INQUESTS ARISING FROM THE DEATHS IN THE

WESTMINSTER TERROR ATTACK OF 22 MARCH 2017

SUBMISSIONS ON THE DETERMINATIONS

MADE ON BEHALF OF THE LONDON AMBULANCE SERVICE

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1. The London Ambulance Service ("LAS") make the following submissions in line with the directions given in the email sent by the Solicitors to the Inquests on 26 September 2018. The submissions concern legal issues about the determinations open to the Chief Coroner and reference to the underlying facts is made only in order to support the legal analysis and argument.

Conclusions available to the Chief Coroner

2. LAS agree with Counsel to the Inquests **[CTI submissions ("CTI"), §3 and 6(c)]** that the conclusions open to the Chief Coroner on the evidence, and in respect of all of the deaths, are (i) the short-form conclusion of unlawful killing and (ii) a narrative verdict. The latter may incorporate or conclude with the former. The choice between the two is a matter for the Chief Coroner.

Article 2 ECHR

3. No evidence has been adduced of any breach of article 2 ECHR by LAS or its staff. No general or systemic failing has been identified: see *Savage v South Essex Partnership NHS Foundation Trust* [2009] AC 681 [§45,§§68-70 per Lord Rodger of Earlsferry], *Lopes de Sousa Fernandes v Portugal* (2018) 66 E.H.R.R. 28 [§§185-196], *R (Parkinson) v HM Senior Coroner for Kent and others* [2018] EWHC 1501 (Admin) [§§82-92], and the submissions of Counsel to the Inquests **[CTI §7(b)-(d)]**. Nor is there any evidence of a breach of the *Osman* operational duty, which does not apply to clinical decisions made by medical (or paramedical) personnel dealing with acute crises such as those faced by LAS staff on 22 March 2017: see *Powell v United Kingdom* (2000) 30 EHRR CD 362, *Rabone*

and anr v Pennine Care NHS Trust [2012] UKSC 2, [2012] 2 A.C. 72 [§§15-19], and *Lopes de Sousa Fernandes* [§187].

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

Judgemental conclusions and causation

Relevant law

5. If the enhanced investigative duty is not engaged, the Chief Coroner is bound by the jurisprudence of *R v North Humberside Coroner, ex parte Jamieson* [1995] Q.B. 1 (CA) to limit any narrative verdict to a brief, neutral statement of facts to answer the question of how (by what means) the victims of the terror attacks came by their deaths. **[**See also **CTI, §6(c)]**

6. If the enhanced investigative duty is engaged, such that s.5(2) of the Coroners and Justice Act 2009 ("the 2009 Act") applies, the Chief Coroner must address the question of how (by what means and in what circumstances) the victims of the terror attacks came by their deaths. In such circumstances the Chief Coroner is required to exercise judgment to identify and address the central issue or issues in the case. In so doing, he may *"make judgmental conclusions of a factual nature,"* including on *"defects in the system which contributed to the death."* See: *R (Middleton) v West Somerset Coroner and another* [2004] UKHL 10, [2004] 2 A.C. 182, [§§35-37], and the submissions of Counsel to the Inquests **[CTI §8]**.

7. The Chief Coroner is not, however, conducting a public inquiry. Any conclusions, including those involving qualitative judgments, must be directed to answering the statutory questions, in particular the question of *how* an individual died. The Chief Coroner is prohibited by s.5(3) of the 2009 Act from expressing any view on wider matters. It follows that his determination must, in law, be limited to matters that were causative of death. Recent Court of Appeal authority has reiterated the importance of a coroner directing his or her attention to the central issues of the case and not straying beyond the coronial jurisdiction: see *Coroner for the Birmingham Inquests (1974) v Hambleton and ors* [2018] EWCA Civ 2081, [§§46-57]. **[**See also **CTI §6]**

8. The case of *R (Lewis) v Mid and North Shropshire Coroner* [2009] EWCA Civ 1403, [2010] 1 WLR 1836, is authority for the proposition that a coroner has a power but not a duty to include within his or her determinations circumstances that were possibly causative of death, as well as those that were probably causative [§§28-29, per Sedley LJ; see also **CTI §8(e)**]. The facts of *Lewis* are instructive as to when it may be appropriate for a coroner to exercise this power, which has the effect of loosening the standard of proof. The case concerned a prison death to which the most anxious scrutiny is applied, article 2 was engaged, there was clear evidence of a failure to provide training and equipment that could have prevented the death, and a report on these matters under (then) rule 43 of the Coroners Rules 1984 (SI 1984/552) was mandatory. It is plain that the Court of Appeal was not suggesting that the usual civil standard of proof should be abandoned in all inquests. Nor was it inviting excessive speculation in coronial determinations. The *Lewis* discretion, it is submitted, should be exercised with caution and only where it would assist a coroner in discharging his or her statutory duties, in particular the duty to establish the salient, central facts that answer the question of how an individual died.

Application to the present Inquests

9. No evidence heard at the Inquests would support any criticism of the care provided by staff of the LAS to any of those that died as a result of the attacks. No expert evidence has been adduced that is critical of any of that care, nor have applicable guidelines or other materials on which criticism may properly be founded been put to LAS witnesses such as to support any negative assessment of the care that they provided. The same is true for Joanne Fant, who is neither employed nor represented by LAS but who was called to give evidence in respect of Andreea Cristea.

10. The pathology evidence is clear that the injuries of Kurt Cochran, Aysha Frade, Leslie Rhodes and PC Keith Palmer, GM were, sadly, unsurvivable regardless of the medical care that may have been provided. **[D7/11, 14** (Kurt Cochran); **D7/26-27** (Leslie Rhodes), **D7/35** (Aysha Frade); **D7/183** (PC Palmer)**]**

11. In respect of Andreea Cristea, hypothetical lines of questioning were pursued as to whether any difference in outcome may have been achieved had she been attended by a HEMS team. The responses of the relevant medical and pathology witnesses were as follows:

a. In response to the question posed by Mr Hough Q.C., Dr Fegan-Earl, consultant pathologist, stated that the neuropathology evidence showing a high degree of diffuse axonal injury. In light of that, *"It is difficult to see what more could be done that would have a significantly different outcome in my view."* **[D7/49]**

b. Dr Fegan-Earl had previously said that it was *"highly likely"* that injuries sustained in the primary impact from Masood's car would have caused unsurvivable injuries, such that *"she would have died irrespective of whether she had entered into the River Thames."* **[D47/45]**

c. In response to questions from Mr Patterson Q.C., Dr Fegan-Earl noted that the point about HEMS treatment was *"quite a clinical question."* He gave his views that he suspected that early intubation and ventilation by HEMS would not have made a material difference to outcome although he could not be certain. When pressed on whether such intervention could have resulted in survival he stated that he could not *"entirely"* rule it out. **[D7/56-57]**

d. Dr Sadek, consultant in emergency medicine, said that there was *"an element of the unknown."* He referred back to answers previously given in which he said he had no way of knowing whether or not Andreea Cristea would have survived had she been removed from the water at an earlier stage (on which, see below). He said that HEMS provided interventions as early as possible *"with the intention and with the hope that it will reduce harm and improve outcomes in patients such as Andreea."* **[D4/182]**

e. Dr Bastin, critical care consultant, was not asked to opine on this matter.

f. Dr Hudson, consultant in emergency medicine and HEMS practitioner, stated that he could not comment on Andreea Cristea's medical management **[D6/72-72, 79]**.

12. Questions were also posed of witnesses as to whether Andreea Cristea would have survived had she been removed from the water after two to three minutes rather than five. Logically, this would be more likely to make a difference to outcome as it would have reduced Andreea Cristea's exposure to immersion-induced injury and would have allowed earlier

administration of medical treatment (see the evidence of Dr Fegan-Earl at **D7/45**). The responses of the relevant medical and pathology witnesses were as follows:

a. Dr Fegan-Earl told Mr Hough that even had Andreea Cristea been removed from the water earlier he suspected that she would not have survived **[D7/47]**. He subsequently agreed with Mr Patterson that he *"could not rule out the possibility that she might have survived"* **[D7/56]**.

b. When asked by Mr Patterson whether earlier recovery from water would have made a difference, Dr Sadek said: *"I really don't think I can say, if I'm honest."* Although the proposition made sense, medically, *"I simply don't know how much of her subsequent brain pressure and the eventual outcome … was due to the initial impact as opposed to all of the issues thereafter."* When asked directly if removal after 2 minutes and 18 seconds might have led to survival, he said: *"I'm really sorry, I've absolutely no way of knowing or being able to answer that."* **[D4/180-182]**

c. Dr Bastin told Mr Patterson that *"it was very difficult to say"* whether earlier removal from the water would have made a difference to outcome. He added that *"all of the teams looking after her were in no doubt that her brain injuries were very, very severe right at the outset."* The immersion in the water had compounded her brain injury, but he thought it *"unlikely"* that six minutes of immersion rather than two minutes had made a difference to outcome although he could not be sure. **[D4/199-200]**

13. At its height, this evidence amounts to a pathologist accepting a lawyer's proposition that he could not *"entirely"* rule out the possibility that an earlier HEMS intervention might have made a difference to outcome. However, the pathologist did not think that this was probable; in fact his view was that it was highly likely that the brain injury Andreea Cristea sustained in the primary impact was unsurvivable. The clinicians involved in Andreea Cristea's care did not even go as far as the pathologist. Dr Sadek considered the hypothetical questions posed of him to be unanswerable beyond a statement that earlier intervention is preferable as it is intended and hoped that it might help. Dr Bastin and Dr Hudson gave no opinion on whether earlier HEMS intervention would have made a difference.

14. In terms of factual causation on the availability of a HEMS team to give such an intervention, the Inquests heard the following evidence:

    a. On 22 March 2017 there was only one HEMS team on duty. **[D6/31-32]**

    b. That team was despatched at 14:43 **[D6/36]**, landed in Parliament Square, arrived in New Palace Yard at 14:54 **[D5/52]**,[1] and thereafter treated PC Palmer until around 15:15 **[D6/45; D5/51]**.[2] The team then packed up their equipment and assisted in triaging and re-triaging patients on Bridge Road and Westminster Bridge **[D6/46-47, 90-99]**.

    c. Dr Hudson explained why he attended PC Palmer **[D6/38-39, 57-60]**. He confirmed that even had he known of Andreea Cristea's condition (as recorded on her Patient Report Form) he would still have treated PC Palmer as his priority patient **[D6/80]**.

    d. A second HEMS team was assembled from doctors and paramedics who were either not on duty or who had other clinical responsibilities **[D6/55-56]**. This team was recorded on a HEMS log as being present on the helipad at the Royal London Hospital at 15:54. This was some 48 minutes after the HEMS log recorded the HEMS declaration of a major incident, and 39 minutes after text messages were sent out to a number of individuals, including a surgeon who attended the helipad at 15:54. **[DC8022/1**, **3; D6/82-4]**

    e. Dr Hudson's evidence was that a second HEMS team would, in his experience, take about that amount of time to muster **[D6/85-86]**. They would then have to obtain equipment, travel to the site of the location, land (if in a helicopter), receive a briefing and move to the location of the casualties **[D6/82, 85-86]**.

    f. It follows that even if efforts had been made to assemble a second HEMS team at the time when the first team was despatched, 14:43, it would not have arrived at

[1] Time taken from CCTV footage in the PC Palmer AV compilation, adduced by DC Simon Osland.
[2] Time taken from the evidence of Dr Hudson and Tobias Ellwood MP, confirmed by the CCTV footage adduced by DC Osland.

Westminster Pier in time to treat Andreea Cristea. She was placed in an ambulance that left the scene at around 15:22 **[DC5257/1; D4/149]**.[3]

g. It is, hypothetically, possible that Andreea Cristea could have been attended by a second <u>on duty</u> HEMS team, had such a team existed (which it did not). However, the Inquests have heard no evidence as to how much such a second team would cost, who would pay for it, where it would be based, how and when it would be deployed in circumstances such as those that developed on 22 March 2017, or whether Andreea Cristea would have been identified as the priority patient for a (hypothetical) second HEMS despatch. No witness was called to give evidence as to why a second on duty HEMS team was not maintained.

h. Even had such evidence been called, the Coroner may well have concluded that a narrative conclusion on such questions of policy would not be appropriate: see the authorities cited by Counsel to the Inquests in their submissions **[CTI §8(f)]**.

15. LAS submit that any conclusion on what may have happened, hypothetically, had a second HEMS team been available, and had it been deployed in sufficient time to Andreea Cristea, would be entirely speculative. Even allowing for the *Lewis* exception to the usual rules of causation it is submitted that no informative or safe determination could be returned on this matter. Nor would such speculation assist the Chief Coroner in discharging his statutory duty to address the central facts in providing an answer to how Andreea Cristea died.

Observations on the narrative verdicts proposed by Counsel to the Inquests

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

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

a. **Kurt Cochran**

[3] Time taken from the Patient Report Form for Andreea Cristea.

LAS proposes including the following underlined words in the final sentence, reflecting the role played in Kurt Cochran's care by Dr Vandermolen of St Thomas' Hospital **[D2/43-45**, **48-49, 63-68, 82]**. This would be consistent with the wording used for Leslie Rhodes, who was treated by Dr Lloyd.

"Despite early medical attention from a nurse, an ambulance crew and a hospital doctor, he died at the scene."

b. **Leslie Rhodes**

LAS proposes referring to care provided by paramedics (plural) in the final sentence. Although the Chief Coroner, understandably, called only Gary Moody, undisputed evidence was adduced that other paramedics assisted in Leslie Rhodes' care **[D2/109-115]**.

c. **Andreea Cristea**

LAS proposes including the following underlined words in the ante-penultimate sentence. This is to reflect the role played by Ms Fant, who is not a paramedic, and her colleague from the UK Specialist Ambulance Service **[D4/136]**.

"She was treated by fire officers and then by an ambulance crew and paramedics, before being taken by ambulance to hospital."

Reports on the prevention of future deaths

18. LAS respectfully agrees with the approach proposed by Counsel to the Inquests **[CTI §§25-26]**.

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