PRE-INQUEST HEARING: 15 JANUARY 2018

CORONER'S INQUESTS INTO THE DEATHS

IN THE WESTMINSTER TERROR ATTACK OF 22 MARCH 2017

SUBMISSIONS ON BEHALF OF THE FAMILIES OF

ANDREEA CRISTEA,

AYSHA FRADE,

P.C. KEITH PALMER

and

LESLIE RHODES,

DECEASED

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1. These submissions are made on behalf of the families of the above four deceased ("the Families") in respect of issues arising at the forthcoming Pre-Inquest Hearing ("PIH").

2. The Families are grateful to Counsel to the Inquests ("CTI") for both the Agenda for the PIH and the update and information provided in their Submissions document.

3. In respect of the numbered items on the Agenda the following submissions are made:

1. Designation

4. As noted in the submissions of CTI at para.6, pursuant to section 47(2)(a) of the Coroners and Justice Act 2009 ("CJA") members of the Families were designated as Interested Persons ("IPs") at the hearing on 19 May 2017.

2. Update on Investigations and Reviews

5. The Families are grateful for the update contained in paras.8 to 12 as to the investigations by the Police and MI5 and the reviews as to security at the Houses of Parliament. For the avoidance of doubt the Families continue to know very little as to the details of how their loved ones each met their deaths and are anxious to begin to

obtain answers as soon as possible to the obvious and understandable questions that arise.

3. The Organisation of the Inquests

6. The Families support the submission of CTI to the effect that there should be two separate inquest hearings, with the inquests into the deaths of the victims, including PC Palmer, being held prior to and separately from a later inquest into the death of Masood. Reasons for this course include:

(i) Hearing the inquests into all the victims together, as opposed to in two separate hearings, would avoid duplication of evidence, namely, background evidence as to Masood, in particular his police record and involvement with MI5 investigations of 2009-2010 and his preparations and actions in the period leading up to the attack.

(ii) The inquest into the shooting of Masood raises issues which are distinct from those arising in the inquests of the victims.

(iii) The inquest into the shooting of Masood has to be held with a jury (by virtue of section 7(2)(b)(i) of the CJA) whereas, for the reasons given below in relation to Agenda item 5, the Families support the submission of CTI that the inquests into the deaths of the victims do not require a jury and would be more appropriately held without a jury. The Families agree that there are positive advantages to the Chief Coroner alone hearing the inquests into the victims. To join the inquest of Masood to the victims' inquests would compel the summoning of a jury and prevent the Chief Coroner from realising these advantages, to the detriment of the interests of both the Families and the wider public. In the 7/7 Bombings Inquests the Families, other IPs and the wider public benefitted from having a reasoned summing-up from the Coroner of a nature that could not have been obtained from a jury.

(iv) There is clear evidence that Masood unlawfully caused the deaths of those killed on Westminster Bridge and PC Palmer outside the Houses of Parliament, as well as injuring others. Masood's attack on the Houses of Parliament evidences an anti-democracy terrorist ideology, such that he regarded the public in London, agents of the State such as British police officers, and the heart of our democracy as legitimate targets. It is likely that the inquests will hear evidence suggesting a warped desire to launch a highly public violent attack on our democratic way of life and use force to seek the implementation of Sharia law. This is further supported by the material reviewed by David Anderson QC ("DAQC") in his Independent Assessment. It is submitted that it would not be in the interests of justice for the inquest into the shooting of Masood to be joined to those of the victims. The Families have indicated that they would find the Inquests extremely distressing if there were to be such joinder. In such circumstances there could be questions asked and submissions advanced that would cause the Families to find

it more difficult fully to participate in the inquests into the deaths of their loved ones. Joinder could also result in similar anxiety for any survivors giving evidence. In the 7/7 Bombings Inquest Lady-Justice Hallett recognised as "understandable" the "undoubted distress" that the families of those victims would have been caused had there been joinder of the inquests into the deaths of the four suicide bombers (see para 16). It is noted that CTI submits that such a wish of the Families should be given "significant" weight: para 13(a). This is supported by the policy objectives of the 2009 coroner reforms which were to "put the needs of bereaved people at the heart of the coroner system": see Explanatory Memorandum to the Coroners (Inquest) Rules 2013.

4. Scope of the Inquests

7. Caselaw confirms that to answer the statutory question "how" the deceased came by his or her death, the investigation at an inquest will normally go further than is strictly necessary.

8. In *Regina v. HM Coroner for North Humberside and Scunthorpe, ex parte Jamieson* [1995] QB 1, the Court of Appeal considered the statutory question "how" in section 11(5)(b)(ii) of the Coroners Act 1988. The Court made clear the important role performed by the Coroner:

(a) *"The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires"*: per Lord Lane in *ex parte Thompson* (cited by Sir Thomas Bingham MR at 17H);

(b) *"It is the duty of the Coroner as the public official responsible for the conduct of inquests…to ensure that the relevant facts are fully, fairly and fearlessly investigated. He is bound to recognise the acute public concern rightly aroused where deaths occur in custody. He must ensure that the relevant facts are exposed to public scrutiny, particularly if there is evidence of foul play, abuse or inhumanity. He fails in his duty if his investigation is superficial, slipshod or perfunctory. But the responsibility is his. He must set the bounds on the inquiry…"*: per Sir Thomas Bingham MR (at 26B).

9. It is respectfully submitted that a Coroner should likewise recognise the acute public concern which is aroused where deaths are caused in a major terrorist attack. The Families endorse such an approach in the circumstance of this unprecedented attack on our democratic institutions, involving targeting of the public in London and the British police force. A sufficiently wide investigation is particularly necessary when no criminal trial takes place which to any degree explores relevant evidence before the public and media.

10. In *R. v. Inner West London Coroner, ex parte Dallaglio* [1994] 4 All ER 141, the Court of Appeal considered the inquests arising out of the deaths caused by the collision on the River Thames between the Marchioness and the Bowbelle. In giving judgment

Simon Brown LJ emphasised the above words from *ex parte Jamieson* (see pp.154D-155A). He noted that if there is reason to suspect the possible recurrence of the circumstances in which death occurred the prevention or reduction of the risk of recurrence would not be assisted if there is a narrow interpretation of the scope of the inquest.

11. In relation to scope he added:

"The inquiry is almost bound to stretch wider than strictly required for the purposes of a verdict. How much wider is pre-eminently a matter for the coroner…"

12. Sir Thomas Bingham MR likewise emphasised that scope is not to be wrongly restricted. He referred to *ex parte Jamieson* and stated (at 164G):

"The Court did not, however, rule that the investigation into the means by which the deceased came by his death should be limited to the last link in the chain of causation. That would not be consistent with the court's conclusion in [ex parte Jamieson] which emphasised the need for full, fair and fearless investigation and the exposure of relevant facts to public scrutiny, and it would defeat the purpose of holding inquests at all if the inquiry were to be circumscribed in the manner suggested. It is for the coroner conducting an inquest to decide, on the facts of a given case, at what point the chain of causation becomes too remote to form a proper part of his investigation."

13. Indeed, in *R. (Takoushis) v. Inner North London Coroner* [2006] 1 WLR 461 the Court of Appeal considered an inquest into the death of a person with mental health problems who was allowed to abscond from St. Thomas' Hospital, following which he jumped into the River Thames and drowned. Giving the judgment of the Court, Sir Anthony Clarke MR stated that even if Article 2 had not been engaged, domestic authorities made it clear that the inquest was flawed since there had been no proper or sufficient investigation of the system at the hospital and how it operated on the day (para. 46-51). The Court of Appeal considered the above words in *ex parte Dallaglio* and noted that *Jamieson* inquests should still involve full investigations of the facts, which in that case included the system at the hospital from which the deceased absconded, coupled with how the system operated on the day: paras 41-57.

14. In *R. (Hurst) v. London Northern District Coroner* [2007] 2 AC 189, the House of Lords considered whether in practice there was much difference in the scope of the actual inquiries to be undertaken in the two types of inquest. The width of the scope of *Jamieson*-type inquests was emphasised: Baroness Hale questioned whether the distinction between *Jamieson* inquests and *Middleton* inquests is that stark (para.19). She noted that the scope of an inquest would almost always be wider than the verdict eventually reached. To limit it to the last link in the chain of causation would defeat the purpose of holding inquests. Like Baroness Hale, Lord Mance was not persuaded that the distinction between *Jamieson* inquests and *Middleton* inquests is that stark (para.74). He noted that the limited verdict under a *Jamieson* inquest is a different thing from the scope of such an inquest, which might lead to a rule 43 report made with

a view to preventing the recurrence of such a fatality (paras.74-5). He said *"The nature of the verdict and the scope of the coroner's investigation are different matters"* (para. 75). Now of course para. 7 of Schedule 5 to the CJA obliges the coroner to make a report if action should be taken to reduce the risk of future deaths.

15. In *R (Sreedharan) v. HM Coroner for Greater Manchester* [2013] EWCA Civ 181, at para 18 the Court of Appeal stated *"There is now in practice little difference between the Jamieson and Middleton type inquest as far as inquisitorial scope is concerned."* The Court also found that certain evidence admitted at an inquest which was of marginal relevance to the circumstances of the death was nonetheless relevant to the issue of preventing deaths in the future and that it was within the Coroner's discretion to regard the evidence as relevant to a possible Rule 43 report (para.36).

16. Accordingly, in the context of the present inquests, a *Jamieson*-type inquest would require consideration of various background and surrounding matters, as was the case in the 7/7 Bombings Inquests.

17. The Coroner has an important obligation in certain circumstances to make a report under Schedule 5. This power exists for the broader public interest (see *Brodrick Report* cited in *ex parte Jamieson* at p.14C) and an investigation with a narrow scope would not assist wider public protection through a Schedule 5 report.

18. The Families note that CTI also submits (at para. 15) that the investigation at an inquest will normally go further than is strictly necessary to answer the statutory question "how" and (at para. 23) that even if the State's procedural obligation under Article 2 is not engaged that *'should have no real effect on the ambit or thoroughness of the inquest'* and that the inquests still *'should and will involve a full and rigorous investigation into the cause and circumstances of the person's death'*.

19. The Families agree that the issues listed by CTI at paras 16 are appropriate matters for inquiry although none of the evidence has been seen yet and it may be that other issues will emerge, or that existing ones will widen, on sight of the evidence. We respectfully invite the Coroner to keep the scope under review, as suggested by CTI at para 15(c) and 16.

20. For the avoidance of doubt listed below are several specific issues into which the Families respectfully invite the Coroner to inquire. It may be that they are subsumed under the issues that CTI already suggests in para. 16 are suitable for inquiry:

    (i) In relation to Masood's 'personal history', was he radicalised in prison (see DAQC para. 2.15)? If so, were the prison authorities aware of this? If they were, what if any steps were taken to prevent his being radicalised?

    (ii) In relation to 'whether his activities gave any warning signs', why was Masood closed as a Subject of Interest ("SOI") in 2012 and why thereafter did he remain a closed SOI (see DAQC at para 2.22-2.23)?

(iii) To what extent was Masood's radicalisation aided or encouraged by material freely available on the internet (see DAQC at para 2.25 and 2.28)?

(iv) To what extent was Masood able to make use of the internet and social media applications in his preparations and terrorist-related activities (see DAQC para 2.29)?

(v) Were any procedures in place to enquire into Masood's rental of the vehicle?

(vi) Why were there no barriers to prevent an attack along the Westminster Bridge pavement, given that by March 2017 the UK's Houses of Parliament were an obvious target for a motorised terror attack?

(vii) An attack on Westminster was distinctly possible if not probable: eg evidence was given in the 2016 trial of *R v Khan and Khan*, on an allegation of preparing a UK terror attack, of the defendants (later convicted) filming themselves driving past the Houses of Parliament, playing in their car a speech by Bagdadi, the leader of so-called Islamic State. Given that an attack was a real possibility, how was Masood permitted to get through the gates? Were the gates wide open and if so why? Were there metal detectors or similar security devices in place? Why was PC Palmer unarmed, apparently stationed alone, with apparently inadequate bodily protection? Why was his fatal attack not prevented? What training and briefings had he been given?

(viii) What security arrangements were in place at the Houses of Parliament? How frequently were they reviewed? Why did they fail to prevent Masood's armed entry?

5. Jury

21. Having regard to section 7 of the CJA, it is not submitted on behalf of the Families that the inquest must or should be held with a jury.

22. Moreover, the Families see positive advantages in the inquests being heard by the Coroner without a jury, such as the Coroner's ability to deliver a reasoned summing-up and to digest expert evidence.

6. Article 2

23. Having regard to the relevant caselaw and the limited information known to-date, it is not submitted at this stage on behalf of the Families that article 2 is engaged. This should however be kept under review, as suggested by CTI at para. 22

24. However, as indicated above, it is submitted that there should nonetheless be a full and rigorous investigation into the circumstances of the victims' deaths.

7. Arrangements for Disclosure

25. As stated above, the Families continue to know very little as to the details of how their loved ones each met their deaths. To paraphrase Lady Justice Hallett in her PIH Ruling in the 7/7 Bombings Inquest (at para.2), for many people grieving and trying to come to terms with tragedy, understanding what happened is an important part of the healing process. The Families are anxious for information as soon as possible about exactly how their loved ones were killed by Masood, what specific injuries were suffered, what treatment was given and whether any more could have been done. It is nearly ten months since the deaths and they are anxious to begin to obtain some answers to understandable, obvious and pressing questions. Prior to the decision that the Chief Coroner would hear the inquests, the Families had been informed that they would start receiving evidence last Summer.

26. For the avoidance of doubt, no requests have been received to sign undertakings. When received they will be dealt with forthwith.

8. Witnesses / 9. Video Evidence and Visual Aids / 10. Expert evidence / 11. Anonymity / 12. PII issues / 13. Venue Etc

27. No submissions.

14. Logistics

28. As the Coroner knows, Andreea Cristea was Romanian. Here sister, Magda Toi, lives in Bucharest. It may be that a 'remote court', as helpfully suggested by CTI at para.48, would be of assistance. Enquiries are being made with the family as to this suggestion and as to whether an interpreter would be needed for her or Andreea's mother to follow the proceedings.

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