death."

He went on to say that interested persons could make submissions on the appropriate means by which a Coroner could return, or elicit from a jury, conclusions on the key issues. However, he stressed that "the choice must be that of the coroner and his decision should not be disturbed by the courts unless strong grounds are shown." Accordingly, a coroner has a considerable margin of judgment in deciding how to formulate or elicit a narrative verdict.

b. On the facts of the *Middleton* case (a prison suicide case), the House of Lords (at [45]) suggested an appropriate wording for a narrative in that case: "The deceased took his own life, in part because the risk of his doing so was not recognised and appropriate

precautions were not taken to prevent him doing so". Lord Bingham explained (at [37]) that this embodied "a judgmental conclusion of a factual nature, directly relating to the circumstances of death".

c. A narrative conclusion must not contravene the provisions of section 10(2) which prohibit any conclusion that appears to determine any question of criminal liability of a named person or any question of civil liability. See: *Middleton* at [37]. Since contravention of substantive obligations under Article 2 gives rise to civil liability under the HRA, an express finding of breach of those obligations is prohibited. See: *R (Smith) v Asst Deputy Coroner for Oxfordshire* [2008] 3 WLR 1284 at [24].

d. The means of eliciting or stating appropriate conclusions on the key factual issues concerning means and circumstances of death will vary from case to case. In *R (P) v HM Coroner for Avon* [2009] EWCA Civ 1367 at [25]-[26], Maurice Kay LJ explained that the first task of a coroner is to identify the central issues, and the next is to devise a means for those issues to be resolved, which may be by a combination of (i) a choice of short-form conclusions and (ii) a supplementary narrative. See also *R (Bodycote HIP Ltd) v HM Coroner for Herefordshire* [2008] EWHC 164 Admin (at [23]), where Blake J found that, in the circumstances of the case before him, it might be appropriate to return a narrative either as well as, or as an alternative to, a short-form conclusion.

e. When addressing in a narrative conclusion whether a factor was causally relevant to death, the test is whether it more than minimally contributed to death: see *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] 4 WLR 157 at [41]; *R (Chidlow) v Coroner* [2019] EWHC 581 (Admin) at [37].

f. Any narrative conclusion must be limited to matters relevant to the death(s) under investigation. Where an event or circumstance may have caused or contributed to the death(s) but cannot be proved probably to have done, the coroner has a power to return or elicit conclusions about that event or circumstance.

    i. In *R (Allen) v HM Coroner for Inner North London* [2009] EWCA Civ 623, at [40], the Court said that a coroner conducting an inquest in which Article 2 was engaged "was only obliged to investigate those issues which were, or at least appeared arguably to be, central to the cause of death."

ii. In *R (Lewis) v Mid and North Shropshire Coroner* [2010] 1 WLR 1836, the majority of the Court (Sedley and Rimer LJJ) concluded that a coroner has the power to seek the conclusions of a jury on matters which did not probably cause the death of the deceased. However, there was no duty to seek such conclusions: see [28]-[29]. See also *R (Le Page) v HM Asst. Deputy Coroner for Inner South London* [2012] EWHC 1485 Admin; *Chidlow* (cited above) at [37].

iii. In *Tainton* (cited above), the Divisional Court held that serious failings (there admitted) 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.[2]

g. A narrative conclusion may also express conclusions on matters properly featuring in the circumstances of death and state that they were not causative of death. This was determined recently in *R (Worthington) v HM Senior Coroner for Cumbria* [2018] EWHC 3386 (Admin). There, the Divisional Court held that the coroner had been entitled to state in his determination that the deceased child had suffered abuse shortly before death and that it had not been causative of death: see [43]-[52].

h. A narrative conclusion should not deal with abstract matters, such as matters of high policy.

i. In *R (Scholes) v SSHD* [2006] EWCA Civ 1343 at [70], Pill LJ expressed concern that a coroner had sought to elicit a narrative conclusion by a jury questionnaire which addressed issues of broad policy, rather than concrete issues arising in the particular case.

ii. In *R (Smith) v Oxfordshire Assistant Deputy Coroner* [2011] 1 AC 1 at 100G-H, Lord Philips said that inquests were fact-finding inquiries and would not be the right forum for resolving questions of policy (e.g. the overall competence with which military manoeuvres had been executed).

[2] There is arguably a tension between this decision and those in *Lewis* and *LePage*, which has not been explored in any cases since *Tainton*.

i. There is no objection to a narrative conclusion in a *Middleton* inquest identifying relevant failures (see *Tainton*, cited above), or describing such failures as "serious": see *R (Smith) v Asst Deputy Coroner for Oxfordshire* [2008] 3 WLR 1284, Collins J.

j. A narrative conclusion ought not to be too long or complicated.

i. In *Coroner for the Birmingham Inquests (1974) v Hambleton* (cited above) the Court of Appeal stressed (at [18]) that a finding of a failure by the authorities to act appropriately would be made by means of a "brief factual conclusion" similar to the short conclusion suggested in *Middleton* itself.

ii. In *Clayton v South Yorkshire Coroner* [2005] EWHC 1196 Admin at [31], the Court doubted the appropriateness of a three-page questionnaire put before it, apparently on the basis that it was disproportionate or overly complex.

iii. *R (de Menezes) v Assistant Deputy Coroner for Inner South London* [2008] EWHC 3356 (Admin) involved a challenge to decisions of the coroner hearing the Stockwell shooting inquest regarding the drafting of a verdict questionnaire. In rejecting the challenge, Silber J said (at [26]-[27]) that the coroner had been justified in taking an approach designed to minimise the risk of confusion or undue complexity in the conclusion.

Article 2 in these Inquests

10. In these Inquests, the Coroner has not to date concluded that the procedural obligation is engaged in the sense considered in the *Middleton* case. The approach has been to keep the matter under review, in the knowledge that (a) the scope of inquiry has been broad enough to enable proper conclusions to be returned on any view (whether or not Article 2 is engaged); (b) it was not necessary to resolve the issue before this stage; and (c) the issue would be informed by evidence in the Inquests hearing. While early pre-inquest resolution of such issues may be recommended in some cases, there are obvious benefits in addressing it at this stage in these Inquests. In particular, the Court is now much better informed about the pre-attack investigation and the topic of protective security than it was before the production of evidence over the last several months.

11. For the reasons given below, our submission is that the procedural obligation under Article 2 is engaged on the basis that it is arguable that there were breaches by the state of the general and operational duties. We should stress the point made above, that the threshold of whether a breach is arguable is a low one; it only requires that an arguable case of breach can be formulated which is more than fanciful.

12. Furthermore, the effect of Article 2 being engaged should not be over-stated. It means that the determination in the inquests in which it is engaged should address the circumstances as well as the means of death. It may be more judgmental and may address underlying contributory causes. However, it should still be concise and must still comply with the statutory requirements.

Prevention of the Attack and the Pre-Attack Investigation – All Victims

13. In our submission, it is not arguable that the Article 2 general duty has been violated in respect of the pre-attack investigation. In brief, the evidence has shown that the state has in place an apparatus for the investigation of terrorist plots which includes the Security Service (MI5) and counter-terrorist police working together. The evidence of Witness L revealed that the Security Service has a range of covert methods of investigation and a rigorous set of systems for running its investigations (which include proper checks and balances). Meanwhile, Witness M in his evidence explained how counter-terrorist police work in concert with MI5 in intelligence-led investigations. While some systemic flaws have been acknowledged (such as the fact that SO15 were not consulted before suspension of investigations), it is impossible to say that any such flaws were causally relevant to the deaths under investigation.

14. In contrast, our submission is that Article 2 is engaged in relation to the Inquests of each of the eight victims on account of an arguable breach of the operational duty. The evidence which has been received during the hearing has significantly informed that view. It is arguable that (a) state agencies knew or ought to have known of a threat to the lives of the public from the attackers (and specifically Khuram Butt); and (b) they failed to take measures which, judged reasonably, might have been expected to avoid a real and immediate risk to life. On the facts, there is an argument which cannot be characterised as fanciful that (i) investigative opportunities were missed, especially in the early part of 2017; (ii) further investigation would or should have resulted in additional monitoring of Khuram Butt, which

in turn would have revealed his actions on the day of the attack (in particular his hiring of the Hertz van); and (iii) discovery of the hiring of the van should have led to it being stopped.

15. There are a number of areas in which it could be argued that MI5 and counter-terrorist police either did not attach sufficient weight to information they had in their possession, or failed to obtain information which was reasonably available to them. It may then be argued that these should have been taken into account in assessing the risk Butt posed and allocating resources to him. For example:

a. Two reports were made by associates of Butt to the authorities: one in September 2015 by Usman Darr to the Anti-Terrorist Hotline[3] and one directly to MI5 by an unidentified caller (in mid-2015).[4] Neither call resulted in any follow-up step. Witness L said about these calls "I don't believe they are terribly important for they simply reflect material that was already known about Butt, but I would accept that they did not reach the appropriate teams in both cases".[5] The failure to follow up the contact from Mr Darr arguably deprived MI5 of the ability to secure further information from him, such as further detail of Butt's intended travel to the Middle East and/or further information about Butt's routine.

b. Butt's electronic devices, which were seized and reviewed at the end of 2016, included significant material relevant to assessment of the risk he posed. On these devices were digital files which including communications with Ahmad Musa Jibril;[6] material demonstrating a strong interest in violent imagery, Islamic State and extremist rhetoric; items showing an interest in working on the London transport system;[7] and a video of Butt slaughtering a cow and then referring gleefully to that same thing having been done to 600 Jewish men.[8] All of this material was available to MI5. Witness L denied that there was a failure to analyse the material in sufficient detail because "it was consistent with the understanding of Butt we already had".[9] However, it is at least

[3] TX/24/83
[4] TX/24/86-88.
[5] TX/25/131.
[6] DC7243/16.
[7] DC7248/18.
[8] DC7243/19.
[9] TX/24/120.

arguable that the material on the devices should have led MI5 to be more concerned about Butt.

c. In the years leading up to the attack, there had been a growth in low-sophistication attacks and plots, as recognised by both Witness M[10] and Witness L.[11] Attacks using knives and vehicles as weapons were advocated in multiple propaganda articles in extremist publications.[12] The attack which was executed was relatively unsophisticated.[13] Despite this, Butt was assessed to have a weak capability to carry out an attack, in September 2015.[14] That assessment was tentatively increased to a moderate capability in October 2016, but without very clear reasoning.[15] It is arguable that, in the context of a known risk of unsophisticated attacks, it was not appropriate to assess Butt's capability in this way. While Witness L said that these Potential Lone Actor Assessments did not substantially affect investigative actions, they were said to be an aid to investigators in deciding what action to take.

16. By early 2017, it may be said that Butt presented a number of risk factors which justified intensive coverage of him: (a) the original intelligence from 2015 (later supported by other intelligence) indicated that he intended to commit an attack in the UK; (b) in 2016, he had been assessed as intending to travel to fight with Islamic State; (c) he was a confirmed extremist with established links to leadership figures in Al Muhajiroun and whose rhetoric had been increasing recently; (d) he had a history of violence, including spontaneous violence; and (e) he had not been working full-time for many months, and his daily routine was apparently not fully understood.[16]

17. There were arguably gaps in MI5 and Counter Terrorism Policing's coverage of Butt in the months leading up to the attack.

a. Zahrah Rehman gave evidence that Butt attended the Ummah Fitness Centre daily from the Summer / Autumn of 2016.[17] Further evidence was heard that Butt worked

[10] TX/19/52.
[11] TX/24/15.
[12] D/Supt Rebecca Riggs, TX/2/126, 132; Deputy Assistant Commissioner Lucy D'Orsi, TX/28/91.
[13] Witness M, TX/20/92.
[14] Witness L, TX/24/77.
[15] Witness L, TX/24/160.
[16] Witness L, TX/24/146-147.
[17] Zahrah Rehman, TX/21/48

behind the counter at the gym from early 2017.[18] MI5 was not aware of his regular attendance at the gym in the early period,[19] and even later did not become aware of the regularity of his attendance or whom he was meeting at the gym. Despite its importance in Butt's life and routine, "the Ummah Fitness Centre was not a significant investigative priority for MI5"[20] and could have feasibly been the subject of greater coverage.[21] It is now clear (and accepted)[22] that the gym was a significant location in the planning of the attack, for example being the location of a "walk-and-talk" meeting of the three attackers in the early hours of 29 May 2017 during which Redouane abandoned his mobile phone, apparently to avoid surveillance.[23] Witness L accepted it was possible that, had MI5 seen these actions, they would have raised suspicions in the days immediately before the attack.[24] Witness M gave evidence to similar effect:[25]

> "The activity of dropping the phone and walking away? That is suspicious activity."

Had such suspicions been raised, MI5 "would have sought to identify very quickly the individuals to whom Butt was talking". Further coverage at the gym would have achieved this.[26] A focussed investigation of the two unknown individuals (Redouane and Zaghba) would have followed, with the potential to uncover their attack preparations.[27] It also seems likely that the three attackers met at the gym on the night of 2 June 2017.[28] However, MI5 and Counter Terrorism Policing had no knowledge of that meeting.[29] MI5 now accepts that the three attackers may well have been regularly meeting there;[30] we shall probably never know what occurred at those meetings.

b. The Ad-Deen Primary School is relevant in two ways. First, it represents an arguable missed opportunity to learn of Butt's very regular association with Zaghba; secondly, the failure to identify the school demonstrates that the surveillance on Butt had significant blind spots. Following the attack, the police established Butt was teaching

[18] DCI Wayne Jolly, TX/17/2.
[19] Witness L, TX/25/71.
[20] Witness L, TX/24/124; Witness M, TX/19/105-107.
[21] Witness L, TX/24/130.
[22] Witness M, TX/19/105;
[23] DCI Wayne Jolley, TX/16/6.
[24] TX/24/171.
[25] TX/19/127.
[26] Witness L, TX/19/131.
[27] Witness L, TX/24/171-172.
[28] DCI Wayne Jolley, TX/16/7-8.
[29] Witness M, TX/19/127; Witness L, TX/24/172.
[30] Witness L, TX/19/131.

a two-hour class (ostensibly on the Quran) every weekday at the Ad-Deen Primary School in Ilford. That school is 0.8 miles by foot from Butt's home address.[31] The school's headteacher, Sophie Rahman, was the partner of the owner of the Ummah Fitness Centre.[32] The students were aged between 7 and 10 years.[33] Zaghba volunteered at the school as well at that time.[34] In early 2017, both the police and MI5 had information that Butt was teaching a class at a school regularly,[35] but the location of the school was not known. Attempts to discover its location appear to have been very limited (a Google search with a narrow geographical focus and enquiries by Prevent officers with some schools). Neither MI5 nor the police was able to identify the school, despite Butt's daily attendance; the proximity to his address; and the links between the school and the Ummah Fitness Centre. The police saw this as an area of concern in terms of safeguarding children from radicalisation.[36] But the limited investigation of the school was arguably also a missed opportunity to learn both of Butt's close association with Zaghba, and the nature of the views he was espousing to the children.

c. MI5 and Counter Terrorist police did not identify Redouane and Zaghba, despite the extensive contact which they had with Butt (individually and together) prior to the attack. In this context, it is significant that MI5's investigation into Butt was suspended for a period between 21 March and 4 May 2017.[37] Even if suspensions of that kind are inevitable, a suspension may arguably justify increased coverage afterwards to build a full picture of the subject's routine and associates. Looking back, Witness L said "I believe we could have identified both Redouane and Zaghba".[38] Witness L recognised that contact between Butt and Redouane was more than "peripheral".[39] "Rachid" was known before the attack to have been a contact of "Abu Zaitouni".[40] Redouane was known to have been with Butt on 7 March 2017 and 14 May 2017.[41] Redouane and Butt (and possibly Zaghba too) went to swimming sessions together on Sunday

[31] Witness L, TX/24/134.
[32] DCI Wayne Jolley, TX/15/83.
[33] DCI Wayne Jolley, TX/15/83.
[34] DCI Wayne Jolley, TX/15/84.
[35] Witness L, TX/24/132.
[36] Witness M, TX/19/108.
[37] Witness L, TX/24/144.
[38] TX/25/102.
[39] TX/24/181.
[40] Witness M, TX/19/134.
[41] Witness L, TX/24/181.

afternoons.[42] Both Zaghba[43] and Redouane used the Ummah Fitness Centre, and Redouane is believed to have worked there.[44] Both Zaghba and Redouane were in regular telephone contact with Butt.[45]

d. The meetings of 7 March 2017 might be said to have been particularly significant. MI5 understood that Butt wanted to be careful about the contents of the meeting at the gym that day and that he might be attempting to obtain an unspecified item (an item assessed after the attack as possibly being a firearm). Witness L said that the individuals at this meeting (probably including Redouane and possibly including Zaghba) were not the subject of further investigation, and that further work could have been done. He accepted this as a possible investigative opportunity which had not been taken.[46]

18. If gaps in the coverage of Butt been filled, and/or had more weight been attached to intelligence which now can be seen to be consequential, it is arguable that a greater level of surveillance would or should have been employed in the days immediately before the attack and on the day of the attack itself. Witness L accepted that there was no live monitoring of Butt on the day of the attack. It is also clear that neither MI5 nor the police was aware on the day of communications relating to hiring of the Hertz van used in the attack.

19. Had further monitoring / surveillance been in place at the time of the attack, it is distinctly possible that MI5 and the police would have become aware of Butt's attempts to hire a lorry and vans. Had MI5 informed the police of those attempts, Witness M would likely have caused Butt's van to be stopped, having regard to recent attacks in Berlin and Nice and taking into account Butt's known risk and extremist ideology.[47] Although Witness L said that MI5 would probably have regarded the hiring attempts as innocent because of Butt's cover story (as told to Habibur Murad) and not informed SO15 at all, there are two answers to that argument. First, it is questionable whether MI5 would have learned of the cover story as well as the hiring attempts. Secondly, it may fairly be argued that MI5 should have informed SO15 of this development, in such a joint investigation.

[42] DCI Wayne Jolley, TX/15/81-82.
[43] DCI Wayne Jolley, TX/16/140.
[44] DCI Wayne Jolley, TX/18/3; Witness L, TX/25/89.
[45] DS Simon Ager, TX/18/131.
[46] TX/24/141-144.
[47] TX/19/132.

20. It is also arguable that further monitoring and coverage (especially coverage of Redouane or Zaghba) would likely have identified other causes for concern. Even following the post-attack investigation, there are gaps in what is known about the attackers and their planning. For example, it is not known why the attackers set their Sat-Nav to Oxford Street. It is not known who purchased the belts used as mock explosive belts or when that was done; or when and by whom the mock explosive devices were made. It is not known exactly how and where the Molotov cocktails and mock explosive devices were made; or how they came to be in the red suitcase, in which it is presumed they were carried from Butt's flat to the van. Any sight of the attack paraphernalia could have prompted sudden and decisive action.

21. For these reasons, we submit that it is arguable that there was a breach of the Article 2 operational duty in state agents not taking steps to stop the attack in the final stages of its planning and preparation.

22. We have considered the ruling of Hallett LJ in the London Bombings Inquests (cited above) for purposes of comparison. At [83], Hallett LJ held that a number of suspicious meetings between two of the bombers in the spring of 2004 did not provide the basis for an arguable case that the authorities knew or ought to have known at the time that they posed a present and continuing threat to life. Hallett LJ engaged in a close analysis of the facts, and continued as follows:

> "even if it were the case that Khan and Tanweer should reasonably have been identified between February 2004 and July 2005, or between the CREVICE arrests and July 2005, and made subject to some form of surveillance or investigation, it does not necessarily follow that their subsequent activities would have been uncovered or disrupted. At best, on the material currently available, counsel have identified a possible missed opportunity or missed opportunities to keep MSK and Tanweer under surveillance. That is not enough."

23. In our submission, there are significant differences between the London bombings case and this one. In that case, the potential targets for surveillance were believed to be peripheral contacts of the CREVICE plotters. The argument that they could have been identified, subject to surveillance and their attack planning discovered involved long chains of uninformed speculation. By contrast, this case concerns an investigation of a priority target (who had been aspiring to conduct a UK attack in the past) which was active at the time of

the attack. Specific investigative opportunities can be identified, and specific preventive steps considered.

24. It is convenient at this stage to address what findings should feature in a narrative conclusion if the Coroner accepts that Article 2 is engaged in this respect. Although we accept that it is arguable that there was a breach of the Article 2 protective duty, our submission is that the narrative conclusion ought not to criticise the investigation of the Security Service and SO15. We say that for the following reasons:

a. Overall, the evidence of Witnesses L and M described a thorough investigation of Butt, involving obviously extensive coverage of the target over a prolonged period. In that regard, it is telling that the MI5 investigation discovered many of the significant facts about Butt before his attack, including for instance: (i) his original attack aspiration; (ii) his association with ALM figures (including periods of engagement and disengagement); (iii) his intention to travel to fight with IS; (iv) his accessing and sharing of extremist material; (v) his involvement in the Regent's Park rally with ALM figures; (vi) his SIA accreditation and employment with Transport for London ("TfL"); (vii) the altercation in Goodmayes Park; (viii) his fraudulent bank refund claims; and (ix) his regular use of the Ummah Fitness Centre. The investigation also identified a number of key meetings and visits, including those of 7 March 2017, 18 April 2017 and 15 May 2017. The failure of the investigation team to discover steps by the attackers to plan their murderous assault does not prove that the investigation was deficient, since (as set out below) the attackers were careful to avoid detection.

b. Witness L explained cogently the need to prioritise investigative resources at a time when the Security Service was under intense pressure. In that regard, his explanations for the two periods of suspension of the investigation were compelling. More generally, it cannot be said that the risk evident from Butt's activities was at any time so obvious that it demanded continuous surveillance over a period of time, which is extremely resource-intensive.[48]

c. While it is possible to identify steps which could have been taken that might have led to Redouane and Zaghba being identified, Witness L maintained that they would still

[48] Witness L, TX/25/156-157.

have been seen as purely social associates.[49] That is convincing, since (i) they attended meetings still considered to be purely or mainly social (such as the trip to Leeds on 18 April 2017 and the barbeque on 15 May 2017); (ii) only one overt meeting with suspicious features has been identified even now (the "walk and talk" on 29 May 2017, which would probably not have been discovered by any practicable means[50]); and (iii) searches relating to Redouane and Zaghba would have revealed no terrorist or other criminal connections. Even if some suspicious features had been identified in relation to them, it must be questionable whether they would have received in depth monitoring.

d. Even if it is possible to say that further investigative steps could or should have been taken, it is difficult to say that they would have led to MI5 keeping Butt under live monitoring on the day of the attack and discovering his efforts to hire vehicles. To have that effect, the hypothetical additional steps would have had to generate enough concern to justify live monitoring. However, the attackers were evidently being careful to keep their preparations covert and the evidence suggests that planning and preparation did not take place at Butt's home. They held discussions in the dead of night and away from phones (as on 29 May 2017) and deployed a careful cover story on the day of the attack. There is no evidence of the mock suicide vests or Molotov cocktails being visible in open spaces before the attack actually began on London Bridge. Even after intensive post-attack investigations by MI5 and all the work of the Operation Dativa l team, there is no evidence that anyone other than the attackers knew the attack plan and only fragmentary evidence that one person was aware that some attack was in prospect.[51]

e. Even if MI5 had learned of Butt's efforts to hire a van, it is at least debatable whether that should have led to the van being stopped or tailed. As Witness L said, such action would have risked compromising the investigation. If there had been live monitoring, there must be a reasonable chance that MI5 would have discovered the cover story of the house move, which Witness L said would have been accepted.

[49] Witness L, TX/24/166.
[50] Witness L, TX/25/147-150.
[51] See Witness L, TX/25/10-11.

25. In summary, while the evidence permits an argument to be mounted that the pre-attack investigation failed to take opportunities that might realistically have led to the attack being prevented, we ultimately find that argument unconvincing. With benefit of hindsight, it has been possible to identify some leads not followed. However, that does not make it right in the end to criticise a generally rigorous investigation. Furthermore, the prospect that any further action would actually have led to steps being taken to prevent the attack involves a good deal of speculation.

Physical Protective Security - the Victims on London Bridge

26. In our submission, it is arguable that there was a breach of the Article 2 general duty in (a) that the systems of the state for protective security in places vulnerable to vehicle-as-weapon attacks were deficient in 2016 and/or the early part of 2017 and (b) superior systems may have led to hostile vehicle mitigation ("HVM") measures being installed on London Bridge before the attack (e.g. temporary barriers, permanent bollards or some form of specially strengthened street furniture). We consider this submission to be only of relevance to the inquests of Xavier Thomas and Christine Archibald. We do not consider it arguable that the presence of HVM of any kind on London Bridge would, judged reasonably, have prevented the attack carried out with knives in and around Borough Market. It would be pure guesswork to suggest that the attackers might have abandoned their attack plan in the area if HVM had been present on the bridge.

27. We have given careful consideration to the question of whether the Article 2 operational duty was arguably breached by any public authorities in failing to install HVM on London Bridge. Our submission is that that duty was not arguably breached, because one cannot identify a point in time at which a specific public authority ought to have taken action which would have led to HVM being installed in advance of the attack. However, that submission may ultimately be academic if it is accepted that there is an arguable breach of the general duty.

28. In simple terms, the systems of the state for having physical protective security installed in sites across the UK were as follows. First, at the level of the Office of Security and Counter-Terrorism ("OSCT") and the National Counter Terrorism Security Office ("NaCTSO"), sensitive criteria were set by which a limited number of sites were classified as prioritised Crowded Places. Secondly, those sites were the subject of pro-active advice and engagement by police Counter-Terrorism Security Advisers ("CTSAs"). Thirdly, other sites could be subject to advice from CTSAs based on decisions at local level. Fourthly, there were

substantial advisory publications about protective security measures, especially on aspects of their engineering. Fifthly, the decision on what measures to take ultimately rested with the owner / operator of a site or a responsible public authority (the highway authority in the case of a roadway). However, there was no specific statutory or regulatory duty governing the owner or authority's duty to assess sites and install protective security.

29. As noted above, a CTSA's priorities are defined with reference to the concept of a prioritised "Crowded Place".[52] There is a public definition of the term "Crowded Place" which has remained almost constant from 2012 to the present day (but has been under review since late 2016),[53] being:[54]

> "a location or environment to which members of the public have access that may be considered potentially liable to terrorist attack by virtue of its crowd density. What counts as a crowded place is a matter of judgment. Crowded places will be found in a wide range of locations including: sports stadia, pubs, clubs, bars, shopping centres, high streets, visitor attractions, cinemas, theatres and commercial centres. Crowded places can also include the public realm – open spaces such as parks and squares. A crowded place will not necessarily be crowded at all times – crowd densities may vary during the day or night, and may be temporary, as in the case of sporting events or open-air festivals."

30. Although that public definition is apparently broad in scope, a site can only be a prioritised Crowded Place if it satisfies certain tests (which have not been disclosed for security reasons). One of the tests involves a threshold level of crowd density, which is depicted by diagrams.[55] If a site does not have the requisite level of crowd density, "it would not progress further to the assessment process" but it "could be retained on a local basis as a Tier 3 site".[56] A location will never be a Tier 1 or 2 site if it does not have the requisite crowd density.[57] It also appears that there is a further threshold test for qualification as a prioritised Crowded Place which requires the place to have a degree of geographic specificity (and which might rule out sections of roadway).

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[52] Sarah Nacey, TX/31/117.
[53] Sarah Nacey, TX/31/129.
[54] Sarah Nacey, TX/31/119; *Crowded Places: The Planning System and Counter-Terrorism, January 2012* DC8338/5 available online at the following link:
- https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/375208/Crowded_Places-Planning_System-Jan_2012.pdf.

[55] Deputy Assistant Commissioner Lucy D'Orsi, TX/28/98.
[56] Deputy Assistant Commissioner Lucy D'Orsi, TX/28/33.
[57] Sarah Nacey, TX/21/122-123.

31. The evidence is that some method is needed to prioritise the allocation of counter-terrorism resources, since resources are finite and a previous system which lacked sufficient prioritisation was deemed ineffective.[58] Crowd density is considered by the Home Office to be an important metric because, simply, dense crowds are attractive to terrorists.[59]

32. If a location is categorised as a prioritised Crowded Place, the local CTSA will allocate it to Tier 1 or 2 in accordance with guidance from NaCTSO. As noted above, a CTSA may also identify a place as a Tier 3 site even though it does not satisfy the tests of crowd density, etc. referred to above. Places within higher tiers are the subject of greater engagement.[60] The Home Office considers that a CTSA's decision to undertake tasks "outside of their prioritised remit" is a matter "up to their own professional expertise".[61]

33. Sarah Nacey, the Deputy Director for Protect and Prepare in the OSCT said that, with respect to protective security, "you need to make sure that you are dynamic and able to respond to events".[62] Furthermore, she very fairly accepted concerns that the definitional tests for a prioritised Crowded Place are too rigid.[63] Ms Nacey said she understood that bridges in the capital, including London Bridge, did not meet the criteria set for crowd density.[64] In addition, they were not suitable for being considered more closely by CTSAs because "at that time the programme was concentrating on reducing vulnerability, and so engaging with… an individual to have a plan to reduce vulnerability"[65] and there would have been no such identifiable person for the bridges. Ms Nacey said that the criteria were understandable when considered against a backdrop of "complex attack threats to places like shopping centres",[66] as was the threat picture in 2014. However, she acknowledged that they had become too rigid in requiring some kind of geographic or topographic specificity, such that a CTSA is able to engage with a responsible person,[67] especially taking into account the on-going threat of low complexity attacks[68] which was seen from 2016.[69]

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[58] Sarah Nacey, TX/31/201.
[59] Sarah Nacey, TX/31/128.
[60] Sarah Nacey, TX/31/121.
[61] Sarah Nacey, TX/31/121.
[62] TX/31/116.
[63] Sarah Nacey, TX/31/127 and 129-130.
[64] TX/31/125.
[65] Sarah Nacey, TX/31/126.
[66] TX/31/169-170.
[67] TX/31/130.
[68] TX/31/166.
[69] TX/31/214.

34. Against the background of the vehicle-as-weapon attacks which had taken place during 2016,[70] London Bridge represented a vulnerable and attractive target. PS Hone, a highly experienced CTSA and the CT co-ordinator for the City of London Police ("CoLP"), ultimately expressed his views about its vulnerability in mid-May 2017 as follows:[71]

    a. It has a very predictable high crowd density;

    b. It does not have any vehicle mitigation in place, and in fact has a lowered kerb allowing access to the pavement at the North East side (where the van did mount the pavement on 3 June 2017);

    c. It does not have any guard force responsible for safety "unlike most of the other crowded places";

    d. It presents an unimpeded path of 450 metres "with nowhere for pedestrians to escape to"; and

    e. "It is one of the most attractive targets in the City of London for low sophisticated attacks due to the points made above".

35. The witnesses generally accepted that these points represented a potent argument that London Bridge merited particular attention. DAC d'Orsi accepted that point and said that "considered in isolation" the document presented a compelling case for the implementation of HVM measures on London Bridge.[72] Sarah Nacey agreed too.[73] Deputy Chief Constable Jayne Gyford (at the time a Commander in City of London Police, with responsibility for protective security) accepted that London Bridge required action.[74]

36. As noted above, London Bridge was not and is not a prioritised Crowded Place. There is no evidence that the bridge was the subject of any consideration or advice by CTSAs in the period before early 2017. None of Mr Hughes, Ms Hayward or PS Hone was aware of any such consideration or advice.

[70] Specifically, the July 2016 attack in Nice and the December 2016 attack in Berlin.
[71] WS5014/33.
[72] TX/28/160.
[73] TX/31/157.
[74] TX/28/203.

37. Even before the Westminster Bridge attack of 22 March 2017, PS Hone regarded London Bridge as an attractive target for a terrorist. In January 2017, recognising that it was outside the scope of national priority criteria, he tasked the Cerastes team to consider it in their study.[75] Following the Westminster Bridge attack of 22 March 2017, he drew attention to London Bridge in a number of communications.

a. Before 09:00 on 23 March 2017, in the immediate aftermath of the attack at Westminster of the previous evening, PS Hone wrote to Superintendent Helen Isaac an email headed "Tactics and advice".[76] In that email, he said that he believed London Bridge to be CoLP's most vulnerable location from marauding vehicle attack, along with a second location (redacted for security reasons). He made this point in the context of urging more police deployments to the bridge using the Project Servator tactic. PS Hone said that he had mentioned this several times in the past when proposing taskings to the Security Group.[77]

b. On 24 March 2017, PS Hone included London Bridge in his list of the five most vulnerable sites to terrorist attack in the City of London area (a set of sites which were to receive additional deployments). He gave as reasons that it was a crowded place, an iconic site and a location with predictable crowds on the eastern pavement.[78]

c. On 27 April 2017, PS Hone received the second Cerastes interim report,[79] commissioned by City of London Police.[80] This was a "friendly hostile" assessment, prepared by a private company, considering a variety of sites which had been identified by CoLP as potentially at risk. In respect of London Bridge, to mitigate the risk of a vehicle ramming attack, Cerastes recommended Project Servator deployments or the installation of HVM on the bridge.[81] Cerastes had not been tasked to assess methods of preventing a vehicle-as-weapon attack on London Bridge, but in their work they had to consider plausible attack methods at London Bridge.[82] They identified the risk that did materialise, and which PS Hone had himself had identified some time earlier.

[75] TX/29/151-152.
[76] WS5014/17.
[77] PS Matthew Hone, TX/29/164.
[78] WS5014/14.
[79] WS5015/15.
[80] PS Matthew Hone, TS/29/169.
[81] PS Matthew Hone, TX/29/171.
[82] PS Matthew Hone, TS/29/173.

d. On 8 May 2017, PS Hone informed Commander Richard Woolford, as a representative of the Corporation of the City of London, that London Bridge was considered to be the most vulnerable site in the City area to low sophisticated attacks using a vehicle.[83] Mr Woolford said that this would be considered by the Corporation Security Board by the end of June 2017.[84]

e. At a CoLP Security Group meeting on 11 May 2017, PS Hone offered copies of the second Cerastes interim report. He undertook to produce a summary of the report and a set of his own recommendations. On or shortly before 16 May 2017, PS Hone produced that document. It included a recommendation to install permanent HVM to specific PAS technical standards on London Bridge. It was generally agreed between all relevant witnesses that the installation of such measures would take a matter of years. PS Hone's recommendations had not been supplied to the CoLP Security Group before the attack.

38. The highway authority with powers and duties for maintaining the A3 roadway on London Bridge was TfL. The structure of the bridge was owned by a trust, with the Corporation of the City of London having responsibility for that structure. Accordingly, any installation of HVM measures on London Bridge would ordinarily be managed by TfL, but in consultation with the Corporation. Before the attack, neither the Corporation nor TfL conducted any systematic assessment of terrorism risks which encompassed London Bridge. The evidence of both bodies was that they were reliant on, and reactive to, advice from the police (specifically, from CTSAs).

39. As to the division of responsibility, Siwan Hayward gave the following explanation:[85]

> "the responsibility for protective security and advising on permanent forms of hostile vehicle mitigation would sit with counter terrorism security advisors and counter terrorism policing who would lead on that, and then they would liaise with us for particular sites or buildings or visitor attractions which have been deemed as requiring protective security. They liaised with us as a highway authority in terms of placing bollards or other measures on our streets, and that would then come into the teams who deal with our highways and our overall responsibilities in terms of highways."

[83] WS5014/21.
[84] PS Matthew Hone, TX/29/228.
[85] TX/30/215-216.

40. The shared responsibility for London Bridge was described as follows by Mr Woolford:[86]

> "A. I now know categorically the highway responsibility for the pavement and the road is that of TfL. The Bridge belongs to the Corporation and there's issues in relation to a partner approach, so categorically the only way that would have been resolved is through an absolute partnership approach….
>
> Q. So… if there had been an urgent recommendation earlier in 2017 of some form of hostile vehicle mitigation on the Bridge, that could or would have gone to a Gold Group which would have included TfL and everybody would have understood the nature of the partnership required?
>
> A. Indeed."

41. Prior to the attack, TfL as highway authority had not received any advice from the police about the vulnerability of bridges generally or London Bridge in particular. TfL was focussed on its top ten prioritised Crowded Places, and subsequently on a list of 50 such places. No bridge or highway ever featured on those lists.[87] Ms Hayward explained that "there was no advice or guidance or recommendations that we should be taking any steps to protect our streets and our crowded spaces [i.e. open areas]."[88] She said that TfL was not able to undertake a risk assessment without the input and specialist knowledge of a CTSA, which was not received.[89] Had TfL been advised to install barriers, it could have used its access to a range of different assets to complete the installation within a period of weeks. It would have accepted a recommendation from the CTSA to install HVM to any particular specification on London Bridge.[90] However, the CTSA who might have advised TfL of this vulnerability (PS Hone) had not believed that there was "a quick fix in terms of hostile vehicle mitigation".[91]

42. As regards the Corporation of the City of London, its position was that a dialogue had begun between PS Hone and Commander Woolford about work required on a local priority list of vulnerable sites. PS Hone commented on a matrix of priority sites and added London Bridge in his communication of 8 May 2017 (see above). The Corporation did not consider PS

[86] TX/30/75.
[87] Siwan Hayward, TX/30/234.
[88] TX/30/232.
[89] TX/30/233.
[90] Siwan Hayway, TX/31/10.
[91] PS Matthew Hone, TX/29/174, 177.

Hone's advice to require urgent action. Had it been considered urgent, the Corporation would have commenced a discussion which would have included TfL.[92]

43. In her evidence, Ms Nacey pointed out that there is a balance to be struck "between a surveillance and barrier society and… going about our daily business".[93] Like DAC d'Orsi, she cautioned about steps to becoming "Barrier Britain".[94] These are fair points to be considered in relation to general systems for protective security. However, in this instance it was quickly accepted following the attack that London Bridge required HVM measures in the short and long term. Even without the benefit of hindsight, the need for HVM measures was identified by PS Hone before the attack and endorsed independently by the work of Cerastes.

44. Against that background, we submit that it is arguable that there was a breach of the general duty under Article 2. Specifically, the systems for assessing vulnerable locations and installing protective security measures were arguably deficient in the relevant period (late 2016 and early 2017). It is arguable that, if those deficiencies had been cured, London Bridge should have had some effective HVM measures installed by the time of the attack.

    a. The first arguable deficiency in the systems concerns the approach to classification of sites as prioritised Crowded Places. It is properly arguable that the tests were too rigid and caused places such as London Bridge not to be the subject of pro-active engagement by local CTSAs. If a less rigid approach had been applied, it is at least possible that London Bridge would have been accorded a higher priority for protective security advice during 2016, given (i) the attacks in Nice and Berlin and (ii) the view later taken by PS Hone.

    b. The second arguable deficiency in the systems was a lack of (i) clear lines of responsibility and/or (ii) procedures for ensuring that highway authorities considered the vulnerability of key areas for which they were responsible. This failing arguably compounded the first, in that TfL and the Corporation were waiting on advice from CTSAs while CTSAs were only required to engage pro-actively with owners of defined sites that qualified as prioritised Crowded Places.

[92] Ian Hughes, TX/30/195-196.
[93] T/31/215.
[94] TX/28/179.

c. The third arguable deficiency in the systems was a lack of clear procedures for reasonably prompt consideration of temporary and permanent HVM measures, which can be said to have been needed against the background of increasing incidence of vehicle-as-weapon attacks. When PS Hone made the Corporation of the City of London aware of the vulnerability of London Bridge, on 8 May 2017, the processes of the Corporation did not allow this to be considered quickly. Overall, it is fairly arguable that the processes of CoLP, TfL and the Corporation lacked the "dynamic" quality which Sarah Nacey said they required.

d. It is a realistic possibility that superior systems would have led to HVM measures being installed on the bridge in advance of the attack. However, that would probably have required a proper assessment of the risks on the Bridge in late 2016 / early 2017 followed by joint consideration of all possible options by police, TfL and the Corporation in partnership. Different procedures and structures would probably have been needed to ensure that outcome.

45. In our submission, it would be appropriate for the narrative conclusions in relation to Xavier Thomas and Christine Archibald to refer to the fact that HVM measures had not been implemented. It would also be appropriate for those conclusions to make the point that the systems and practices for assessing London Bridge and comparable sites for HVM measures were not adequate in light of the developing threat profile and the increasing prevalence of vehicle attacks.

46. In respect of the operational duty, our submission is that it is not arguable that there was a breach by one or more particular state agents and that the two deceased persons lost a substantial chance of surviving as a result of the breach. We make that submission for the following reasons:

a. As regards TfL, it cannot be said that that body knew or ought to have known of a real and immediate risk to users of London Bridge. Neither can it be said that TfL should have appreciated the need to install HVM measures (temporary or permanent) and completed the installation in advance of the attack.

b. As regards the Corporation, it cannot be said that that body ought reasonably to have taken additional measures. London Bridge was first brought to its attention as a

vulnerable site in mid-May 2017, at which time Commander Woolford was told by PS Hone to await further advice.[95]

c. As regards CoLP, while there may be some scope for criticism of individual decisions and communications, there is no basis for a finding of breach of the operational duty by that body. PS Hone was acknowledged by all who questioned him as a diligent, rigorous and expert CTSA. Nobody criticised his conduct. The time and context for the concerns he raised within CoLP about London Bridge are critical. When he first aired concerns, it was to urge greater use of the Servator tactic (advice which was acted upon). When he raised his more detailed points in mid-May 2017, they were to advocate the installation of permanent HVM measures (which required detailed consideration and would have taken years to implement). He was only involved in advising about London Bridge relatively late in the day, and he was understandably not aware of realistic options to install temporary HVM measures more quickly.

47. In our submission, the right legal analysis reflects a common sense conclusion: the absence of effective HVM on London Bridge despite its apparent vulnerability was not due to individual human errors but to systems which had not caught up with the developing threat picture.

The London Ambulance Service - the Victims near Boro Bistro

48. The Inquests have given detailed consideration to the response of the London Ambulance Service ("LAS") to the attack. In particular, extensive evidence has been heard, and time given to exploring, the question of whether LAS might have (a) entered the Boro Bistro courtyard and the area around the Mudlark public house earlier or (b) communicated to people in that area to the effect that ambulance officers could not enter. These matters have been properly explored, and some points have been made about delays and breakdowns in communications. However, our submission is that the facts do not disclose any arguable breach by LAS of the Article 2 positive duties in relation to any of those who died.

[95] Even at the time of giving evidence, PS Hone, Deputy Chief Constable Gyford and Richard Woolford were all unaware that TfL had the ability to install hostile vehicle mitigation within weeks, and without accessing the National Barrier Asset.

49. In summary, the relevant chronology of events outlined in the evidence is as follows:

a. **22:07** – First emergency calls to LAS;

b. **22:11** – Several LAS resources (including ambulance and various first responders) despatched to the scene;[96]

c. **22:11** – First calls received about a stab victim;[97]

d. **22:13** – First LAS staff on scene, who go straight to the casualties on the Bridge;[98]

e. **22:16** – Operation Plato is declared by the MPS;[99]

f. **22:17** – LAS is informed by the MPS that the incident is being treated as a terrorist attack;[100]

g. **22**:**19 –** Keir Rutherford, LAS Advanced Paramedic, declares a Major Incident;[101]

h. **22:20-22:29** – Forward Command Post is set up with police Tactical Firearms Commanders with responsibility for warm and hot zones;[102]

i. **22:23** – Keir Rutherford reports to his control room "multiple patients stabbed and shots fired by police"[103] (at this time, he has reached Boro Bistro and is directed away by armed police);

j. **22:27** – Andrew Beasley, LAS Incident Response officer, arrives on scene at the south end of London Bridge;[104]

k. **22:34** – Mr Beasley is made aware of an unattended victim under the Bridge;[105]

l. **22:45** – Police officers begin to bring the victims up from Boro Bistro; James McMullan is brought to street level at 22:46 and Sébastien Bélanger is brought to street level at 22:47;[106]

[96] DC8209/27.
[97] DC5207; DC5197.
[98] DC8209/28.
[99] Paul Woodrow, TX/27/27.
[100] DC8209/36.
[101] DC820937.
[102] Paul Woodrow, TX/27/28.
[103] DC8209/40.
[104] DC8209/27; DC5029/3.
[105] DC8317/2.
[106] Paul Woodrow, TX/27/37-38.

m. **23:37** – Marc Rainey, LAS Bronze for Plato, reports that Borough Market remains a hot zone and that Borough High Street is a warm zone;[107]

n. **00**:**03** – First AIT team enters Borough Market;[108]

o. **01:05 –** LAS AIT team 4 is tasked with going to the crashed van and the surrounding area, after which members go through the Boro Bistro area (at this time, the adjacent Cathedral is still regarded as a hot zone).[109]

50. In relation to the four victims in the Boro Bistro area who lost their lives, clinical and pathological evidence leads to the following conclusions as to time of death:

a. Dr Poole believes that **Kirsty Boden** was dead by the time she was first seen by an off-duty clinician, at approximately 22:12. No particular treatment, had it been rendered earlier, could have saved her.[110]

b. Dr Chapman gave evidence that **Alexandre Pigeard** had probably died before PC Attwood attended to him, which was at approximately 22:14. No practicable treatment could have been given in the pre-hospital environment that would have saved Alexandre.[111]

c. The evidence of Dr Wrigley, a senior A&E doctor, was that **Sébastien Belanger** could not have survived his injuries after 22:16.[112] While Dr Swift, the pathologist, suggested that treatment at the scene by the London Air Ambulance might have given further possibilities, he was unable to say how long Sébastien's window of opportunity would have been, other than that "the rule of thumb in medicine is that the quicker you receive the treatment the better the outcome".[113] He also acknowledged that the agonal gasp described by Lisa Deacon at the start of CPR was a feature of the last moments of life.[114]

[107] DC8209/61.
[108] WS1370/38.
[109] WS1370/40.
[110] TX/17/79.
[111] TX/19/28-29.
[112] TX/27/177-178.
[113] TX/17/16.
[114] TX/17/25-26. For Ms Deacon's evidence, see TX/6/133.

d. Dr Chapman believes it likely that **James McMullan** had died before PC Miah got to him, which was at 22:20. No practicable treatment could have been given in the pre-hospital environment that would have saved James.[115]

51. Reading those two timelines together, it is clear that any action or inaction on the part of LAS after 22:20 (or perhaps even earlier) could not have caused or contributed to the deaths of these four victims. We do not consider there is any proper argument that the LAS failed in its operational duty before this time. The first ambulance staff who arrived immediately tended to victims and initiated appropriate triage procedures for a Major Incident, as it clearly was. Moreover, there is no evidence that LAS was aware of the four victims in the courtyard before 22:34, when Andrew Beasley received information about them.

52. For these reasons, we submit it is not arguable that Article 2 is engaged as a result of any acts or omissions of LAS. Furthermore, it would be wrong to suggest in narrative conclusions that any failing on the part of LAS was (or may have been) causative of any of the deaths.

53. For completeness, we would add two further points. First, as explained in detail in the *Parkinson* case (cited above) at [82]-[91], individual errors by clinical staff in the healthcare context or failures of co-ordination between staff are not usually sufficient to constitute a breach of the Article 2 operational duty. For a breach to be found, some broader dysfunction in the overall clinical service must usually be established. Secondly, we would not support the critique of Mr Beasley which has been articulated. Overall, his conduct in remaining in harm's way and seeking to co-ordinate medical services was commendable. Although there was apparently a short delay (around 10 minutes) between him becoming aware of those in the Boro Bistro courtyard and them being brought to the ambulances, the period was one when he was being covered by armed officers and handling many communications.

Article 2 Engagement – Other Grounds

54. We are not at present aware of any other basis on which any Interested Person might seek to argue that the Article 2 procedural obligation is engaged. If any such argument is made, we shall address it in our oral submissions.

[115] TX/19/12-13.

Proposed Determinations

55. We propose that, for each of those who died, a Record of Inquest should be produced with all sections completed (including medical cause of death, as given by the relevant pathologist) and the following entry in each of sections 3 and 4: "See attached Determinations sheet". That sheet should then contain the determination as to how the person died.

Unlawful Killing Conclusion

56. As submitted above, we propose that for each of those who died the determination includes a short-form conclusion of unlawful killing and a narrative. It is clear beyond any doubt that each of those who died was murdered in a terrorist attack. As the Court heard from many eye witnesses, the attackers' van was driven deliberately onto the pavement three times, each time evidently targeting pedestrians. Witnesses, including Christine Delcros and Tyler Ferguson, described the van driven directly at them. When the attackers continued their rampage on foot, a significant number of victims received knife wounds to their necks and throats. Many victims individually received a great number of stab wounds, in double figures. It is clear that the attackers intended to kill each person they assaulted, or at least to inflict very serious injury.

57. It is right that each Record of Inquest should record that the person who died was unlawfully killed. Whatever else the documents say, that basic fact should be stated at the outset.

Narrative Conclusions

58. As submitted above, it is legitimate for some narrative conclusions to be provided in relation to each of those who died (irrespective of the engagement of Article 2). We put forward the following suggested forms of words for those conclusions (beginning, in each case, with the short-form conclusion). These first passages describe only the means of death of each deceased. We make further submissions below in respect of further passages which may be included in respect of the broader circumstances of the deaths.

59. However, no doubt the Court will wish carefully to consider any amendments or alternative forms of words provided by the bereaved families in particular. We should stress that these are being suggested as the narratives for the Records of Inquest. We are aware that a much

more detailed factual account will be given in relation to each deceased person in the Coroner's summing-up.

a. *Xavier Thomas*

Xavier Thomas was unlawfully killed.

On 3 June 2017, Xavier Thomas was visiting London. He had been walking south across London Bridge with his partner, Christine Delcros. They had reached a point about midway across the Bridge when a Renault van was driven deliberately towards them and other pedestrians on the pavement. This was part of a terrorist attack. Xavier was struck by the front offside of the van with significant impact. Christine was struck by the van as well. He was thrown over the balustrade of the Bridge into the River Thames below, falling from a height of at least 13 metres. Xavier died immediately or almost immediately upon entering the water. A search was carried out by the Coastguard and Metropolitan Police Service, the first boat arriving approximately seven minutes after Xavier entered the water. Xavier was probably not on the surface of the water during the search. Xavier's body was recovered from the River Thames on 6 June 2019. He was assessed as dead by a police officer.

b. *Christine Archibald*

Christine Archibald was unlawfully killed.

On 3 June 2017, Christine Archibald was visiting London. She had been walking south across London Bridge with her fiancé, Tyler Ferguson. They had passed the midpoint of the Bridge when a Renault van was driven deliberately towards them and other pedestrians on the pavement. This was part of a terrorist attack. Christine tried to avoid the van and Tyler tried to protect Christine with his arm. Christine was struck with full force by the vehicle. She was carried forward with the van until it crossed the central reservation, where Christine's body was released. She was run over by the van. Christine was immediately unconscious and died nearly instantly from these injuries, which were not survivable. Christine was treated by Tyler, members of the public, police officers, paramedics and doctors. She was assessed as dead at the scene by a doctor.

c. *Sara Zelenak*

Sara Zelenak was unlawfully killed.

On 3 June 2017, Sara Zelenak was with a friend in the Borough area. Three attackers had deliberately driven a Renault van into multiple pedestrians on London Bridge and into railings on Borough High Street, next to the Barrowboy and Banker public house. That was part of a terrorist attack. The attackers left the van and immediately began attacking further pedestrians, including Sara, with knives. During or immediately before the attack, Sara lost her footing. She suffered a number of injuries when stabbed by one or more of the attackers, dying at or very near to the place where she was attacked. One of Sara's injuries was a stab wound to her neck, of which she died extremely rapidly. That injury was not survivable. She was treated by police officers and was assessed as dead at the scene by a paramedic.

d. *Sébastien Bélanger*

Sébastien Bélanger was unlawfully killed.

On 3 June 2017, Sébastien Bélanger was with a group of friends around Borough Market. Three attackers had deliberately driven a Renault van into multiple pedestrians on London Bridge and into railings on Borough High Street, next to the Barrowboy and Banker public house. The attackers had left the van and had immediately started attacking further pedestrians with knives. The attackers went down a stone stairway towards Boro Bistro. This was all part of a terrorist attack. At or around the base of the stairway, Sébastien was attacked and suffered a number of injuries when stabbed with the knives of one or more attackers. His most significant injuries were to his chest. Sébastien received prompt treatment from members of the public and police officers, including CPR. At the time at which treatment commenced, Sébastien had not died. However, his injuries were very serious and he could not be saved, despite the best efforts of the police officers and members of the public. Sébastien was carried to an ambulance where he was assessed as dead by a paramedic.

e. *James McMullan*

James McMullan was unlawfully killed.

On 3 June 2017, James McMullan was with a group of friends in the Borough Market area. James left the Barrowboy and Banker public house and went towards Boro Bistro. Three attackers had deliberately driven a Renault van into multiple pedestrians on London Bridge, before crashing it into railings on Borough High Street, next to the Barrowboy and Banker public house. The attackers left the van and immediately began attacking further pedestrians with knives. The attackers then went down a stone stairway towards Boro Bistro. This was all part of a terrorist attack. Around the area at the top of the stone stairway, James was attacked and suffered stab wounds, resulting in rapid blood loss. It is likely that he was attempting to assist a young woman who had been attacked when he himself was stabbed. He moved from where he was attacked, entering an alleyway at one side of Boro Bistro. This location was out of sight from most of the Boro Bistro courtyard. He collapsed in that alleyway. James later received treatment from police officers, who saw no sign of life. He had died very quickly after receiving his injuries, which were not survivable. Police officers carried James to a paramedic, who assessed him as dead.

f. *Alexandre Pigeard*

Alexandre Pigeard was unlawfully killed

On 3 June 2017, Alexandre was working at Boro Bistro as a waiter. Three attackers had deliberately driven a Renault van into multiple pedestrians on London Bridge and into railings on Borough High Street, next to the Barrowboy and Banker public house. The attackers had left the van and had immediately started attacking further pedestrians with knives. The attackers then went down a stone stairway towards Boro Bistro. This was all part of a terrorist attack. Alexandre was aware that there had been a collision at street level and moved towards the base of the stairway. In that area, Alexandre was stabbed with the knives of one or more attackers and suffered serious injuries, including to his neck. Alexandre then moved back into Boro Bistro, following the wall to his left hand side. At the other end of the courtyard he was stabbed again, during which time he fell to the floor. As a result of his multiple injuries, he suffered rapid and fatal blood loss, particularly from the wounds to his neck and chest. He died very quickly. His injuries were not survivable. Alexandre received treatment from a police

officer, who saw no sign of life. He was later assessed as dead at the scene by a paramedic.

g. *Kirsty Boden*

Kirsty Boden was unlawfully killed.

On 3 June 2017, Kirsty was with a group of friends at Boro Bistro. Three attackers had deliberately driven a Renault van into multiple pedestrians on London Bridge and into railings on Borough High Street, next to the Barrowboy and Banker public house. The attackers had left the van and had immediately started attacking further pedestrians with knives. The attackers then went down a stone stairway towards and into Boro Bistro. This was all part of a terrorist attack. Kirsty was aware that there had been a collision at street level and she moved towards the entrance to Boro Bistro. She was a nurse and told her friends that she needed to go and help anybody who might be injured in the collision. Kirsty was with a seriously injured man when she was assaulted by one or more of the attackers and was stabbed with their knives. She received a stab wound to the left side of the chest, which was the fatal injury. Kirsty was able to move along an alleyway a short distance towards the Mudlark public house where she collapsed. She died within minutes. Her injury was not survivable. Kirsty received treatment from friends, members of the public, police officers and a doctor. She was assessed as dead at the scene by a paramedic.

h. *Ignacio Echeverria Miralles de Imperial*

Ignacio Echeverria Miralles de Imperial was unlawfully killed.

On 3 June 2017, Ignacio had been skateboarding in London with friends. He and his friends had been cycling north up Borough High Street towards the river. Meanwhile, three attackers had deliberately driven a Renault van into multiple pedestrians on London Bridge and into railings on Borough High Street, next to the Barrowboy and Banker public house. The attackers had left the van and had started attacking further pedestrians with knives. This was all part of a terrorist attack. They had entered the courtyard of a restaurant and had assaulted people there, before continuing south on Borough High Street. The attackers set upon a number of members of the public and a uniformed police officer. Ignacio saw this and got off his bicycle, moving forward on foot to confront the attackers. Ignacio used his skateboard as a weapon and

endeavoured to protect the victims of the attack, including the police officer who had been stabbed. Ignacio suffered a number of injuries when stabbed with the knives of one or more attackers. During the attack he fell to the ground where the attack continued. He received a stab wound to the upper back, which was the fatal injury. Ignacio rapidly lost consciousness and died within minutes. His injury was not survivable. Ignacio received treatment from his friends, members of the public, and police officers. He was moved to the north side of the Bridge because the area in which he was attacked was unsafe. He was assessed as dead by a doctor at that location.

60. If the Coroner concludes that Article 2 is engaged in the inquest of a particular deceased person (for whatever reason), we submit that the narrative conclusions in that inquest may and should be in two parts: first, the relevant passage describing the means of death (see above); and secondly, one or more short passages expressing further conclusions on the broader circumstances. We set out below, for consideration by Interested Persons, possible forms of words for those additional passages.

61. First, we submit that serious consideration should be given to recording the fact that Khuram Butt's family were aware of his extremist views and behaviour but did not report those matters to the authorities. A passage of the following kind might be suggested:

> Multiple warning signs about the extremist views and conduct of one attacker were known to a number of his close family members in the months and years before the attack. In the main these were not reported to the authorities.

62. Secondly, we submit that the narrative conclusion could properly record the fact of Butt being a subject of interest under active investigation at the time of the attack. For reasons given above, we would not support a set of conclusions critical of the pre-attack investigation. The following form of words is therefore suggested:

> One of the attackers was a Subject of Interest under active investigation by the Security Service at the time of attack and for around two years before it. He was subject to surveillance in varying degrees but was not the subject of live monitoring in the days immediately before the attack. The other attackers had not been identified before they carried out the attack together.

63. Thirdly, we submit that the narrative conclusions for Xavier Thomas and Christine Archibald can and should properly record the absence of physical protective security on London Bridge

and any findings as to failures of systems which led to that state of affairs. We would suggest the following form of words:

> At the time of the attack described above, there was no form of physical protective security on London Bridge, despite the fact that it was a location which was particularly vulnerable to a terrorist attack using a vehicle as a weapon. The failure to implement appropriate hostile vehicle mitigation measures on London Bridge was due to a lack of adequate systems for assessing the need for such measures on the bridge and implementing them promptly.

64. The passages set out above are proposed for comment by others and further discussion. We are entirely open to considering amendments, or alternative / additional passages for inclusion in the narrative conclusions.

PFD Report

Legal Background

65. Schedule 5 to the CJA, which is given effect by section 32, provides as follows at paragraph 7:

> (1) Where –
>
> (a) a senior coroner has been conducting an investigation under this Part into a person's death,
>
> (b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and
>
> (c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,
>
> the coroner must report the matter to a person who the coroner believes may have power to take such action.

Further provision is made at paragraph 7(2)-(3), for (i) the recipient of a report to reply in writing and (ii) both the report and reply to go to the Chief Coroner.

66. Part 7 of the Coroners (Investigations) Regulations 2013 contains provisions for the making of PFD Reports. Regulation 28 provides as follows:

> (1) This regulation applies where a coroner is under a duty under paragraph 7(1) of Schedule 5 to make a report to prevent other deaths.

(2) In this regulation, a reference to "a report" means a report to prevent other deaths made by the coroner.

(3) A report may not be made until the coroner has considered all the documents, evidence and information that in the opinion of the coroner are relevant to the investigation.

67. Before July 2013, the power to make such reports was contained in rule 43(1) of the Coroners Rules 1984. That provision was in terms similar to those of paragraph 7(1) of Schedule 5 to the CJA, but it provided that if the coroner considered that preventive action should be taken, then he/she "may" make a report.

68. The following principles govern the making of PFD Reports:

a. As the Court of Appeal observed in the *Lewis* case (cited above), the regime makes it mandatory for a coroner to make a report if he/she forms the view that the relevant action needs to be taken. A coroner may no longer conclude that action ought to be taken but decide for some extraneous reason not to make a report. That is the effect of the words "must report" in paragraph 7(1).

b. However, the power and duty to make a report only arise where the coroner forms the opinion, based on evidence relevant to his/her inquiry, that particular risks of death exist for which preventive action is required. In *R (Cairns) v HM Deputy Coroner for Inner West London* [2011] EWHC 2890 (Admin) at [74], Silber J explained that the statutory expression "in the coroner's opinion, action should be taken…" reflects a discretionary judgment by the coroner.

c. The jurisdiction to make PFD Reports is not limited to the reporting of circumstances and risks which were causally relevant to the particular deaths under investigation: see *Lewis* at [14]-[19]; Rule 43 Report of Hallett LJ following the London Bombings Inquests, [161]; Chief Coroner's Guidance No. 5, [17]. However, it does require that the material in the particular investigation has highlighted systemic risks or failures which may recur or continue, with potentially fatal consequences: see *R (Francis) v HM Coroner for Inner South London* [2013] EWCA Civ 313 at [7]-[8], Davis LJ.[116]

[116] Note also that a PFD Report should be made by reference to the material gathered and evidence given during the coronial inquiry. The jurisdiction to make a report is thus ancillary to the inquiry, and a coroner should not radically expand the scope of his/her inquiry in order to provide the foundation for a possible PFD Report. See:

d. A coroner may properly decide not to make a PFD report on an issue on the basis that he/she is not satisfied that further action is necessary. If, for example, it appears that a risk or issue has likely been addressed by action of some kind, or if circumstances have changed substantially since the death in question, the coroner may reasonably say he/she is not satisfied further action is required. Equally, a coroner may decide that he/she simply has insufficient material to form a view that there are particular risks of future deaths and/or that further action is required. See, for example, the approach taken by Hallett LJ to various issues in her Rule 43 Report after the London Bombings Inquests (e.g. [70] and [217]). See also *Jervis on Coroners (13th ed.)* at [13]-[125].

e. The purpose of death investigation in both domestic and Convention law includes a concern to identify systemic failures and risks. See, for example *R (Amin) v SSHD* [2004] 1 AC 653 at [31]; *R (Sacker) v West Yorkshire Coroner* [2004] 1 WLR 796 at [11]. The domestic law scheme deliberately confers on a professional adjudicator (the coroner) the judgment whether such risks exist and whether they need to be addressed by action: see *Lewis* at [40]; *Middleton* at [38].

69. Chief Coroner's Guidance No. 5 also addresses PFD Reports. That document makes the following relevant points, with which we respectfully agree:

a. PFD Reports are important, and their importance has been emphasised by Parliament modifying the rules in the way described above. See Guidance at [2]-[3].

b. "Broadly speaking reports should be intended to improve public health, welfare and safety. They should not be unduly general in their content; sweeping generalisations should be avoided. They should be clear, brief, focused, meaningful and, wherever possible, designed to have practical effect." See Guidance at [5].

c. If a report is made, it need not (and generally should not) prescribe particular action to be taken. It need not (and generally should not) apportion blame or be prejudicial (see, to the same effect, *Jervis* at [13-123]). The content of the report should be focussed and limited to the statutory remit. See Guidance at [24]-[27].

R (Butler) v HM Coroner for the Black Country [2010] EWHC 43 (Admin) at [74], Beatson J; Chief Coroner's Guidance at [14].

70. In summary:

a. A coroner should make a PFD report if (but only if) satisfied of two propositions: (i) that there is a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and (ii) that in his/her opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances. In making a judgment on these issues (especially the second), the coroner is exercising a judicial discretion.

b. The coroner must form his/her judgment based on the information revealed by the coronial investigation.

c. It is not necessary for the coroner to conclude that the particular death under investigation was caused by the circumstances or risks which may be the subject of the report. However, it is necessary for the coroner to find that systemic risks or failures have been highlighted by the material in the particular investigation.

d. It is perfectly proper for a coroner to say that a risk or issue has apparently been addressed, or that on the available material he/she cannot be satisfied that preventive action need be taken. In making a decision, the coroner is entitled to take account of the passage of time and changes of circumstances since the deaths.

e. Before deciding whether to make a report, the Coroner should consider whether it would be directed to improving public health, welfare or safety and whether it would be focussed, practical and within the statutory remit.

71. We would finally stress the point that PFD Reports will often draw attention to matters of concern or to risks, rather than prescribing particular solutions. A coroner is often not qualified to propose specific action and may not be aware of all the consequences of taking such action. A coroner may be unaware of exactly what remedial action is practicable and/or unaware of competing demands for resources. These considerations should not, of course, lead to paralysis. A coroner may raise a concern and be properly told that the problem cannot be perfectly solved.

Proposed Approach in this Case

72. In our submission, it would be appropriate in this case to adopt the following approach:

a. Interested Persons who wish to make submissions that a PFD Report should be made, and the points which they consider might usefully be included in such a report, should make those submissions in writing within a period of (say) 28 days from the conclusion of these Inquests (i.e. by 26 July 2019).

b. Other Interested Persons should then be given the opportunity to respond to those submissions in writing, again within 28 days (i.e. by 23 August 2019), making observations on the proposed points. Those submissions should so far as possible be provided in open form (which can and will be circulated to all Interested Persons), but may if absolutely necessary include a closed annex.

c. There should be a final round of responses in writing if necessary, within a period of 14 days (i.e. by 6 September 2019).

d. The Coroner should then consider the original submissions and any responses, before preparing and issuing any PFD Report. The issuing of any Report would then trigger the process of responses in the way laid out in the statutory provisions.

73. We propose this sequence of submissions, responses and Report for the following reasons. Given the subject-matter of these Inquests, it may be that representations are made for a PFD Report to address very complex subject-matter (e.g. protective security of public places, emergency service first response protocols and/or police counter-terrorism and Security Service procedures). In some cases, the points raised may address subjects which have already been covered by reviews undertaken before or since the attacks. In order that the Coroner can ensure that any PFD Report serves its proper purposes (as identified

above), it would be best to allow public authorities to make observations on suggested points before the content of any Report is decided.

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24 June 2019