THE CHIEF CORONER OF ENGLAND AND WALES

SITTING AT THE CENTRAL CRIMINAL COURT

CORONER'S INQUESTS INTO THE DEATHS

IN THE WESTMINSTER TERROR ATTACK OF 22 MARCH 2017

CLOSING SUBMISSIONS

ON BEHALF OF FAMILIES OF

KURT COCHRAN

LESLIE RHODES

AYSHA FRADE

ANDREEA CRISTEA,

DECEASED

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1. These submissions are made on behalf of the families of the above four deceased ("the Families").

2. The Families would like formally to record their gratitude to the Chief Coroner for the very thorough investigations that he and his counsel have conducted into the circumstances of Masood's horrific attack and the deaths of their loved ones.

3. On the first day of the inquests the presentation of the pen portraits highlighted the irreversible loss that each family suffers, along with the many other ways in which the deaths have impacted on members of the Families. Findings that each of their loved ones was *unlawfully* killed are but one thing achieved by these inquests[1]. In addition,

[1] We endorse the suggestion of narrative conclusions set out in the submissions of CTI. The only suggested amendments are to add in relation to Leslie Rhodes "He was unconscious from the time of the impact until his

through the calling and examination of significant witnesses, the inquests have already provided real assistance to the Families in helping them to understand the circumstances of these deaths. Bereaved persons respond to their loss in differing ways of course. Some do not want to confront potentially painful facts about the death. However many others do want to know the details, whether it is fact that provides them with a degree of consolation or reassurance, or whether it is a fact that they find shocking or upsetting. The evidence in these inquests has included examples of both. For such persons, by learning all the facts, they can better understand and process what happened; they can then try to move on with their lives, recognising that at least something might have been learnt from the death and that steps are being taken to try to improve public protection and reduce the likelihood of others going through what they continue to have to go through.

4. At the hearing in January it was recognised that inquests without a jury would allow the Chief Coroner to give detailed and helpful findings at the end of the evidence. The approach of Dame Heather Hallett in the 7/7 inquests provides a good example of the assistance that can be derived from such findings and reasons. The Families supported such an approach in January and they repeat their support now. Written findings and reasons would be strongly welcomed, benefitting not only the Families but also the wider public, facing as we sadly do, a continued and severe threat of terrorist attack, not only in London but also across the country. We note that CTI has indicated at para 15 that a "more detailed account" will be given in the summing-up in relation to each of the victims on the bridge and we encourage the Chief Coroner to have regard to the particular factual issues which have been explored on behalf of the Families.

5. Mindful of the gravity of what happened on 22 March 2017, the Court set a wide scope to the inquests and explored many areas of real concern to the Families. Caselaw has repeatedly emphasised the rigour with which independent coroners investigate deaths in this country, particularly where there are features of serious concern for public safety, such as these inquests involving multiple-casualty Terror attacks. These inquests have been a good example of our coronial system seeking to leave no stone unturned. The evidence has been given in open court and the subject of intense scrutiny by the public

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death." and to amend the wording relation to Kurt Cochran to read "Showing no concern for himself, Kurt instinctively and courageously pushed Melissa….. " (a suggestion endorsed by the team for Melissa Cochran)

and the Press. Now, the evidence having been heard and the issues explored, an excellent opportunity arises for the public to receive the assistance of the Court. The Families strongly encourage the Chief Coroner to report circumstances of risk in order to improve public protection.

Lessons to be Learnt: The Coroner's Duty to Report

6. The submissions made below as to a PFD Report are not made lightly. There have been some areas of concern that we previously thought we would be highlighting, but which after hearing the evidence and considering the competing arguments, or recent improvements, we recognise would not be appropriate for report (see for example the improved resources that have recently been made to the Helicopter Emergency Medical Service (HEMS)). Those that are suggested have therefore been considered carefully. They should not add unnecessary burdens or introduce unhelpful complexity. They are focussed, practical and are advanced with the intention of assisting the public.

7. We specifically endorse the submissions of CTI at their para 24. Just because the Chief Coroner may feel unable to prescribe the best solution to a concern does not mean he should decline to raise a concern. Such an approach would undermine Parliament's intention and represent a mere counsel of despair. Complexity of solution therefore should not lead to paralysis or defeatism. The families invite the relevant agencies to at the very least try to make improvements.

8. Para. 7 of Schedule 5 to the CJA 2009 *obliges* the coroner to make a report if action should be taken to reduce the risk of future deaths. This is an important obligation that Parliament has imposed in order to protect the public. A PFD Report should not be regarded for example as an optional afterthought; rather this obligation is an integral part of the inquest procedure:

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.
(2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.
(3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner.

9. It is to be noted that the obligation arises where:

   (a) the Coroner identifies a concern that there are circumstances creating a risk of death, and

   (b) action should be taken to reduce this risk.

10. The importance of this obligation was considered by the High Court in *Chief Constable of Devon and Cornwall Police v. HM Coroner for Plymouth* [2013] EWHC 3729 (Admin).

11. Stuart-Smith J noted that the mandatory terms of paragraph 7(1) of Schedule 5 are direct statutory responses to the need for the State to comply with its obligations under Article 2 of the ECHR as enacted by the Human Rights Act. He noted that *"The substantive requirement of Article 2 is that States are required …to establish a framework of laws,… procedures and means of enforcement which will, to the greatest extent reasonably practicable, protect life… "* He referred to the change that was effected when paragraph 7(1) superseded rule 43 of the Coroners Rules 1984, noted that this was done with a view to the Article 2 obligation, and stated that this had therefore required that the permissive language of rule 43 should be changed into one of obligation. [para.13]

12. He made it clear that the obligation to report can arise even if there was no contribution to the death by the circumstances of concern:

"The coroner's duty to report (now under paragraph 7(1) of Schedule 5) is an integral part of the procedure that satisfies the requirements of Article 2… It is to be noted that the obligation arises whenever there is a "concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future." It is not necessary for the inquest to have disclosed that the circumstances giving rise to concern have in fact caused or contributed to a death already, or that the circumstances giving rise to the concern have been shown to involve a breach by the State of its Article 2 obligations (or by any person of their obligations, though not arising under Article 2)": para. 16(iv)

The Security Service

13. To any objective and independent onlooker, the live evidence of witness L, and the further revelations that emerged during his examination, disclosed areas of concern.

14. The Director-General of the Service has indicated a wish to *"squeeze every last drop of learning"* from this case in order to improve procedures where appropriate. The Families are confident that this indication was not made forensically, and that it remains the genuine desire of the Service.

15. It emerged that no contemporaneous written record was made of the reasons why Khalid Masood ("KM") was closed as a Subject of Interest ("SOI") in December 2010: day 12, p123-124. This was despite the fact that he was still believed to be an extremist: page 122 and 137.

16. Witness L was asked about the weighing of factors for and against closing an investigation and agreed that *"greater structure clearly reduces the chances of inconsistent decision-making"*: page 135. This was in the context of KM not being investigated despite his record for very serious violence and the repeated nature of his associations with terrorist suspects.

17. Witness L agreed that assessments as to whether somebody should be investigated or not are *"critical"* and that everything flows from the decision whether MI5 do or do not

investigate, because if they do not investigate they will not get the information: page 146.

18. It emerged that it was not certain at what level the decision to close had been made: page 136.

19. It is submitted that poor record-keeping reduces the efficacy of later reviews of the suspect by eg the Legacy Team and of later decisions as to whether he should be re-opened (see recommendations below as to managing closed SOIs and as to re-considering them in the light of freshly received information). In her Rule 43 letter after the 7/7 inquests Dame Heather Hallett expressed the view that *"It might be thought that some form of record keeping is essential to proper review… a reviewer would wish to know about the decision and the reasons…"*: para 103: DC8025/23. L accepted that this was a legitimate point she had made, albeit appeared to be resistant to better record keeping: page 165.

20. **It is recommended that when making a decision to close an investigation into an SOI, a contemporaneous record should be made by the Security Service, using a proforma document or otherwise, considering and weighting relevant factors for and against closing, giving reasons for the decision, and noting the level at which the decision has been made and approved.**

21. Witness L agreed that the Intelligence and Security Committee ("ISC") was very troubled by how the Service manages closed SOIs: page 138 [see ISC report and criticisms at pp21-24]. In the case of KM, there was no evidence of any management of KM whatsoever after his investigation was closed in December 2010. There had been some procedures introduced by MI5 to address this problem (namely Programme Belaya, Programme Congo and Programme Danube) however it emerged that none of these programmes led to KM being considered or revisited: pages 141-2. Witness L agreed that both the Westminster Bridge terrorist (Masood) and the Manchester bombing terrorist (Salman Abedi) had been closed SOIs who had nonetheless gone on to commit major atrocities: pages 146-7. He agreed that if the Service had wanted to continue to monitor KM to a degree after December 2010, this could have been done, subject to necessity and proportionality: pages 147-8.

22. **It is recommended that the Service reviews its procedures for managing closed SOIs.**

23. It emerged that in the years after KM's investigation was closed, there was nothing in the records to suggest that the Service gave any consideration to revisiting KM as an SOI. Had he been revisited L would have expected to see a record to that effect. This was despite further information being received suggesting repeated associations with SOIs who were members of the terror group ALM, several of whom in fact were prosecuted: pages 148-152. This failure was despite the fact that for many years notable convicted terrorists have been linked to ALM: see list at DC8037/93-96 and research showing that 25% of terrorists between 1998 and 2015 were linked with ALM: page 151. The failure to revisit KM also occurred despite the fact that L appeared to acknowledge that KM should have been looked at again:

"Q. Do you agree with this: DCI Brown stated that it would be a cause for concern to an investigator if a person was suspected of being linked with or associating with ALM individuals?

A. It would certainly cause us to take a look at them at some level, yes." [page 152]

24. Yet there was no evidence that the Service did look at KM again, at any level. Nor was investigation reconsidered when he was reported to have expressed support for 9/11, something DCI Brown stated would indicate that the person presented a risk: page 153.

25. **It is recommended that procedures are reviewed to ensure that closed SOIs are re-considered for investigation in light of the receipt of fresh information (whether singular or cumulative) which is judged to be potentially significant.**

26. It emerged that the Service drew a distinction between accessing extremist material which reached the threshold for investigation, and accessing extremist material which did not albeit that it nonetheless suggested a radical belief in the obligation to use violence: pages 142-5. For example, when asked about the material on KM's laptop between 2012 and 2016 (an image of an IED; an audio speech encouraging killing kaffirs; a PDF of a speech calling for engaging in violent jihad; images of zombie and

combat knives; the flag used by ISIS; a biography of Bin Laden, an image of 9/11), and the hateful ideology propounded by Bilal Phillips, L appeared to dismiss their significance on the grounds that it did not disclose attack planning: pages 154-6.

27. This was in the context of the Service acknowledging that it often does not investigate those it knows to be extremists, and in the case of KM, knew he was repeatedly associating with terrorist suspects (page 138).

28. **It is recommended that the Service reconsiders the weight that it attaches to information suggesting that individuals have a radical belief in the obligation to use violence, in the absence of information suggesting attack planning.**

29. It emerged that when the Service requested from the police records as to KM's background, they only obtained his PNC record: page 128-130. It is submitted that highly significant information about suspects could be missed by limiting requests in this way.

30. **It is recommended that procedures are put in place to ensure that when police records are obtained as to an SOI's background, all relevant records are requested and provided.**

31. It emerged that the Service judged it appropriate to request information from the prison service but may never have received this, and yet went ahead and closed KM as an SOI: page 126-7. Such an omission could result in highly significant material not being taken into account and investigations into SOIs being wrongly closed.

32. **It is recommended that procedures are considered to ensure that intelligence which it is judged it is necessary to request is obtained and considered before it is decided to close an SOI.**

Protective Security / Barriers

33. On 22 March 2017 the presence of the barriers around the Elizabeth (Big Ben) Tower caused Masood to steer his 4x4 off the pavement. They acted as a visual deterrent and served to protect pedestrians on that part of the pavement.

34. Both Chief Superintendent Aldworth and Siwan Hayward gave evidence that Westminster Bridge was not designated as a 'crowded place', even though it appears to fall within the definition of a crowded place made available to the public [see DC8045/5 for definition]. It emerged that there are confidential criteria and designations to which the public are denied access. The state of the evidence appeared to be that, like Westminster Bridge itself, there are others places in the country which may appear to satisfy the public definition of 'crowded place' but which in fact are not so treated. Both witnesses appeared to attach disproportionate weight to transient events as being the trigger for protection, even though the threat of terrorist attacks to civilians in public places was, and remains, not so limited. When considering the definition Mr Aldworth also stated that a "problem I would have with it is what does "impact" mean… that's the piece that needs to be clarified": day 11 page 54, 56. He did not know what the impact element meant. It also emerged that despite the Westminster and London Bridge attacks there are to this day prominent and busy places where the public appear to be vulnerable to attack given the absence of barriers or bollards (see document provided by Hogan Lovells DC8049/4-7 and locations not referred to in court by name): Aldworth t/s day 11 at p 144; Hayward day 14, p.56.

35. **It is recommended that procedures relating to protective security for 'crowded places' are reviewed, along with the definition of 'crowded places' and its interpretation, and the roles and responsibilities of relevant organisations, to ensure that there is effective and adequate public protection from acts of terrorism.**

Railings on Bridge Parapets

36. DC Osland's evidence was that a higher parapet on Westminster Bridge, or a railing on top of the parapet, would have prevented Kurt Cochran from being propelled over the parapet:

"Q. if the wall had been higher, if there had been a railing on the wall, he may not have gone over?

A. I'm sure that's the case…"
[day 1, p 155]

37. Without a railing to prevent the fall, Kurt Cochran's body can be seen on the CCTV footage pivoting on the wall. He fell over 6 metres and sustained the fatal head injury when he landed on the pavement below.

38. There is no evidence that the parapet of Westminster Bridge has been raised in the 150 years since it was built, even though the average heights of men and women have risen in that period. Of 14 central London bridges analysed, it has the lowest parapet, with 13 others having been built with higher parapets: DC8051. It was clearly felt for example that the parapet on Lambeth bridge needed to be as high as 127 cm, significantly higher than Westminster (99 cm) and Blackfriars bridges (100 cm).

39. It is submitted that as a result of the low height of the parapet pedestrians on Westminster bridge are vulnerable and at risk if they suffer a loss of balance: see image of model at DC8051/9. This also applies to Blackfriars bridge.

40. Siwan Hayward appeared to recognise the problem and states that this is being looked at. Whether anything will be done is uncertain. Considerations as to aesthetics and listings are manageable but in any event should not trump public safety.

41. **It is recommended that the height of the parapets on Westminster and Blackfriars bridges should be raised in an appropriate way to reduce risks to the public.**

Rescuing Unconscious Casualties from the River

42. Andreea Cristea was propelled into the river and was hooked by an employee of City Cruises using a boot hook. However, the boatman held her face down in the water for several minutes making no attempt to remove her from the water or even to raise her face from the water. As a result she remained immersed for something over 5 minutes, as opposed to something in the region of 2 minutes 18 seconds: see Markley day 4, pages 103 ff. The pathologist, Dr Fegan-Earl, stated that if she had been removed at the earlier stage and given the available first aid and resuscitation he could not rule out the possibility that she might have survived, albeit possibly with quality of life issues: day 7 page 56.

43. The boatman's evidence was that he had a Boatman's Licence issued by the Maritime and Coastguard Agency ("MCA"). He agreed he had received training in first aid and immersion issues and could give resuscitation: p 110. Mr Cooper's evidence was that the rest of the crew had also received training in maritime safety and what to do if somebody needs to be brought onto the vessel: p 74-5.

44. Mr Cooper's evidence appeared to be that only if a person was conscious would they try to remove them from the water: pages 75-6. His employer's manual made no provision for removing unconscious persons from the water: page 46. Mr Cooper said that in such situations other boats would have to be used: p 47. This means that if no other small boat is available the period of immersion would be even longer. He revealed that they had had no training or guidance in getting unconscious persons out of the water. This is not desirable from a public safety perspective.

45. It is submitted that it would be perfectly possible for training and procedures to be introduced to allow crews on such pleasure crafts to remove casualties from the water when they are, or may be, unconscious.

46. **It is recommended that the MCA and those operating pleasure craft consider the introduction of procedures and training to provide for the removal from the water of persons who are, or may be, unconscious and in need of emergency treatment.**

Vehicle Rentals

47. DCI Brown stated that the 4x4 rented by KM and used in his terror attack was obtained by him without any checks being made by the car hire firm (besides consideration of his driving licence and presumably proof of address). There were no checks into his criminal record and no regulation of any kind in relation to such a person renting the vehicle. Nor was he aware of any kind of watch list procedure being in place. He did not know if there had been any staff training to be alert for suspicious rentals: day 9, p 85-6.

48. It is submitted that the Department of Transport and the car rental industry could and should introduce procedures to provide regulation in order to try to protect the public. Even now, 18 months after the attack, our researches have identified no actual compulsory measures in place, despite the repeated use of rented vehicles to launch terror attacks. Examples of terrorists using rented vehicles include:

3 March 2006 – North Carolina, USA: Mohammed Taheri-azar drove a rented SUV into an area crowded with students at the University of North Carolina at Chapel Hill. Teheri-azar claimed it was retribution for the killing of Muslims overseas.

14 July 2016 – Nice, France: Mohamed Lahouaiej Bouhlel drove a 20-ton rental truck into the crowd in Nice, France, striking and killing, 86 people. The perpetrator drove nearly a mile on the beachfront promenade before being shot and killed by authorities.

22 March 2017 – London, UK: Westminster bridge – rental car.

3 June 2017 – London, UK: London Bridge – rental van. Kharum Butt originally planned to hire a larger vehicle: Commander Dean Haydon, of Scotland Yard's counter-terrorism command, said: *"Concerningly, Butt had earlier attempted to hire a 7.5-tonne lorry that same morning. When he did not provide payment details, the rental did not go ahead. The effects could have been even worse."*

19 June 2017 - London, UK: Finsbury Park Mosque – rental van.

17 August 2017 – Spain: 13 people were killed when a rental van struck a crowd of people in a Barcelona, Spain. This was one of three vans hired.

30 September 2017 – Edmonton, Canada: Abdulahi Hasan Sharif intentionally struck a police officer with a white Chevrolet Malibu before exiting the vehicle and stabbing the officer several times with a knife. An ISIS flag was found in the car. Later that day, when fleeing in a rental U-Haul truck the perpetrator was identified and deliberately attempted to hit pedestrians in crosswalks and alleys, injuring at least four.

31 October 2017 – New York, USA: Sayfullo Habibullaevic Saipov killed eight people (and injured others) in a rented pickup truck that he drove down a cycle path near the World Trade Centre. A note was found near the truck claiming the attack was made in the name of ISIS.

49. **It is recommended that procedures should be introduced to require the car rental industry to take measures to try to prevent the rental of vehicles to persons intending to use them for terrorist purposes.**

The Power of Individual Paramedics to Declare a Major Incident

50. Paramedic James Richards stated, in summary, that when Kurt Cochran's heart monitor flat lined he did not carry out chest compressions, something which he would have done had he not treated the situation as a major incident: day 2, page 73 ff. The significance of this decision was made clear: compressions can keep a patient's brain perfused, alive, until a reversible cause of cardiac arrest can be addressed. It can buy time for more specialist treatment to be given. He stated that no-one had radioed to him that a major incident had been declared. Rather, he stated that it was a decision that he himself made at the scene. He stated that individual paramedics are given the discretion to decide that there has been a major incident and that special procedures accordingly apply, such as not carrying out chest compressions or CPR. He said that this was 'a heavy responsibility' he bore. He stated that he did not think the nature of a major incident was easily classified and that Westminster was a very "stratified" scene, with patients "going along a large stretch".

51. When asked if it would assist those in his position to have greater guidance as to when they should make the very important decision that there was a major incident, requiring modified treatment, he said "I believe there is always more room for further guidance and training in every element of pre-hospital care".

52. It is submitted that the granting of power to an individual paramedic to declare a major incident, and as a result not to give treatment that would otherwise be given, is cause for concern. The result of this heavy responsibility being vested in individual paramedics is made all the more troubling by the definition of major incident [page 84] which merely requires an occurrence that is likely to cause such numbers of casualties as to require special arrangements to be implemented. Accordingly, several paramedics attending a multi-casualty scene could adopt inconsistent approaches resulting in a casualty being denied life-saving treatment that is given to others at the scene. It is submitted that consideration should be given to the power to declare a major incident vesting at a more senior level.

53. **It is recommended that the Department of Health and London Ambulance Service review the appropriateness of individual paramedics being permitted to declare major incidents thereby introducing modified treatment guidelines.**

Radicalising Material

54. There was a wealth of evidence as to the free availability of extremist and radicalising material. Examples include:-

55. The evidence of DCI Brown of the CT Command was that controversial organisation IERA maintain charitable status despite being associated with hate speech: day 9 page 75ff. See report "Evangelising Hate" DC8025. Despite this the Charity Commission did not remove IERA's charitable status. We do not make a recommendation in relation to the Charity Commission's exercise of its duties, however we do wish to record the Families extreme surprise at the failure by the Charity Commission to remove IERA's charitable status in light of the shocking association between IERA and hate speech.

56. DCI Brown stated that KM was believed to have read Bilal Phillips, prohibited from entering the UK because of his extremism: page 72-3.

57. The Call to Islam website, associated with ELAS, was publishing material encouraging violence against Jewish people: page 66.

58. Found on KM's laptop were audio recordings encouraging violent jihad and an image of an IED coming from Dabiq, a propaganda magazine supporting ISIS: day 9 page 48,50.

59. There have been repeated exhortations by ISIS propagandists, such as Adnani, to carry out terror attacks in the West: day 9 page 75. There is such material available on the internet.

60. DCI Brown stated that there is a wealth of material available on the internet: page 53. DCI Brown stated that anything that could be done to prevent radicalisation would be welcomed: page 11.

61. **It is recommended that measures are taken to reduce radicalisation by the removal from the internet of extremist material encouraging violence and terrorism.**

Prisons

62. There was evidence that Muslim prisoners were leading prayers within prison and that there is a major problem ("pressing security concern") from radicalisation within prison: day 9, page 6, 10. DCI Brown of the CT Command stated that anything that could be done to prevent radicalisation would be welcomed: page 11.

63. **It is recommended that measures are taken to prevent prisoners from being radicalised in prisons or from being given unsupervised religious instruction by other prisoners.**

Teaching

64. DCI Brown stated that inquiries suggested that KM was said to have been teaching English to children in Birmingham: day 9 p74.

65. Such regulation as is in place did not prevent KM from carrying out such teaching.

66. **It is recommended that measures should be introduced to regulate the teaching of children by persons with convictions for violence and extremist ideologies.**

End-to-End Encryption

67. DCI Brown stated that the social messaging application, WhatsApp, has end-to-end encryption. It was used by KM to send his Jihad document: day 9 page 87.

68. It is submitted that there is no good or sufficient reason for end-to-end encryption to be used in social messaging. Members of the public exchanging innocent messages or sharing photographs do not need the enhanced security of end-to-end encryption, a feature which frustrates investigations and provides a means for terrorists to exchange messages in secret.

69. **It is recommended that measures are introduced to remove end-to-end encryption from social media messaging applications.**

Covering bodies

70. There was a delay in the body of Aysha Frade being covered: see Webb-Stevens day 3 page 78. Even though the delay was only minutes, this showed insufficient regard for the dignity of the casualty and allowed photographs to be taken, some of which found their way onto the internet causing distress to Mrs. Aysha Frade's family and children. Although this falls outside the scope of a PFD Report the family of Mrs Frade are anxious that no other bereaved families suffer the distress they have been caused. They ask the LAS and Police to consider whether guidance needs to be given, or amended, to ensure the immediate covering of casualties declared dead.

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2 October 2018