

OPUS 2

INTERNATIONAL

Inquests arising from the deaths in the Westminster Terror Attack of 22 March
2017

Day 16

October 3, 2018

Opus 2 International - Official Court Reporters

Phone: +44 (0)20 3008 5900

Email: transcripts@opus2.com

Website: <https://www.opus2.com>

1 Wednesday, 3 October 2018
 2 (9.45 am)
 3 (Proceedings delayed)
 4 (9.52 am)
 5 THE CHIEF CORONER: Mr Keith.
 6 MR KEITH: Is that a convenient place for you, sir? It is
 7 rather difficult ---
 8 THE CHIEF CORONER: It is convenient for me, I can --- there
 9 we go.
 10 Submissions on determinations to be made by the Coroner by
 11 MR KEITH QC
 12 MR KEITH: Sir, there can be no doubt whatsoever that you
 13 have conducted, as Mr Patterson QC rightly submitted
 14 yesterday, a full, rigorous and fearless inquiry as the
 15 law requires and as these tragic deaths demand.
 16 On the issue of parliamentary security, you heard
 17 many hours of examination of Commander Usher and Chief
 18 Superintendent Aldworth, and their long testimony is
 19 testament to the rigour of your inquiry, because their
 20 examination was lengthy, comprehensive and, at times,
 21 pitiless.
 22 You heard from the AFOs on duty, you heard from the
 23 majority of the unarmed officers at Carriage Gates and
 24 from Inspector Rose, and you inquired into the tactical
 25 hinterland, you examined the tactical planning reviews

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1 for November 2014 and June 2015, the post instructions
 2 for January 2015 and December 2015, and the relevant
 3 parts of the post instructions going all the way back to
 4 2010.
 5 You received evidence of the relevant parts of the
 6 historic security reviews going back to September 2004.
 7 You've inquired into patrolling, supervision of the
 8 system, into the unarmed and armed officers'
 9 appreciation of their own working practices as well, of
 10 course, of the immediate events surrounding the murder
 11 of PC Palmer.
 12 Has it been enough? Well, in light of some of the
 13 submissions made yesterday, I'm required to address that
 14 further issue. The fact that further evidence may not
 15 exist, or that you have not heard from everyone,
 16 absolutely everyone connected with the terrible events
 17 of 22 March, does not mean that this Inquest has not
 18 been fair, full and fearless. Nor does it mean that
 19 material has been hidden from you for malign or
 20 conspiratorial reasons. Sensible and fair limits have
 21 to be imposed, and if material does not exist or is not
 22 available, in fact, to the forensic benefit of those of
 23 my learned friends who seek to make the point that the
 24 absence of witnesses or checks or supervisory structures
 25 is, in fact, demonstrative of failings, then no number

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1 of applications for disclosure will avail the seeker of
 2 further material.
 3 It was also suggested yesterday that the
 4 Metropolitan Police Service had acted unfairly and in
 5 a way calculated to cause distress and outrage because
 6 Commander Usher had been selected to be the primary
 7 witness concerning the issues of the geography of
 8 New Palace Yard, its security arrangements,
 9 post instructions, the historic reviews and the events
 10 surrounding the investigation into Messrs Ashby and
 11 Sanders' actions.
 12 The forensic and legal decision-making processes of
 13 the Metropolitan Police Service are not designed, or
 14 applied, to cause distress. More importantly,
 15 Commander Usher was palpably the best placed person to
 16 deal with the multitude of issues arising because he is
 17 the protection commander with strategic responsibility
 18 for PaPD. Had he not been called by the Inquest team,
 19 there would undoubtedly have been calls for him to give
 20 evidence, and, perhaps more importantly still, the
 21 decision to make him available was one endorsed by your
 22 own team, both directly and by the implication of having
 23 him respond to your and their further requests for
 24 additional information.
 25 He and the MPS properly and unilaterally disclosed,

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1 after no little diligence behind the scenes, the
 2 historic reviews of parliamentary security, the issue of
 3 Messrs Ashby and Sanders being off-post, the MM1 --- you
 4 can imagine the reaction if that had not been disclosed
 5 by Mr Usher in his statement --- the post instructions,
 6 the tactical planning reviews, the Inspector Munns chart
 7 and the ADAM-checked figures.
 8 So by way of introduction, we say you are very well
 9 placed to address the genesis and legal consequences of
 10 the sole issue that you are required to engage with at
 11 this stage, which is whether there was an arguable
 12 breach of Article 2 on the basis that the absence of
 13 PCs Ashby and Sanders from the close proximity of
 14 Carriage Gates, which is common ground, was the result
 15 of a systemic failure of reasonable state measures and
 16 causative of PC Palmer's murder, or the result of
 17 individual failure and/or not causative of his death.
 18 Beyond the legal issue of Article 2 and its
 19 arguability there is, of course, the factual matter of
 20 your narrative conclusion. I'm not permitted to address
 21 you in relation to the facts but, of course, the two
 22 matters are linked, even if they are not mutually
 23 dispositive, because even if there was, and you find
 24 there was, an arguable breach of Article 2, that does
 25 not of itself determine the wording of the conclusion on

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1 the issue of system failure and causation. Those are
 2 separate matters, couched not in terms of Article 2 but
 3 in the well known common law concepts of possibility.
 4 Turning to the evidence in broad terms, it
 5 establishes beyond any doubt that Masood’s attack on
 6 PC Palmer was completely unexpected and brutal in its
 7 implacability, speed and violence. PC Palmer had no
 8 option but to try to get away and was, therefore, unable
 9 thereafter to defend himself as he fled from those
 10 knives. He had no other option, but he bravely
 11 attempted to put himself in harm’s way in the best
 12 traditions of the police.

13 No other officer had any time at all to react. I’ve
 14 set out in our written submissions in the footnote on
 15 the first page the evidence of PC Glaze. The CCTV
 16 proves that just five seconds elapsed between Masood’s
 17 entering through Carriage Gates at 14.41.10 and his main
 18 attack on PC Palmer, 14.41.15.

19 And, as a matter of common sense, therefore, we
 20 suggest that the rapidity of the attack was such that
 21 any proposition to the effect that PC Palmer’s murder
 22 might have been prevented had PCs Ashby and Sanders been
 23 in close proximity to Carriage Gates is speculative.
 24 The stark reality is that Masood entered through
 25 Carriage Gates so quickly that not a single officer had

1 time to react, let alone prevent the fatal attack.
 2 No one was able to draw a baton and use it, or use CS
 3 spray. No one was able to physically intercept Masood.

4 Of course he was armed, viciously, with two knives,
 5 and that would have shut down a number of tactical
 6 options for dealing with him. But on any view, no
 7 officer came close to being able to engage him because,
 8 as you heard so vividly in evidence, for the majority of
 9 them, they turned round and Masood was already in.

10 We say that a determination that such shortcomings
 11 as there were in the system of supervision, which is
 12 what the Inquest has largely turned to focus on, were
 13 causatively linked to PC Palmer’s murder would be
 14 unjustified in law. It’s a matter of regret that I have
 15 to say that we intend no disrespect for advancing
 16 proper, evidence-based legal submissions to that effect.
 17 It is not right to challenge another interested person’s
 18 case in *terrorem* by suggesting that the submissions that
 19 it advances have caused a person offence or distress,
 20 when in truth they are simply disagreed with.

21 We submit it is not arguable that there was a breach
 22 of the state of general duty to safeguard PC Palmer’s
 23 life, because any shortcomings as contributed to Ashby
 24 and Sanders’ failure to be in close proximity of
 25 Carriage Gates were the result of individual failure and

1 not systemic.

2 And, in any event, such shortcomings as you find
 3 systemic, if you make that finding, were causatively too
 4 remote from his murder as to give rise to a real
 5 prospect that his death might have been prevented.

6 Putting it another way, in common law terms, for the
 7 purpose of the narrative, such shortcomings as you find
 8 to exist were not possibly, let alone probably,
 9 causative of his death, and thus, there can be no phrase
 10 such as "due to the shortcomings in the system of
 11 supervision" in the narrative.

12 In any event, and I say this with the greatest of
 13 respect to my learned friend Mr Hough QC, the phrase in
 14 the current draft in either version is inapt in relation
 15 to shortcomings and causation because the narrative
 16 speaks in terms of not being certain. Certainty is not
 17 the relevant threshold on any view.

18 Further, Ms Stevens’ suggested variant, which
 19 introduced the legal notion of contributory causes,
 20 plainly violates section 10(3)(b) on the prohibition on
 21 findings of civil liability.

22 The threshold, if the threshold is to be applied, is
 23 one, we suggest, of possibility, probability, if you
 24 find that or impossibility, not of "not certain".

25 Looking more broadly at the proposition advanced to

1 you that there was an arguable Article 2 breach, we
 2 submit that there are a number of issues that you must
 3 first address. Even on the basis that PCs Ashby and
 4 Sanders were unaware of the requirement to be in close
 5 proximity to Carriage Gates, it is not at all clear that
 6 their understanding, their personal understanding, was
 7 the result of a failure in supervision. There was just
 8 no evidence that even if more thoroughly supervised, and
 9 on the premise that they would have followed the
 10 post instructions religiously, that they would
 11 necessarily have been at Carriage Gates as opposed to
 12 being somewhere else in New Palace Yard, towards the
 13 Cromwell Green search point or, as it transpired, by the
 14 members’ entrance.

15 Nor can the Inquest conclude, in any event, that
 16 they would not, in any event, have stepped out beyond
 17 the limits of the post instruction, and the truth of
 18 that proposition can be seen in this way. On PCs Ashby
 19 and Sanders’ account, on their own account, they were
 20 guided by the laminated map which PC Ashby kept with
 21 him, and/or by the alarm map on the wall, or by the
 22 patrol area sent out as part of Superintendent Causer’s
 23 PowerPoint.

24 But even on that account in which they understood
 25 the delineation of their patrol duties to be the alarm

1 map, the laminated map or the PowerPoint, nothing in
 2 those documents ever permitted them to be in the
 3 colonnades, static, for up to 40 minutes.
 4 Even then, the evidence overwhelmingly establishes
 5 that had they been in close proximity to Carriage Gates
 6 or at Carriage Gates, they would have been drawn away to
 7 the noise, the explosive noise in Bridge Street, which
 8 they could not reasonably have ignored.

9 Further, even had they positively ignored that duty
 10 and remained at Carriage Gates, had they even been
 11 there, there is no evidence to support the proposition
 12 that Masood could have been shot, and either disabled or
 13 killed before the fatal attack on PC Palmer.

14 Properly analysed, there was an unusual sequence of
 15 events. Because, sir, what you are grappling with is
 16 a compounded hypothetical scenario. It's not just
 17 a consideration of whether the real prospect of survival
 18 was denied by a single event, such as in the
 19 Mastromatteo case, the wrongful release of a murderer
 20 from parole who goes on to commit an armed robbery and
 21 kills the driver of a stolen getaway car. You are
 22 dealing, sir, with multiple levels of hypothesis,
 23 concerning the assessment of the impact of better
 24 supervision. Would Ashby and Sanders have been in close
 25 proximity to Carriage Gates anyway? Would they have

1 been drawn away by the noise? What could they have
 2 done? What would they have done?

3 It's speculation built upon pre-existing
 4 speculation, or, putting it more charitably, as Mr Hough
 5 QC said in his written submissions, the tracing back of
 6 separate chains of events and causes often gives rise to
 7 difficult questions of judgment; with delicious
 8 understatement, that is an excellent exposition of the
 9 problem.

10 Secondly, the inherent difficulties, or inherent
 11 difficulties arise at every stage of a hypothetical
 12 timeline because the reality is that PCs Ashby and
 13 Sanders themselves, the very persons whom the family of
 14 PC Palmer suggest could have stopped Masood, do not
 15 themselves accept, ultimately, that they could or would
 16 have stopped him. So there is no evidential foundation
 17 for that essential proposition.

18 Of course, it remains a hypothetical exercise.
 19 Ms Stevens complained yesterday that the issue of what
 20 they might have done remains hypothetical. Of course it
 21 does. It remains hypothetical in relation to any
 22 consideration in any inquest of whether causatively
 23 a breach might have given rise to a denial of a real
 24 prospect of survival. But that doesn't bar you from
 25 reaching a conclusion, and nor, should I say, does the

1 absence of an expert, whose evidence would, by the very
 2 same approach adopted by her, would have remained
 3 hypothetical anyway.

4 Putting it another way, counsel to the Inquest have
 5 properly recognised that the issue of whether
 6 PC Palmer's chances of survival may have been improved
 7 by a better supervisory system is a challenging question
 8 which involves a good deal of speculation. Again, we
 9 agree.

10 Thirdly, the alleged failings put generally as
 11 a lack of supervision, but more specifically as
 12 a failure to audit and spot-check the dissemination of
 13 and the putting into practice of the post instructions,
 14 are essentially failures to audit the precise means by
 15 which the AFOs carried out their patrols. They are not
 16 failings addressed towards an alleged absence of
 17 patrols, or the absence of AFOs generally, or the
 18 absence of proper equipment or the absence of training.
 19 AFOs were in the yard. They were patrolling. And we
 20 know, moreover, that PCs Gerard and Sanders were at
 21 Carriage Gates themselves between 13.29 and 13.43,
 22 an hour before.

23 The failing, we suggest, properly analysed, is one
 24 that concerns the practical operation of the patrol at
 25 Carriage Gates, not the tactical security system. Even

1 then, the specific failing, and Article 2 obliges
 2 everybody to concentrate on the specific facts of the
 3 alleged breach, the specific failing was not the wide
 4 practice we suggested with general circular patrol
 5 around New Palace Yard, nor of a patrol not being
 6 a short patrol but remaining disproportionately in areas
 7 of New Palace Yard that were not required to be
 8 patrolled, but because, again, Messrs Ashby and Sanders
 9 were statically located in the colonnades at the time of
 10 Masood's entry.

11 Fourthly, you recognise the speculative nature of
 12 the exercise, because in your 16 September ruling,
 13 rejecting the application under section 7 of the
 14 Coroners and Justice Act made by Ms Stevens, you noted
 15 at paragraph 45 that it was somewhat speculative at that
 16 stage to suggest that PCs Ashby and Sanders could have
 17 saved PC Palmer's life even if they had been standing in
 18 close proximity to Carriage Gates when the attack began.
 19 You said:

20 "They might have moved away from their post in
 21 response to the sound of the vehicle colliding with the
 22 north wall of New Palace Yard. Even if they had not
 23 done so, they would have had seconds to react, and any
 24 attempt to take a shot would have been complicated by
 25 the attacker's close proximity to Keith Palmer and other

1 unarmed officers.”
 2 Your understanding, sir, of the authorised firearms
 3 officer supervisory system is obviously plainly greater
 4 than it was at 16 September, because you have now heard
 5 the actual evidence. Your understanding of the
 6 post instruction issued and its dissemination is greatly
 7 enhanced now that you have heard the evidence. You know
 8 far more about the ADAM checks, the maps, the documents
 9 and the Inspector Munns’ chart.

10 But the position concerning the heart of your
 11 observation, which was that the causative chain remains
 12 essentially speculative, is unchanged because since you
 13 have received the evidence, it is now apparent, when it
 14 was not apparent before, that no witness can say, with
 15 the requisite degree of possibility or chance, that even
 16 if PCs Ashby and Sanders had been at Carriage Gates when
 17 they had only seconds to react to take a complicated
 18 shot, that they would necessarily have disabled Masood.

19 We’ve set out in our written submissions at pages 15
 20 to 17 what we say in relation to those parts of the
 21 evidence governing that issue.

22 Can I now turn and make seven points in relation to
 23 the law. Paragraph 15 of our written submissions
 24 describes the Osman Article 2 obligation, and I hope,
 25 genuinely, that the propositions that we advanced in our

1 written submissions are not contentious and do, indeed,
 2 accurately reflect the legal position.

3 The font of the test in Osman is one of
 4 reasonableness, not an absolute standard. Article 2
 5 will only be breached where the authorities fail to take
 6 measures within the scope of their powers which, judged
 7 reasonably, might have been expected to avoid the risk
 8 of a real and immediate to life of a person or persons.

9 So reasonableness is a necessary part of the test,
 10 as is an expectation, not any prospect at all, but
 11 a reasonable expectation that the risk might have been
 12 avoided. It’s that concept of expectation that engages
 13 the difficult issue of causation, but it also goes to
 14 the nature of the obligation, because where the nature
 15 and location of the exact terrorist attack is
 16 necessarily unknown, it is more difficult to say what
 17 reasonably should have been expected.

18 Secondly, it’s not endless in scope, it only applies
 19 to certain well defined circumstances — paragraph 14 of
 20 our submissions.

21 Three, the test is stringent, or high,
 22 paragraph 17(a).

23 Fourth, not every claimed risk can entail
 24 a requirement to take operational measures to prevent
 25 a risk from materialising, and we have set out in

1 paragraph 17(b) the point that because not every claimed
 2 risk can entail such a requirement, that approach has
 3 particular resonance here in which any assessment of the
 4 risk of a terrorist attack, as I say, was hindered by
 5 the unpredictability of any such attack, and the
 6 procedures adopted to meet the risk included difficult
 7 operational choices in terms of response, means of
 8 response, availability of resources and the particular
 9 requirements of the Palace of Westminster.

10 In addition, of course, the risk which must be set
 11 against, ultimately posed by Masood, was sudden and
 12 unexpected. It is, of course, right to say that the
 13 tactical position at New Palace Yard was premised on the
 14 existence of a terrorist risk, whether armed by knife or
 15 by gun or by vehicle or bomb. Of course that risk was
 16 planned for and anticipated, but in practice, the
 17 extremely violent and speedy way in which he came
 18 through the gate, intending to kill and to die himself,
 19 and preceded by a noise that, whilst not calculated was
 20 diversionary in effect, made for a more difficult,
 21 operationally more difficult set of circumstances.

22 Fifthly, guard should be taken against hindsight, of
 23 course. Sixthly, the causative test is also not
 24 an infinite one. It is not permissible to ask whether
 25 but for some claimed failing, the death would not have

1 resulted.

2 We have set out and cited the admissibility decision
 3 in Pearson and made a reference to *Mastromatteo v Italy*,
 4 to which I’ve already referred, in which the ECHR
 5 rejected the claim where it was argued that but for the
 6 murderer was released on parole, he would not have
 7 robbed the bank, stolen a getaway car and murdered the
 8 driver. A single change, you may think, in the chain of
 9 events will not generally suffice. The test, instead,
 10 is whether the reasonable measures which were not put in
 11 place, so it is said, would have had a real prospect of
 12 avoiding the deaths if they had been instituted.

13 So the question may be posed in this way: even if
 14 there had been charts, dip sampling, auditing, auditing
 15 of oral briefings, constant assured testing of the
 16 dissemination of post instructions, would those steps
 17 have had a real prospect of meaning that PC Palmer would
 18 not have been killed by a maniacal man determined to
 19 kill.

20 Lastly, there is the important divide between
 21 systemic failing and individual breach. We accept that
 22 PC Palmer was, of course, in a sufficiently vulnerable
 23 position legally — not factually but legally — so as
 24 to engaged principled application of Article 2, and in
 25 paragraph 19 of our submissions we have set out the

1 broad context or categories in which the Osman test has
 2 been held domestically, or at Strasbourg, to apply:
 3 killing by state agents; death in custody; conscripts;
 4 mental health detainees and other situations where the
 5 state has a positive substantive obligation to take
 6 steps to safeguard life .

7 What we suggest, though, is that where the Article 2
 8 obligation is assessed in this particular context, where
 9 PC Palmer, whilst not, of course, armed, and at
 10 a position where he interfaced with members of the
 11 public, was not in any particular vulnerable position
 12 vis-à-vis the state. In such a situation we say the
 13 obligation applies in an attenuated form. The nature of
 14 responsibility owed by the state in terms of expected
 15 measures to be undertaken is more akin to those,
 16 perhaps, in the services or in hospital, as opposed to
 17 police custody, and in that type of case, where there
 18 must be a reasonable assessment of the measures, there
 19 is a stark divide drawn between errors of judgment by
 20 individuals and negligent coordination, and systemic
 21 failure , and you will see from the citations from the
 22 case -- your case of Parkinson at paragraph 23 of our
 23 written submissions, also Stoyanovi v Bulgaria at
 24 paragraph 24, and Susan Smith at paragraph 26, that that
 25 divide is clearly drawn: there is a distinction between

1 individual error, failing or coordination and systemic
 2 failure .

3 Putting it another way, and to apply the test in
 4 Long v Secretary of State for Defence, was this a matter
 5 over which the state had substantial control? We
 6 suggest that the unanticipated violence and speed of
 7 Masood was something over which the state had very
 8 little control, and we would invite you to pay
 9 particular regard to the observations made in the case
 10 of Scarfe which we set out at paragraphs 54 to 59 -- 54
 11 and 59 of Scarfe, I think they are set out in
 12 paragraph 19 of our written submissions -- to the effect
 13 that there is a difference between errors of practice
 14 which might point to a systemic fault in the design or
 15 supervision of a system, and, notwithstanding that they
 16 are repeated, operational errors such that it may be
 17 impossible fairly to characterise those areas as
 18 a system fault . You will remember that that case which
 19 concerned suicide prevention at HMP Woodhill concerned
 20 a series of distinct but separate operational mistakes,
 21 in fact, a very substantial number of mistakes, but the
 22 court concluded that that frequency evidenced not
 23 a failure of the system but, rather, a system that
 24 allowed operational error.

25 Turning to the evidence and applying the principles

1 that we suggest should be adopted, we make four or five
 2 points at paragraphs 29 to 37 of our submissions. They
 3 are these: firstly , the submission from counsel to the
 4 Inquests rightly implied that no breach arises from any
 5 alleged failing on the part of the MPS to respond to the
 6 general terrorist threat or to respond to specific
 7 intelligence suggesting terrorism-related activity in or
 8 near Carriage Gates. There is nothing to suggest that
 9 the general security arrangements were deficient,
 10 whether strategically or tactically in a way relevant to
 11 PC Palmer's Inquest. I say general. The evidence is
 12 that the security was constantly under review. Tactical
 13 firearms advisors, specialist advisors, constantly
 14 reviewed and sought to improve the security arrangements
 15 in Parliament, and at Carriage Gates in particular . The
 16 security arrangements were elaborate and under constant
 17 review, as those detailed reports evidenced in
 18 Commander Usher's first statement readily demonstrate.

19 In particular , that dichotomy between mobility which
 20 might lead to AFOs not being in the precise location of
 21 an emerging threat and fixed patrols which might lead to
 22 predictability and vulnerability , was under constant
 23 examination, and you will recall the evidence from
 24 Commander Usher that the history of the MPS's tactical
 25 consideration of that issue, that dichotomy, established

1 that there is no easy solution .

2 (b), secondly, in addition no system of security is
 3 perfect . It would have been and remains quite
 4 impossible to entirely remove the risk of a determined
 5 marauding suicide attack . As I've said, Masood plainly
 6 intended that he would die trying to kill people in and
 7 around the Palace of Westminster, and you will recall
 8 Commander Usher's evidence that the number of attacks
 9 which might have been considered are bounded only by
 10 imagination.

11 Three, it is also clear that the fact that Masood
 12 was able to gain access to New Palace Yard was through
 13 no fault of the Metropolitan Police Service. The
 14 evidence is one way. It is to the effect that the will
 15 of Parliament was that Carriage Gates had to be kept
 16 open, both as a practical measure and as a symbol of the
 17 openness of the United Kingdom's Parliament, and that
 18 was also reflected by the evidence of Commander Usher.

19 And, of course, the attack occurred at the time of
 20 the division , which meant that the gates had to have
 21 been open under the standing arrangements.

22 You will recall evidence to the effect that it was
 23 simply not a matter upon which the MPS had any
 24 discretion . Even if a decision had been made that the
 25 gates ought to be closed between the entrance and exit

1 of individual vehicles, the gates had to have been open
2 to allow access for the division.

3 Fourthly, you have plain evidence to the effect that
4 consideration was given by the Metropolitan Police
5 Service specifically to the risk to unarmed officers.
6 Indeed, that risk was brought to the attention of
7 Parliament because, as I repeat, it wasn't a matter that
8 lay within the sole discretion of the MPS, and Chief
9 Superintendent Aldworth raised the issue of whether or
10 not the most obvious mitigation was surely to close the
11 gates altogether.

12 Whilst that was not the subject of a formal
13 recommendation, Parliament was aware of the risk, but
14 the tactical planning review could not give effect to
15 that individual officer's suggestion.

16 So then turning to the short patrol. The schedule
17 of post instructions at {DC8040} is the clearest
18 evidence of the Metropolitan Police continually
19 reviewing and improving the security arrangements at
20 Carriage Gates, because you know that from that
21 schedule, the policing model was modified on six
22 different occasions between 2010 and 2016, in order that
23 the arrangements at Carriage Gates were best suited to
24 meet the threat appreciated at each of those particular
25 times.

21

1 The fact that there was a recognised vulnerability
2 at the gates when they were open does not mean of itself
3 that the arrangements to meet that risk were deficient,
4 nor that there was necessarily a breach of Article 2
5 because, as I have ventured to suggest, no risk can be
6 entirely eliminated, and of course it's possible to
7 imagine actions which could have been taken which might
8 have -- again, hypothetically -- removed the possibility
9 of the attack taking place at one particular location.
10 None of the reviews have ever recommended an absolute
11 increase in the number of armed officers or the complete
12 closure of the gates.

13 You may conclude that the tactical planning
14 generally favoured the unpredictability of a patrol as
15 providing a better model, and that accorded with the
16 evidence of PC Ross who himself spoke of the risk of
17 attackers attacking unarmed officers or, indeed, armed
18 officers, whose presence could be too predictable in the
19 course of a static patrol.

20 PC Glaze also spoke of the danger of predictability
21 and the need to protect not just Carriage Gates but also
22 an attacker entering New Palace Yard over the railings.
23 PC Ashby spoke of patrols having the advantage of
24 unpredictability. Commander Usher explained the risk of
25 a static post to hostile reconnaissance and to the

22

1 seizure of a firearm.

2 And so there can be no doubt that in light of these
3 competing and difficult considerations, a short patrol
4 was the best tactic to strike a balance between armed
5 support and unpredictability, and that accords with the
6 issues which you are obliged to consider in Osman,
7 namely the difficulties in policing modern societies,
8 unpredictability of human conduct, and the difficult
9 operational choices which must be made.

10 Sir, it is common ground that PCs Ashby and Sanders
11 were not patrolling as required by the post instructions
12 at the time of the attack. The evidence of
13 Commander Usher, Chief Superintendent Aldworth and
14 Inspector Rose was that officers should have been
15 patrolling in accordance with their post instructions.
16 No one seriously disputes that post instructions were
17 generally clear and accessible. They were described,
18 I think, as the very function, or the very essence of an
19 AFO's functions.

20 It was also clear that the ADAM system was generally
21 known of and accessible. But the fact that Messrs Ashby
22 and Sanders did not patrol in close proximity of
23 Carriage Gates is of itself not necessarily evidence of
24 a systemic failing. We suggest that what failed was not
25 the post instruction system; the failure was instead

23

1 a failure to prevent Messrs Ashby and Sanders from
2 spending 40 minutes in the colonnades.

3 We've set out at paragraph 43 of our written
4 submissions those steps that were taken, properly by the
5 Metropolitan Police Service, to meet the needs of the
6 threat posited at New Palace Yard. The computerised
7 system, ADAM, allowed officers to access
8 post instructions online, it was in place
9 from October 2012. There was significant evidence of
10 inspectors and sergeants being informed by email of the
11 introduction of the system, the purpose of that system,
12 the means by which AFOs could access post notes and
13 briefings on demand.

14 You've seen the emails that demonstrated that
15 supervisors were sent links to updated post notes. Hard
16 copy post instructions, we suggest, were available in
17 the patrol room. Mr Ashby did finally accept that it
18 was possible that such a binder was present, but he did
19 not look at it.

20 In terms of monitoring, there was inspection
21 between September 2015 and February 2016, including
22 supervision of PCs Ashby and Sanders on sector 3.
23 Inspector Rose said supervision did continue, even if
24 not recorded. And you have clear evidence that where
25 officers, senior officers, appreciated officers were not

24

1 adhering to post instructions, action was taken as
2 a result.

3 Chief Superintendent Aldworth stated he had taken
4 action himself when he had seen officers not on post,
5 and you will remember he also described the daily
6 management meetings which involved a review of the
7 previous 24 hours, plans for the day ahead, and
8 discussion of any failure to comply with
9 post instructions.

10 So it's a necessary part of the Article 2
11 arguability argument advanced to you by my learned
12 friends that it was not just Ashby and Sanders, but the
13 majority of the AFOs who did not follow the obligations
14 of a short patrol, because if you conclude that the
15 failing here was an individual failing of those two
16 officers by virtue of their remaining in the colonnades,
17 then there will be no systemic element. For that
18 argument to succeed, you need to go further and
19 conclude, in essence, that Messrs Ashby and Sanders were
20 telling the truth and were correct in suggesting that it
21 wasn't just them, it was -- I paraphrase, I hope to no
22 disrespect to them -- everybody else.

23 But the evidence to the effect that AFOs generally
24 were out of position due to the unfamiliarity of the
25 post instructions is very limited. The ability of

25

1 unarmed officers to gauge how long AFOs were in close
2 proximity to the gates was, of course, itself quite
3 limited. PC Ross accepted that his back would be to the
4 AFOs and that he focused on the gates and it would be
5 hard to say when the AFOs were present. PC Glaze gave
6 similar evidence, that he was busy doing his own job.
7 PC Ross said that ADAM was not in use when he was
8 an AFO, we could date his own AFO duties to
9 before October 2012, but that he was familiar with
10 post instructions of the kind of at {WS5103}.

11 His AFO experience in fact predated our relevant
12 post instructions and so it's not at all unsurprising
13 that he was, or may have been, unaware of the recent
14 short patrol obligation.

15 PC Glaze transferred from an armed patrol to
16 Lewisham in 2012 so he wouldn't have used ADAM and he
17 wouldn't have known of the most recent
18 post instructions, and Commander Usher's evidence was
19 clear that it would be extraordinary for sergeants and
20 inspectors who received post note updates not to have
21 briefed constables upon the content of them. He,
22 himself, had seen the AFOs at Carriage Gates, as had
23 Chief Superintendent Aldworth. He said:

24 "AFOs were at the gates more often than not."

25 There is also evidence of emails being sent to both

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1 the leadership and the entire command of the heightened
2 threat, and you will recall the evidence from Chief
3 Superintendent Aldworth to the effect that he had slept
4 on his office floor overnight to ensure that he had
5 properly briefed officers coming on duty the next day,
6 and he carried on doing so until every new officer
7 coming on duty had been personally briefed.

8 Inspector Rose, the most recent witness on this
9 subject, said in essence that he was surprised to hear
10 of officers being unaware of the post instructions or of
11 generally not being on short patrol, or of following the
12 alarm map, because it was contrary to the supervisory
13 practices and his own understanding.

14 He was asked:

15 "Question: [Was] there anywhere in the area of
16 New Palace Yard, the cobbled area, where you would not
17 expect them to be or would not expect them to stand for
18 any period?"

19 "Answer: Certainly not [he said] underneath the
20 colonnades, or further than the entrance to -- beyond
21 the entrance from Carriage Gates to members' entrance.
22 Not beyond that."

23 "Question: How important to the life of
24 an authorised firearms officer is a post instruction?"

25 "Answer: It certainly guides their actions and

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1 their attentions.

2 "Question: Is there any document that you can think
3 of which is designed to describe to them the limit to
4 their patrol area?"

5 "Answer: No."

6 Then in relation to the alarm map:

7 "Question: Is there anything ... which ... is to be
8 taken as a post instruction ...?"

9 "Answer: No, there's not."

10 He was asked to comment on the evidence of PC Ashby
11 to the effect that his patrol duties had been guided
12 exclusively by the map on the wall and that he had been
13 told every day to follow the map. He said:

14 "Answer: It would be surprising that that was the
15 briefing. I would be surprised, given the time that
16 PC Ashby worked at Parliament, that he would have to be
17 reminded of the detail of the same sector he had worked
18 many, many times before each and every day ... I was
19 surprised that they used the map and used those terms as
20 a briefing for him."

21 PC Ashby has, of course, given evidence to the
22 effect that nobody ever informed him that ADAM was the
23 primary means of accessing post instructions, but we
24 suggest that you must approach that evidence with
25 a little care, because he himself accepted he had

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1 accessed ADAM in June 2015, and had he done so, he would
 2 presumably have found the post instructions which he was
 3 availed upon eventually to agree.

4 He was a long-standing officer who must, we suggest,
 5 have been well aware of the presence and status of the
 6 post instructions. He accepted that he may have been
 7 aware of emails as well.

8 The base room map in relation to which he asserted
 9 was the primary guidance for the carrying out of his
 10 patrolling duties, and indeed, was followed by everybody
 11 else over a matter of years, is, we suggest, something
 12 of a red herring. The map was self-evidently not
 13 a post instruction, it had red personal alarm locations
 14 on its face and a legend detailing the alarm locations.
 15 It said nothing about patrolling and it underwent no
 16 alteration over six years.

17 The laminated map was not a post instruction. It
 18 provided a guide for incoming patrols, it would seem.
 19 It said nothing about the extent or nature of any
 20 patrol.

21 PC Sanders accepted that the post instructions were
 22 clearly available on ADAM and everybody knew there was
 23 a terminal on ADAM available for such use.

24 You have heard close questioning of the witnesses
 25 responsible for security at the Palace of Westminster

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1 about shortcomings. Of course they are there. You have
 2 heard evidence of it, and indeed the problems in
 3 New Palace Yard have been openly exposed. We have
 4 summarised them at paragraph 52.

5 There is evidence that the short patrol was
 6 interpreted differently by individual officers.
 7 PCs Ashby and Sanders' practice was, according to the
 8 author of the MM1 document, reflective of a wider
 9 practice. There was inadequate recording of the
 10 supervisory checks made of compliance with
 11 post instructions: an auditing level assurance, not,
 12 we suggest, an operational one. And there is evidence
 13 that only a comparatively small proportion of officers
 14 accessed ADAM after December 2015.

15 In relation to the evidence that short patrol was
 16 interpreted differently by individual officers, no
 17 possible interpretation of the post instructions,
 18 however lacking in clarity, could possibly have excused
 19 the static patrol in the colonnades for 40 minutes.
 20 Inspector Rose gave evidence that he would have
 21 intervened to stop it, whatever, in effect, the
 22 post instruction could be interpreted to mean.

23 So we say that when there is a proper analysis of
 24 what actually went wrong in a fact-specific way for the
 25 purposes of the arguable Article 2 issue, the failing

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1 was not in the promulgation of post instructions, the
 2 existence of ADAM, or ultimately even in the wording of
 3 the post instruction, because the post instruction was
 4 tolerably clear. It was a short patrol in
 5 New Palace Yard, or Carriage Gates towards the
 6 Cromwell Green exit. The failing, if there was
 7 a failing, was simply this: that the two authorised
 8 firearms officers were in the colonnades and not at
 9 Carriage Gates, and it cannot necessarily be supposed
 10 that on any alternative interpretation of the
 11 post instructions, or the supervision, or the auditing
 12 process, or the assurances which were meant to be kept,
 13 that they would have been at Carriage Gates. Because
 14 even on their own approach to the map, the alarm
 15 document, the laminated document and the PowerPoint,
 16 they were not doing what even those documents would have
 17 had them do because none of those documents said "remain
 18 static for 40 minutes in the colonnades".

19 In relation to causation, our submissions are set
 20 out shortly at paragraphs 55 to 61 of our written
 21 document. Even if there had been a tighter supervision
 22 or downloading or reading of post instructions, this
 23 would not necessarily have meant that PCs Ashby and
 24 Sanders would not have decided to go to the colonnades,
 25 not because that was not in the documents, but because

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1 they were inclined to do so.

2 There is evidence that officers did speak to AFOs
 3 and tell them when they were not on post, so it cannot
 4 be said that that decision by them to be in the
 5 colonnades was the result of a failure in that
 6 supervisory practice.

7 Secondly, even if they had been following the post
 8 notes, whether they would have been at Carriage Gates is
 9 a matter of complete speculation, because we will never
 10 know whether they might have been on the short patrol
 11 into New Palace Yard and thus unable to deal immediately
 12 with the threat in immediate proximity to the gates, or
 13 down towards the Cromwell Green search area exit.

14 A number of points were made about that yesterday.
 15 Of course it is a hypothetical analysis, but for the
 16 reasons I've given, all issues concerning causation are
 17 necessarily hypothetical.

18 My learned friend Mr Adamson made the point that the
 19 purpose of the post instructions and the plain
 20 obligation on PCs Ashby and Sanders was to protect
 21 unarmed officers at the gates. But that point, whilst
 22 right in principle, takes no account of the effect of
 23 the noise at Bridge Street, or of the speed and rapidity
 24 of Masood's entry.

25 The evidence clearly demonstrates that even if they

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1 had been at Carriage Gates they would have moved towards
 2 the noise at Bridge Street and would have had at least
 3 20 seconds in which to do so before the crowd, and then
 4 Masood, appeared at Carriage Gates. So they would have
 5 been drawn away from the gates for a sufficiently great
 6 elapse of time and of distance for them to be unable to
 7 respond in the three seconds that it took Masood to get
 8 through the gates and to start attacking PC Palmer.

9 There is evidence, of course, on top of their own
 10 evidence about their obligation to respond to the noise
 11 of how there is an obligation to respond to other
 12 threats in the sector, in effect to self-deploy. That
 13 evidence is in the post instructions and, as you are
 14 aware, was also contained in the evidence of
 15 Commander Usher.

16 PC Ashby said to this effect:

17 "Question: Could you have ignored that threat?"

18 That's to say the threat of a terrorist attack in
 19 Bridge Street.

20 "Answer: No, sir.

21 "Question: What would you have had to have done?"

22 "Answer: I would have made my way to that location.

23 "Question: Would the same apply if you had been
 24 standing on Carriage Gates?"

25 "Answer: Yes, sir.

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1 "Question: Why would you have had to have gone to
 2 the emerging threat ...?"

3 "Answer: Because of the nature of the threat, sir
 4 ... it's important that I get there to see if I can
 5 help ...

6 "Question: What do you think you would have done on
 7 that day if you had heard the sound of that car
 8 exploding up against the railings in Bridge Street?"

9 "Answer: I would have gone there, sir, to assist.

10 "Question: Would you have gone even though it left
 11 Carriage Gates unprotected in terms of an AFO?"

12 "Answer: Quite possibly, sir.

13 "Question: Why would you have done that?"

14 "Answer: Because I had no idea that it was what
 15 it's turned out to be so, you know, first and foremost
 16 I'm a police officer as well and I want to help."

17 And PC Sanders gave evidence to similar effect.

18 A point was made that PC Carlisle, of course, didn't
 19 go to the noise, but what you were not reminded of
 20 yesterday is that part of his evidence where he accepted
 21 that his duty was not that of an AFO on a roving patrol,
 22 expected to self-deploy to threats, but of an officer
 23 directly on post at north Carriage Gate, and the reason
 24 that he went to explore the noise outside the gate was,
 25 of course, because he had already been relieved.

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1 Lastly, such evidence as there is points towards it
 2 being highly unlikely that PCs Ashby and Sanders would
 3 have been able to shoot Masood even if they had remained
 4 out and returned to Carriage Gates because they simply
 5 would not have been -- and there is no evidence that
 6 they would have been -- in the physical position to deal
 7 with Masood when he came barrelling through Carriage
 8 Gates, let alone that they would have been in a position
 9 to neutralise him, and it needs very little exposition
 10 to set out the obvious difficulties that would have
 11 presented themselves to PCs Ashby and Sanders, taking
 12 a shot not with the gun that the close protection
 13 officer used, but with a carbine, at a fast-moving man
 14 carrying knives with other unarmed officers around him
 15 and with the crowd and members of the public behind him.

16 Q. PC Ashby accepted that he could not say whether he would
 17 have had a clear shot due to the need to create
 18 a reactionary gap in the backdrop. PC Ross gave similar
 19 evidence.

20 The fact that those officers who were the AFOs were
 21 unable to say that they would have taken a shot and
 22 could go no further than the position that they reached
 23 is the clearest possible evidence that the proposition
 24 that had AFOs been at Carriage Gates, and therefore able
 25 to take a shot which would have or might have disabled

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1 Masood, remains entirely speculative.

2 For all those reasons, sir, we say that it is not
 3 arguable that there was a breach of Article 2, although
 4 we too adopt the proposition advanced by Mr Hough QC
 5 that it may make very little difference to the wording
 6 of your determination, and it has certainly made no
 7 difference to the format, scope, and rigorous inquiry in
 8 this Inquest. But in relation also to the findings, to
 9 like effect, the proper determination is one that does
 10 not suggest that it is possible that due to shortcomings
 11 in the systemic arrangements in New Palace Yard,
 12 a prospect or real prospect of PC Palmer being saved was
 13 negated.

14 Those are our submissions.

15 THE CHIEF CORONER: Thank you very much indeed. Mr Hough.
 16 Reply submissions on determinations to be made by the
 17 Coroner by MR HOUGH QC

18 MR HOUGH: Sir, in reply I shall deal only with issues
 19 relating to PC Palmer. In taking that approach,
 20 I should make clear that it is with no disrespect to the
 21 other persons who died or to their loved ones. I hope
 22 we have made clear both in our written document and in
 23 our initial submissions, and indeed in our approach to
 24 the Inquests, that we have given them equal weight and
 25 significance.

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1 THE CHIEF CORONER: Yes.
 2 MR HOUGH: We address the issues concerning PC Palmer only
 3 because those issues are controversial between
 4 interested persons.
 5 Sir, all interested persons have addressed you on
 6 the legal issues by reference to the facts. That is
 7 entirely proper because, as Lord Justice Moses said in
 8 the case of R (on the Application of Lin) v Secretary of
 9 State for Transport [2006] EWHC 2575 (Admin), it would
 10 be beating the wind to address you, sir, on the law,
 11 without reference to the facts in a case such as this.
 12 So I propose to deal first with the question of
 13 whether Article 2 is engaged in relation to PC Palmer's
 14 Inquest, and then to address the determination and what
 15 content it should have, depending on your answer to the
 16 first question.
 17 Those who are not steeped in the law of Article 2
 18 may wonder why such energy is being put into this
 19 argument and what the Article 2 procedural obligation is
 20 all about.
 21 The Strasbourg courts have determined that where it
 22 is arguable that the state has breached one of the
 23 substantive Article 2 duties formulated under the
 24 Convention, it is essential that the state establish
 25 an investigation which satisfies certain criteria.

1 In most respects, our inquest system satisfies those
 2 criteria, as was held in the Middleton case. But there
 3 is one respect in which the House of Lords in the
 4 Middleton case felt it was necessary to read down the
 5 statutory provisions so as to ensure compliance, and
 6 that was that the determination at the end of an inquest
 7 should answer a slightly broadened form of "how"
 8 question: how the deceased came by their death, to
 9 address the circumstances as well as the means of death.
 10 That, as I said in opening, permits or may permit
 11 a coroner to deliver a more expanded form of narrative
 12 conclusion which addresses the underlying circumstances.
 13 The coroner does so in order to satisfy a Convention
 14 standard of effectiveness.
 15 So the question to be asked and addressed at this
 16 stage is whether there is an arguable case on the
 17 evidence that one of the substantive duties owed by the
 18 state under Article 2 was breached. The threshold is
 19 set low, at one of arguable breach, because the
 20 Convention institutions are concerned that deaths in
 21 which the state may be implicated — may be
 22 implicated — receive an independent investigation with
 23 the standards which the Convention institutions have
 24 identified.
 25 The threshold, as I say, of arguable breach is a low

1 one. In the AP case, which we've identified in our
 2 submissions, it was said that a case of breach which was
 3 more than fanciful would suffice. So the question for
 4 you is whether there is a more than fanciful argument,
 5 a more than fanciful basis, for saying that the state or
 6 its agents breached one of the two recognised
 7 substantive duties.
 8 So I will focus upon the general duty because that
 9 is the basis of our submission that Article 2 is
 10 engaged.
 11 My learned friend Mr Keith QC, at points in his
 12 submissions, elided principles applying under the
 13 general duty with those applying under the operational
 14 duty. In the Osman case and in subsequent cases, the
 15 Strasbourg institutions have been careful to set precise
 16 and relatively narrow parameters for the operational
 17 duty to ensure that it is not every act of negligence by
 18 a state agent which calls into question the state's
 19 responsibility for a death under Article 2.
 20 The general duty, however, is different. It is not
 21 concerned with the acts or omissions of individual or
 22 state agents; it is concerned with systems and
 23 procedures.
 24 Sir, we set out the way that the general duty has
 25 been characterised at paragraph 7(b) of our document on

1 page 6, that it is a duty on the state to establish
 2 a framework of laws, precautions, procedures and means
 3 of enforcement to protect the lives of citizens.
 4 How is that systemic duty to be distinguished from
 5 individual duties and the individual acts of state
 6 agents?
 7 Well, sir, that question was addressed most recently
 8 in this country in the case of R (on the Application of
 9 Parkinson) v Kent Senior Coroner [2018] 4 WLR 106, with
 10 which you will be very familiar.
 11 Sir, if I may just take a couple of passages from
 12 that, from paragraph 82, where the relevant principles
 13 are summarised in the judgment of the court. At
 14 paragraph 83, the court recognised that Article 2
 15 imposed:
 16 "... substantive positive obligations on the state,
 17 and procedural obligations."
 18 At paragraph 84, the court stated that:
 19 "The primary substantive obligation is to have in
 20 place a regulatory framework compelling their hospitals
 21 to adopt appropriate measures for the protection of
 22 their patients' lives."
 23 At paragraph 87, the court said that:
 24 "Where the state has made adequate provision for
 25 securing high professional standards among their health

1 professionals in the protection of lives of patients,
 2 matters such as an error of judgment on the part of
 3 a health professional, or negligent coordination among
 4 health professionals in the treatment of a particular
 5 patient are not sufficient of themselves to call the
 6 state to account under Article 2.”

7 The court then dealt at paragraph 88 with
 8 exceptional cases where individual errors might
 9 nonetheless be suggestive of a dysfunction in a system,
 10 and at paragraph 89 the court said that:

11 “At the risk of oversimplification, the crucial
 12 distinction is between a case where there is reason to
 13 believe that there may have been a breach which is
 14 a systemic failure in contrast to an ordinary case of
 15 medical negligence.”

16 But, sir, systems are not just about textbooks.
 17 Written procedures may be impeccable, but systems may
 18 nevertheless be defective. In this respect, the
 19 Strasbourg decisions have been ruthlessly pragmatic.

20 At paragraph 7(c) of our document on page 6, we have
 21 made reference to the Kakoulli and Makaratzis cases as
 22 examples of this: that the duty may extend beyond
 23 written procedures to ensuring that arrangements are in
 24 place for state operations to protect the lives of
 25 citizens to work properly and effectively.

1 The question, therefore, in this case is whether it
 2 is arguable that the security arrangements for the
 3 Palace of Westminster, including at its perimeter, were
 4 defective not merely through a number of individual
 5 errors, but through a defective system, and we submit
 6 that it is arguable that that’s the case.

7 I don’t propose to reiterate what I said earlier,
 8 and that which we address at paragraph 11 of our
 9 document, specifically pages 14 and following.

10 Sir, by way of brief summary, the Carriage Gates
 11 entrance had been recognised as a particularly
 12 vulnerable point, and one in need specifically of armed
 13 protection. It was therefore incumbent on those
 14 responsible for the security arrangements there to
 15 ensure that there was adequate protection at that
 16 perimeter point. Setting aside for one moment the
 17 important question of unarmed officers’ protection, this
 18 was an estate including thousands of people, many of
 19 them very important people who would be very attractive
 20 targets for terrorists, and protection at the perimeter
 21 was the most important line of security, as
 22 Commander Usher recognised. It was for this reason that
 23 it was regarded as important that armed officers be
 24 tethered to the gates.

25 The system, in that respect, was arguably failing in

1 that armed officers were not complying with the
 2 requirement to tether themselves to the gates on
 3 a regular basis. The suggestion was made at one stage
 4 in my learned friend Mr Keith’s submissions that you
 5 would have to find that there was non-compliance by
 6 a majority of officers.

7 Sir, we don’t accept that proposition. If the
 8 system was such that 10, 20 or 30 per cent of the time
 9 this important entrance was not protected, that may be,
 10 at least arguably, due to a failed system.

11 Furthermore, the evidence in these Inquests has
 12 shown that this level of non-compliance which we
 13 identify by reference to evidence at subparagraph (e) on
 14 page 15, was due to deficiencies in the system of
 15 supervision.

16 The systems which existed for ensuring observance of
 17 changing post instructions were, at least arguably,
 18 deficient in that so few officers had recently logged
 19 into the ADAM system, and key officers were unaware of
 20 their post instructions, at least on one view, and
 21 a legitimate view of the evidence.

22 We also see that the system could readily be
 23 improved. The MM1 document ends, critically, with
 24 recommendations and a commitment to improve the system
 25 dramatically to ensure compliance with

1 post instructions.

2 It cannot be that it is unarguable that there was
 3 a means of ensuring that all, or at least almost all of
 4 the time, officers in this critical place were complying
 5 with their instructions.

6 As to causation, the question is whether it’s
 7 arguable that a systemic breach deprived PC Palmer of
 8 a real and substantial chance of survival. As
 9 I submitted earlier, that involves a low threshold test,
 10 arguable, and a loose test of causation, a real and
 11 substantial chance.

12 As to real and substantial chance, may we address
 13 the point about speculation and the level of proof in
 14 this way: first of all, there must be a real prospect
 15 that if compliance with post instructions had been
 16 better enforced, PCs Ashby and Sanders would have been
 17 at or close to Carriage Gates at the time of the attack.
 18 The suggestion that they would not have been, that they
 19 would have ignored their instructions no matter what
 20 better procedures had been in place, is an extraordinary
 21 counsel of despair, and it’s also one without obvious
 22 rationale to back it up.

23 My learned friend Mr Keith said it may have been
 24 that they would have stayed in the colonnades whatever
 25 the degree of instruction and assurance processes,

1 because they would have been inclined to do so. Why
2 would they have been inclined to be otherwise than their
3 orders told them? There was no rationale or objective
4 suggested behind such potential inclination.

5 At the next stage, there must be a real prospect
6 that PC Palmer would not have moved towards the gates
7 had there been armed officers supporting him, or that at
8 least one of those armed officers would have stayed at
9 the gates while the other moved towards the loud bang,
10 or that they would have moved slowly away and returned
11 quickly with either the screams of the crowds coming
12 around the corner, or the shouts of the man in the suit
13 that men were attacking with knives.

14 At the next stage there must be a real prospect that
15 if one or more of them had been at the gates, they would
16 have taken an effective shot. True it is that that
17 would have involved some difficulties. True it is that
18 it's speculative whether they would have had the clear
19 shot. But the speed and effectiveness of the close
20 protection officers' actions, surrounded as they were by
21 fleeing officers, helps to make the point that there
22 would have been a real prospect.

23 If there was a real prospect at each of those
24 stages, we find it difficult to accept that it is not
25 arguable that the arguable defect in systems caused

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1 PC Palmer to lose a real and substantial chance of
2 survival.

3 So for those reasons we remain of the view that
4 Article 2 is engaged in relation to PC Palmer's Inquest.

5 May I move, then, to the form of determination.
6 First of all, sir, Ms Stevens has informed us of the
7 change of wording to the uncontroversial first paragraph
8 of the form of determination we proposed --

9 THE CHIEF CORONER: Yes.

10 MR HOUGH: -- and I think that has been made known to you.

11 Sir, as I say, it is not a controversial passage: it
12 simply asks for a change of wording to reflect the fact
13 that PC Palmer stepped forward --

14 THE CHIEF CORONER: Yes.

15 MR HOUGH: -- and challenged the attacker.

16 Sir, if Article 2 were not engaged, then it would
17 only be the paragraph at 17(a) of our document which
18 ought to form part of the determination.

19 If, however, Article 2 is engaged, then we submit
20 that your determination ought to first of all set out
21 the relevant circumstances underlying PC Palmer's death,
22 address and resolve the key issues, and do so not in
23 an anodyne way but in a relatively succinct way. Of
24 course, all of that is more easily said than done but,
25 sir, you have been assisted by the various proposals by

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1 the interested persons as to forms of words.

2 May I say a little about causation in this regard.

3 After you have decided what circumstances to identify,
4 we agree with others that it is appropriate to say
5 whether, for example, any defects in systems you have
6 identified probably were causative of PC Palmer's death,
7 or possibly were causative of PC Palmer's death.

8 My learned friend Ms Stevens makes reference in her
9 submissions to the test of causation whether a factor
10 was more than minimally contributory to a death. That's
11 a test, sir, you will be familiar with in the context of
12 gross negligence manslaughter. Its purpose is to make
13 clear that where there may have been multiple causes of
14 a death, a particular cause which gives rise to criminal
15 responsibility does not need to be the sole cause: it
16 need only be contributory.

17 But here the critical question which has to be
18 addressed is whether a cause or a circumstance, was
19 probably causative or possibly causative. In the Lewis
20 and Tainton cases, the courts have made clear that
21 circumstances which may have been causative, which
22 possibly contributed to death, may fall within the
23 circumstances of death that appear within the coroner's
24 determination. In the Tainton case, it was specifically
25 suggested that if significant failures or system defects

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1 had been identified that were possibly causative of
2 a death, they ought to feature.

3 We agree with the submissions that have been made
4 that if you find that system defects probably
5 contributed causally to PC Palmer's death, you ought to
6 say so. Equally, if you consider that you cannot reach
7 the threshold of probability, but you consider that
8 system defects possibly contributed to his death, you
9 should say so similarly, using words indicative of
10 possibility.

11 My learned friend Mr Keith is quite right in his
12 gentle criticism of our wording which used the phrase
13 "not certain". He is right to say that the
14 determination ought to speak either in terms of
15 a probable causal link or a possible causal link.

16 In a similar spirit, however, of gentle and friendly
17 criticism, we would point out that his form of words in
18 naming Masood as the attacker infringes section 10(2)(a)
19 of the Coroners and Justice Act 2009.

20 Sir, drawing the threads together, it is
21 a challenging question involving some speculation
22 whether the various arguable, or actual, deficiencies in
23 the system of security at the Palace of Westminster were
24 causative of PC Palmer's death. But we say, sir, that
25 that should not cause you to abandon hope and abandon

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1 the challenge of determining whether these deficiencies ,
2 if they were found to exist , were contributory or
3 possibly contributory to his death.

4 As Mr Adamson said, it is sometimes the task of the
5 court to engage in hypotheticals which may involve some
6 speculation. But we say the question here is whether
7 the set of uncertain hypotheticals reaches a threshold
8 of realistic possibility or probability .

9 Sir , may I assist in any other way with the
10 challenges you have to face?

11 THE CHIEF CORONER: No, Mr Hough, thank you very much. Can
12 I, again, simply thank everyone for their very helpful,
13 both written and oral, submissions.

14 Mr Hough, it is just shy of 11.10. What I'm going
15 to do is I'm going to rise and I'm going to suggest we
16 sit in an hour's time and take matters on to the next
17 stage at that point.

18 (11.08 am)

(A short break)

20 (12.12 pm)

21 THE CHIEF CORONER: Mr Hough, can I just say, I'm about to
22 start on reading my summary of the evidence that's been
23 called in the course of the Inquests. Inevitably that's
24 going to take me a little time to deal with, so I say
25 that to start with.

1 Secondly, I don't intend to show any imagery, but
2 clearly the descriptions of some of the things I'm going
3 to talk about, some may find distressing .

4 MR HOUGH: Yes, sir.

5 Chief Coroner's Summary and Conclusions

6 THE CHIEF CORONER: On 22 March 2017, one of the most iconic
7 areas of London was the site of a deliberate act of
8 terrorism. Westminster Bridge, the areas around the
9 River Thames, and the Palace of Westminster are visited
10 by tourists from all around Great Britain and Ireland,
11 and the rest of the world.

12 22 March was a day like most others in that area:
13 groups of people of all ages making their way to see the
14 Houses of Parliament, going towards the London Eye, the
15 London Dungeon and the numerous other sites in that
16 area. Others in the area were on the river , seeing the
17 sights of London from the water. They were all there to
18 enjoy the day. For many, it would have been their first
19 time of seeing those sights ; for others a return visit ,
20 and perhaps sharing their favourite views with friends .
21 Others were in the area for work, or for business. Each
22 was going about their day as if it was any other day.

23 These Inquests commenced with relatives and friends
24 of the five who died giving me a picture of the person
25 they loved in life . It was both powerful and moving.

1 There was some humour. There were photographs, showing
2 people full of life . The families have shown great
3 dignity throughout this process. I have had the
4 opportunity to meet with maybe all of them privately ,
5 and it 's been important for me to do so.

6 These Inquests are concerned with the deaths of five
7 people. A coroner only looks into matters around death.
8 This is not a general inquiry into the circumstances of
9 those who were also injured. However, it would be wrong
10 for me not to say something about those who did not lose
11 their lives , but for whom 22 March was a life-changing
12 day.

13 Four people were struck by the car driven by Masood
14 and were killed . Many others were also struck by
15 Masood's car. In some of the CCTV footage shown in the
16 course of these Inquests, men, women and young people
17 are seen to have taken an impact to their body from the
18 car. In addition to those who lost their lives , no
19 fewer than 29 people received serious injuries . The
20 scene has been described by some as "carnage". It was
21 clearly the deliberate targeting of pedestrians crossing
22 the bridge.

23 On average, the vehicle was driving at between 30
24 and 32 miles an hour. From a standing start , it quickly
25 got to that speed, and throughout its passage across the

1 bridge, on the roadway, on the pavement, in the cycle
2 lane, and moving between those places, it was driven
3 with a clear , murderous intent.

4 I am sure that one of the reasons that many more did
5 not die from the serious injuries they sustained is due
6 to the quite overwhelming acts of those who responded.
7 Many doctors and nurses rushed from St Thomas' Hospital
8 to give what assistance they could. Many members of the
9 public did what they could to provide aid. Many stayed
10 with the people they came across on the bridge, and
11 comforted them and treated them where they could. Sadly
12 some members of the public chose to photograph and film
13 rather than help.

14 I have been struck by the particular work of
15 a number of those who responded and cared for people
16 with the most catastrophic injuries and who died. They
17 could assess how serious the injuries were and the
18 likely prognosis, but nonetheless they did all they
19 possibly could to care for and comfort people. I am
20 sure that what they did has been a great comfort to the
21 families who could not be with their loved ones at that
22 time.

23 It is clear that those who attended to casualties
24 not so seriously injured also provided the best care
25 they could, and I wish to put on record my sincere

1 thanks to all those from the emergency services who
2 responded on the day as they did.

3 The City of Westminster is covered with CCTV
4 cameras. The footage from the cameras in that area has
5 provided helpful material in the investigation of these
6 deaths. It has enabled the police to investigate the
7 lead-up to and the carrying out of this atrocity. It
8 has also meant, sadly, that the full horror of what took
9 place has been fully recorded. That material has been
10 displayed with sensitivity in these Inquests. The most
11 graphic material has not been shown outside this
12 process.

13 Westminster was busy on the day and many of the
14 people there would have had with them mobile phones and
15 cameras. From some of the CCTV footage it is clear that
16 some people took photographs and moving footage of what
17 took place. Some of that was sent to the police to
18 assist with the investigation. Sadly some people, for
19 whatever reason, have posted some material on the
20 internet. Some of that material has been very
21 distressing to the families, and I would encourage that
22 it is removed.

23 Masood began his attack when he drove into the east
24 side of Westminster Bridge from a bus lane in which he
25 had remained stationary for a short period of time.

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1 Masood's vehicle first mounted the kerb at 14.40.08.
2 Masood was shot at 14.41.30. The attack lasted
3 82 seconds.

4 Kurt Cochran. Kurt Cochran and his wife, Melissa,
5 were visiting London for a day as part of a tour of
6 Europe. They were visiting Europe and celebrating their
7 25th wedding anniversary. They walked across the bridge
8 from Parliament to the south bank. As with other
9 tourists they were taking in the sights and sounds of
10 London. They had visited Westminster Abbey and were
11 planning on going down the stairs to the embankment to
12 sit on a bench.

13 They had been in London for about two and a half
14 hours when tragedy struck. Melissa was taking
15 photographs on her phone as they walked across the
16 bridge. She had put her phone in her purse and was
17 looking at the postcards on the stand by the edge of the
18 bridge. She heard a car revving, saw the front of the
19 car, and then her next memory is of being on the ground
20 with someone's hand on her head. Melissa received
21 serious injuries from the impact she sustained and was
22 in hospital for over three weeks.

23 The CCTV footage makes clear that in what must have
24 been an instinctive act, Kurt, when he saw the car
25 coming towards where he and Melissa were stood, pushed

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1 his wife away from the path of Masood's vehicle. Masood
2 was clearly intent on driving into them at some speed,
3 with the devastating consequences that would have.

4 Kurt's action almost certainly had the effect of
5 saving the life of his wife. Had he not taken the
6 action he did, it is clear that she may have died or
7 sustained even more serious injuries than she actually
8 sustained.

9 It was clear to those who saw the car being driven
10 towards Kurt and Melissa that this was a deliberate act.
11 Ms Smith, a school teacher, was in the area with a group
12 of her students. They were visiting various parts of
13 London. Ms Smith, who was stood close to where the
14 incident took place, described what she saw as
15 a calculated act, a deliberate act towards those by the
16 postcard stand.

17 The impact between the car and Kurt was such that
18 Kurt was thrown into the air. He was thrown over the
19 side of the bridge and fell on the lower embankment
20 area. He fell from a height of some 5.12 metres. The
21 car was being driven at a speed of between 32 and
22 36 miles per hour.

23 On the lower embankment was Neil Hulbert. He was
24 with his nephew and they had just been on the London Eye
25 and were looking at the sights along the embankment.

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1 They had just taken some photographs when they heard the
2 sound of a crash and then saw the sad sight of Kurt
3 flying through the air and landing close to where they
4 stood. Neil Hulbert describes Kurt hitting the solid
5 ground with a terrible thud. He immediately went to
6 where Kurt was lying.

7 Mr Hulbert had some first aid training. His
8 assessment was that Kurt had broken legs and a serious
9 head injury. There was a lot of blood and his breathing
10 was laboured. He checked for signs of consciousness but
11 could not detect any. The emergency services were
12 called by a lady who was close to Mr Hulbert. Kurt's
13 breathing became more laboured and Mr Hulbert sought to
14 comfort Kurt.

15 Ms Henshaw, a clinical nurse specialist from
16 St Thomas' Hospital, was by the entrance to the hospital
17 when some people came in to say there had been
18 a terrible accident and mentioned that someone had gone
19 over the side of the bridge and onto the path below.
20 Staff called an ambulance and Ms Henshaw decided to go
21 and see what she could do rather than return to her
22 office. She made her way to where Kurt was with
23 Mr Hulbert. She made a preliminary assessment of Kurt
24 and formed the view that he was obviously very badly
25 injured. In her view, his head must have made contact

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1 with the pavement from the bridge. He was not conscious
2 and there was a lot of blood. His breathing was
3 staggered. She described it as "stridal", something she
4 associated with people at the end of their life. She
5 checked for a pulse but was not able to detect one
6 peripherally. None of the signs were good.

7 An ambulance crew were soon to join them. A doctor
8 also arrived. All were deeply concerned about the
9 condition of Kurt.

10 James Richards is a paramedic who went to where Kurt
11 was lying on the ground. He explained all of the steps
12 they took with Kurt for his airway, breathing and
13 circulation. Despite the most valiant of efforts of all
14 who attended to Kurt, his injuries were such that he did
15 not survive. Kurt Cochran sustained catastrophic head
16 injuries and was declared dead at 15.00 hours on
17 22 March. He was then aged 54.

18 Dr Simon Poole, a Home Office pathologist, carried
19 out a post mortem on Kurt on 25 March at Westminster
20 Mortuary. He noted multiple injuries on an external and
21 internal examination, the most severe of which were to
22 the head and trunk. Those injuries can be attributed to
23 blunt force trauma. There was a skull fracture running
24 across the top of the scalp. There were injuries to the
25 lower limbs, around the knee joints, the right ankle, to

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1 the backs of some of the ribs and a partial dislocation
2 of the left shoulder joint. There were a large number
3 of areas of bruising underneath the surface of the
4 scalp, as well as many other areas of internal injury.

5 The brain was formally examined by
6 Professor Al-Sarraj. The conclusions he came to as a
7 result of all the examinations were that there were
8 multiple injuries found on external and internal
9 examination, the most severe of which were to the head
10 and the trunk. All the recent injuries and marks can be
11 attributed to the result of the strike against a moving
12 car, the throw and the impact or impacts against a hard
13 surface, such as paving, carriageway or street
14 furniture.

15 Given the severity of the head injuries, Dr Poole
16 considers it likely that after coming to rest, Kurt
17 would have been rapidly rendered unconscious. He also
18 regarded it as probable the post-injury survival period
19 would have been brief. He gave the cause of death as
20 multiple injuries. His view was that any medical
21 attention which could have practically been given at the
22 scene, these injuries were not survivable.

23 The pen portrait material showed how much Kurt was
24 loved by his family and by all who knew him.
25 A statement from Kurt's sister, Sandy Cochran, was read,

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1 as was a statement from Melissa, read by her sister,
2 Angela Stoll. In Melissa's statement, she included some
3 thoughts and comments from other family members. I had
4 the pleasure of meeting with and speaking to Melissa and
5 her sister before they had to return home to Utah. We
6 spoke about Kurt, the process of these Inquests, and
7 also about her medical treatment.

8 Leslie Rhodes. Leslie Rhodes was walking along the
9 pavement on Westminster Bridge from south to north. He
10 was walking from St Thomas' Hospital across the bridge.
11 He was struck by the Hyundai driven by Khalid Masood as
12 it went across Westminster Bridge, veering on and off
13 the pavement as it did so. The car struck him when he
14 was on the pavement, and he was carried along it into
15 the carriageway. From the point of impact to where he
16 came to rest is a distance of some 33 metres.

17 DNA from Leslie was later found on the underside of
18 the Hyundai. At the time of impact the accident
19 reconstruction experts, Police Constable Keen and Police
20 Constable Clark, estimated the average speed of the car
21 to be between 29 and 36 miles per hour at the point of
22 impact. The CCTV footage shows the use of the Hyundai
23 as a weapon by Masood on Leslie, as it was with the
24 others on the bridge that day.

25 Dr Lloyd, an ear, nose and throat registrar, then

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1 working at Guy's Hospital and St Thomas' Hospital, was
2 undertaking what he described as the role of the "hot
3 registrar of the week" meaning that he was on call
4 between 8.00 am and 5.00 pm for referrals and in patient
5 reviews for patients within his key discipline,
6 primarily at guys, but also at St Thomas' and King's
7 College Hospitals.

8 He was on Westminster Bridge on his way to review
9 a patient in intensive care at St Thomas', having
10 travelled there by underground from Guy's to
11 Westminster. He was walking across the bridge on the
12 opposite side of the road to the attack. He heard
13 a loud bang coming from the area in front of him and to
14 the right of him. He looked to where the noise came
15 from and saw the Hyundai travelling erratically. The
16 engine was making a loud roaring noise suggesting to him
17 that the accelerator was being pressed. It seemed to be
18 gathering pace. He was aware of damage to the front of
19 the car, dents to the bonnet and bumper. He estimated
20 that the car was driving at 30 miles an hour. It was on
21 and off the pavement. He saw three people struck by the
22 car.

23 It appeared to him to be a deliberate act, and he
24 wondered initially if it was a car evading a police
25 chase, but no police vehicle seemed to be in pursuit.

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1 He crossed the road to where he had seen three
2 people struck. He went to one of the three, Leslie. He
3 went to Leslie as he had appeared to take a significant
4 impact and then made no attempt to move once he had
5 landed on the ground. Leslie was unresponsive and
6 needed immediate medical attention.

7 Dr Lloyd noted that the other two did not seem to
8 need such urgent attention and had people attending to
9 them. He had seen that Leslie was in the direct path of
10 the Hyundai and had been hit by the front bumper of the
11 car, lifted over the bonnet towards the windscreen,
12 which then lifted him further before then falling to the
13 road. Another person called an ambulance, and so
14 Dr Lloyd attended to Leslie.

15 He felt for a pulse, first on the arm and then on
16 the neck. In doing so, he noted an injury to the head.
17 It was very serious. To him it looked like
18 an immediately life-threatening injury. It would, he
19 said, be a significant injury for any age, but with the
20 age, the potential for significant and life-threatening
21 injury was severe.

22 Leslie did not appear to be making any effort to
23 breathe. With the assistance of the lady who had called
24 for the ambulance, he moved Leslie. He noted other
25 injuries to Leslie, to the right eye, and there was

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1 blood coming from the nose and mouth. Dr Lloyd sought
2 to open Leslie's airway. He carried out a jaw-thrust
3 manoeuvre and Leslie began to breathe spontaneously. He
4 then tried to remove secretions and blood from his mouth
5 by putting him in the recovery position and using his
6 fingers. At this stage he had no medical equipment and
7 was doing what he could.

8 A paramedic arrived by bike and the two of them
9 continued to treat Leslie. They used an aspirator to
10 remove blood from the back of Leslie's mouth and they
11 gave oxygen. With the equipment the paramedics had and
12 then the ambulance, they were able to obtain intravenous
13 access and apply monitoring. They also placed two
14 needles in the front of the chest with the aim of
15 decompressing any chest injury.

16 Initially the observations were, in the view of
17 Dr Lloyd, quite remarkable: pulse, blood pressure and
18 oxygen saturations which were better than they had
19 anticipated, and made them more optimistic about his
20 chance of survival. Definitive treatment needed to
21 happen quickly. They were awaiting allocation of
22 a hospital. As they were on the south side of the
23 bridge they felt the best course was to head south.

24 Dr Lloyd went with Leslie to the hospital. His role
25 was to maintain the airway and also be involved in the

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1 monitoring of Leslie. As they went to hospital,
2 Leslie's oxygen saturation was slowly dropping. The
3 journey took eight minutes. Leslie's care was then
4 handed over to the major trauma team on arrival, but
5 Dr Lloyd remained at the hospital.

6 Leslie went for a CT scan. That scan revealed
7 extensive injuries to the head, chest and abdominal
8 organs. The head injury was significant, and had caused
9 potentially irreversible changes to the brain. Leslie
10 was to die later.

11 Dr Lloyd said that from the moment he saw the head
12 injury on the bridge and the age of Leslie, he feared
13 that it was likely to be an unsurvivable injury. On the
14 bridge he had asked about the possibility of assistance
15 from HEMS. Leslie fitted the criteria and type of
16 patient for their assistance. As far as Dr Lloyd was
17 concerned, there was no direct contact with HEMS, but he
18 understood they would be coming, but minutes later it
19 became apparent they were attending the scene on the
20 north side of the bridge.

21 Dr Lloyd did not think there was anything he could
22 have done to have materially changed the outcome for
23 Leslie. It is clear to me that Dr Lloyd not only did
24 all that could be done medically to aid Leslie, but also
25 all he did to comfort Leslie in the time after he

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1 sustained such catastrophic injuries.

2 Gary Moody, a paramedic with the London Ambulance
3 Service, arrived on Westminster Bridge at 14.44.
4 Dr Lloyd told him of his observations and he worked with
5 Dr Lloyd in giving care to Leslie. He was told that
6 HEMS were on their way and he was aware of the
7 helicopter above them. There was some delay in landing
8 and he did ask if they were still coming for Leslie.
9 There was, he said, however, no delay in Leslie's
10 treatment.

11 He was then told that there was another patient who
12 had been stabbed somewhere around Parliament, and so
13 they continued with their treatment of Leslie.
14 An ambulance was on the scene quickly, and they decided
15 to take Leslie to the major trauma facilities at King's
16 College Hospital. He, too, went with Leslie to the
17 hospital.

18 The patient form he completed shows his arrival time
19 at the scene as 14.44 and the time with the patient at
20 14.45. He had completed details as to his observation,
21 including a Glasgow Coma Score suggestive of
22 unconsciousness. Airways were inserted and there was
23 then continued spontaneous respiration. They left the
24 scene at 15.08. Had HEMS been present and taken further
25 steps, Leslie would have remained on the bridge for

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1 longer, possibly another 15 minutes. They were at the
2 hospital by 15.18.

3 Dr Simon Calvert, a consultant in emergency medicine
4 and intensive care medicine at King's College Hospital
5 was covering the major trauma rota on this day. He was
6 the initial leader of the team that provided care to
7 Leslie on his arrival at about 15.18 that day. He was
8 given a full history of the interventions by Dr Lloyd
9 and they set about securing his airway and maintaining
10 his breathing. The CT scan showed a severe traumatic
11 brain injury and a depressed skull fracture. There was
12 air inside the skull cavity. The scan also showed some
13 haemorrhage and a loss of grey/white differentiation in
14 the brain which would suggest either severe swelling or
15 a severe lack of oxygen had occurred and this would be a
16 very significant finding early on in a CT scan.

17 Dr Calvert explained that they wouldn't normally
18 expect to see that for a day or two after an injury like
19 this, so that in combination with the fact that he was
20 unconscious at the scene and his pupils were not
21 reacting to light painted a picture that the injury
22 would not have been survivable.

23 Other, slightly less significant injuries, were also
24 shown on the scan: there was a dislocation of the right
25 knee that may be consistent with the moment of impact

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1 from the car, as well as injury to the lumbar vertebrae.

2 There were discussions between consultants from
3 various disciplines: neurosurgery, the trauma team, the
4 intensive care team, and the conclusion was that this
5 injury was likely to be unsurvivable. There was no
6 surgical intervention that would be able to help. In
7 effect, the damage had been done at the time of the
8 event, and surgery would be of no value.

9 Leslie was transferred to the intensive care unit.
10 Despite the care they provided, Leslie became
11 increasingly unstable and died at 20.44 on
12 23 March 2017. It is clear to me that all those who
13 cared for Leslie on the bridge, in the ambulance and on
14 his arrival at King's, did all they humanly could to
15 help him, but his condition was so grave nothing more
16 could be done.

17 Dr Ashley Fegan-Earl, a Home Office pathologist,
18 carried out the post mortem examination on
19 25 March 2017. He noted significant injuries from both
20 his external and internal examinations. The most
21 significant injuries were those to the head and brain.
22 Again, Professor Al-Sarraj examined the brain to make
23 an assessment. From his examination and all of the
24 additional information he was provided with,
25 Dr Fegan-Earl concluded that Leslie had died as

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1 a consequence of an act of violence. The external
2 examination showed features of impact to an upright
3 individual, probably to the right-hand side of the body.
4 This was a reference to injuries to Leslie's right lower
5 limb with fractures and instability of the ankle joint,
6 and the significant head injury to the right-hand side.
7 Leslie had suffered a devastating head injury to the
8 right-hand side of the head. There is a rounded skull
9 fracture that may be relevant to impact against
10 a patterned object. That could either be by impact
11 against a vehicle or as a result of his projection onto
12 the road.

13 Leslie also suffered from bruising to the brain
14 caused by the moving head striking the ground. In
15 Dr Fegan-Earl's opinion it was devastating, unsurvivable
16 and would have rendered him deeply unconscious
17 straightaway. Professor Al-Sarraj found evidence of a
18 particular type of injury: diffuse axonal injury. This
19 refers to the shearing of nerve fibres caused by violent
20 application of force. Such injuries are graded out of
21 3, with 3 as the most severe, and Leslie had suffered
22 grade 3 axonal injury.

23 Such an injury further confirmed his view both as to
24 the unsurvivability of this injury, and the fact he
25 would have been rendered immediately and deeply

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1 unconscious.

2 Various other injuries on Leslie's body are
3 consistent with road contact, with the most relevant of
4 those being the impact injury to the lower right leg.
5 Dr Fegan-Earl also expressed the opinion there was no
6 issue with the medical treatment Leslie received, and
7 the formal cause of death was head injury. He was aware
8 that after Leslie was hit by the vehicle, he was thrown
9 into the road and carried forward some distance, and
10 that there is a combination of head injury in part
11 caused by primary contact with the vehicle, but
12 exacerbated by his subsequent projection onto
13 the roadway.

14 There were signs of injury to the brain, suggesting
15 that it was moved from side to side within the skull.
16 When he was hit and then thrown onto the roadway, his
17 head would have stopped suddenly and that can cause
18 a particular pattern of bruising that had been
19 identified.

20 In relation to whether it might have been possible
21 to transport Leslie to hospital more quickly through the
22 action of the HEMS, his clear opinion was that, leaving
23 aside whether that was practical, as a matter of
24 probability, in the light of the neuropathology results,
25 Leslie would not have survived if he had either been

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1 transported to hospital earlier or received earlier
 2 medical intervention. Leslie had been deeply
 3 unconscious from the start and would have suffered
 4 little or no conscious pain or suffering.

5 Mr Patterson QC read a moving statement from
 6 Amanda Rhodes, a niece of Leslie's. That statement
 7 covered all aspects of his life, including his work as a
 8 window cleaner, his family and his interests,
 9 particularly those in cricket and fishing.

10 Aysha Frade was walking towards Parliament Square
 11 across Westminster Bridge. She was carrying a shoulder
 12 bag. Aysha was working at the DLD College on
 13 Westminster Bridge Road. She had just left work and was
 14 heading home to collect her children. Masood drove the
 15 Hyundai into her. Three other pedestrians were also hit
 16 at about the same time.

17 Aysha and the others were plainly in view of the
 18 driver of the vehicle. Aysha was thrown into the air
 19 and propelled forward. She was thrown a distance of
 20 some 17.4 metres from where she was first struck and
 21 into the path of the nearside rear wheels of a bus. The
 22 bus applied the brakes, but sadly, the rear wheels
 23 passed over her body. Such were the injuries she
 24 sustained that death would have been instantaneous.

25 In the moments before the impact, Aysha can be seen

1 on her mobile phone. Masood's car hits Aysha at the
 2 front, or the front driver's side of the car. The time
 3 of impact is 14.40.16. Aysha does not turn around or
 4 make any other movements suggesting that she knew what
 5 was to happen or that she had noticed the car.

6 There was clearly a hard impact with her head on the
 7 windscreen of the car. The time when she landed on the
 8 road was at 14.40.17, and then the bus brakes and it is
 9 at a halt about five seconds later. Although there is
 10 limited CCTV footage to give an accurate view of the
 11 speed of the Hyundai at the point of the impact, soon
 12 after the impact the calculations from the
 13 reconstruction experts put the speed at between 31 and
 14 42 miles per hour.

15 Rob Lyon was in London for business commitments,
 16 including an interview at the ITV Studios on Millbank.
 17 He was with some colleagues and they had left the
 18 studios at about 14.30. They were staying at the Park
 19 Plaza Hotel and so they went past the
 20 Houses of Parliament and were due to cross
 21 Westminster Bridge to their hotel. Mr Lyon recalls the
 22 bridge being fairly busy with the usual mix of tourists
 23 and businesspeople.

24 They were about two-thirds of the way across the
 25 bridge when one of his colleagues, James, shouted to get

1 out of the way. He heard a crunch, a sound like the
 2 kerbing of a wheel of car but much louder, and some
 3 really high revving of an engine. It sounded to him as
 4 if someone had floored the wheel in first gear. He then
 5 saw three people being hit by the car. He heard lots of
 6 noises, bangs and shouts, and his next memory is of
 7 being stood in the road.

8 He saw the Hyundai mounting the pavement in front of
 9 him, the engine was revving incredibly loudly and he
 10 almost expected it to crash into the wall of the bridge.
 11 He thought it was a car crash, but the car seemed to be
 12 revving louder and louder. The car then corrected
 13 itself in terms of its direction, before heading
 14 straight down the pavement. The pavement was thronged
 15 with pedestrians. He saw the car hit two women and
 16 a man. It all happened incredibly quickly.

17 His first reaction was to freeze. He described the
 18 picture as one of carnage. He did not remember hitting
 19 the side of the bus, but he had tried to slow the bus
 20 because he could see that it was going to run over
 21 Aysha. He thought the Hyundai had been travelling at
 22 about 40 miles an hour. It felt to him as if it was
 23 accelerating and the loudness of the impact gave him
 24 that impression. Then he was aware that the bus ran
 25 over Aysha. This was very close to him, perhaps 6 foot

1 away. He saw it and heard the sound. Aysha was
 2 face-down with her upper body under the bus.

3 He used his phone then to contact the emergency
 4 services. He wanted to help Aysha, but he knew it was
 5 too late.

6 Another man, Robert English, picked up Aysha's phone
 7 from the road. The phone had rung and he answered it
 8 and it was John, Aysha's husband.

9 Richard Webb—Stevens is a motorcycle paramedic based
 10 at Waterloo ambulance station. At 14.42 he received
 11 a text message, saying "Westminster Bridge RTC". As
 12 a motorcycle paramedic he gets sent to a job and the
 13 ambulance comes to support him. He and another
 14 colleague were both being sent to one call.
 15 Mr Webb—Stevens is also a HEMS paramedic. It seemed to
 16 him that they were both going to the call, and he
 17 deduced that he was going as a HEMS paramedic to give
 18 support to the patients and ambulance crews on the
 19 scene.

20 When he arrived on the bridge he was trying to get
 21 an overview of what had happened. En route he had his
 22 first manual message to the effect that it was an RTC
 23 with multiple casualties. He could see the police
 24 running to the south side. He could see it was
 25 a significant job that was brewing. He spoke of the

1 advantage of being on the helicopter in the HEMS crew,
 2 that you have the massive advantage of seeing the scene
 3 from a good height. It might be an error, he said, to
 4 run for the first patient, so he tried to give himself
 5 a few seconds to have that overview. He could see where
 6 Leslie Rhodes was, another group of people to the left
 7 of him, and Aysha underneath the bus.

8 He stopped at Leslie first. He stayed on his bike
 9 and shouted out to each group, because all the
 10 casualties were either sitting down or lying down and
 11 being tended to by members of the public. He was able
 12 to get a visual on their faces and to see if they were
 13 breathing and conscious. He asked each group in turn if
 14 the patient was conscious and breathing. He then
 15 carried on further onto the bridge.

16 He identified Leslie as a priority 1 patient. He
 17 could see that he had multiple injuries. He then made
 18 his way to the bus where Aysha was lying. He also
 19 needed to get an overview of her. He felt that if he
 20 was to stay with one patient, he would have lost the
 21 initiative. He noted other casualties as he rode to the
 22 bus.

23 At the bus he could see that Aysha was pinned by two
 24 wheels at the back of the bus. He rode along, and
 25 although the bus was pretty low he could see, he said,

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1 some brain matter just beneath the bus. He was
 2 convinced that Aysha was dead. Aysha was lying on her
 3 front and was not giving any opportunity to ventilate.
 4 He sought to ascertain if the driver was still in the
 5 bus and if there was any damage to the bus as part of
 6 trying to piece together what had happened.

7 He tried to communicate with a group of Korean
 8 tourists who were looking into the river. They didn't
 9 speak English. He also found four other casualties with
 10 broken limbs and head injuries and then did an initial
 11 report to the HEMS control desk to update them.

12 He formed the view that sadly he could do nothing
 13 further to help Aysha. Had he seen any sign of life or
 14 any prospect of saving Aysha, he would have treated her
 15 by carrying out resuscitation, but based on the injuries
 16 he saw, which were unequivocal, and which were
 17 absolutely incompatible with life, he decided not to do
 18 any further assessment or treatment and went to the help
 19 of others.

20 He made his way to where the Hyundai had crashed
 21 into the perimeter wall where he found a young French
 22 teenager conscious and bleeding with limb fractures and
 23 external head injuries. Next to him was another French
 24 child with the same pattern of injuries and an Italian
 25 lady with injuries. Members of the public or a doctor

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1 were tending to all of those he saw.

2 When he saw the damage to the Hyundai he thought it
 3 was a terrorist attack. In his view, this was
 4 a deliberate act, that he had run all these people over
 5 and made further contact with the control room to report
 6 to them what he had seen and what he believed was now
 7 a major incident and probably a terrorist attack. He
 8 was told to change his radio channel, consistent with
 9 this now being a major incident.

10 He noted that at 14.47 he was clear in his own mind
 11 that Aysha was dead. At 14.53 he confirmed this to
 12 a police officer and a blanket was placed over Aysha at
 13 14.48.

14 In normal circumstances with a single patient,
 15 a blanket would have been placed sooner, but as the
 16 emergency services were dealing with so many casualties
 17 he said it didn't happen.

18 Mr Patterson asked him about the HEMS team. He was
 19 aware of the arrival of the HEMS team. As to a second
 20 HEMS team he said he thought that was pretty unlikely.
 21 They have one team operating every 12 hours and that is
 22 a team of a doctor, a paramedic and a consultant. In
 23 the event of a major incident or multiple casualties,
 24 other paramedics or doctors who may be at the hospital
 25 in operation can declare themselves as a second team.

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1 He said it was not something you can do every 24 hours,
 2 but he was told that in this situation there were
 3 a couple of paramedics and doctors that were able to
 4 form such teams.

5 Having said that, he said, by the time they had been
 6 dispatched and arrived at Leslie Rhodes, Gary Moody had
 7 already left the scene and done the right thing. Had
 8 a second HEMS team landed, they would not have been able
 9 to do so in such a timely fashion as Gary Moody had
 10 already made his way to hospital with Leslie.

11 PC Kirsty Bambrough was also by Aysha. She arrived
 12 at 14.54. A doctor from St Thomas' was with Aysha at
 13 that stage. The doctor was looking for a pulse and
 14 holding Aysha's wrist. The officer spoke to
 15 a Mr Yacine Alouia who told her what had happened to
 16 Aysha. The doctor looked at Aysha after she arrived.
 17 She too saw the horrific injuries to the face and the
 18 head. She looked into the handbag to seek to identify
 19 Aysha and found a letter with the name of the school on
 20 it and made the decision to contact the school to inform
 21 them of the accident. PC Kirsty Bambrough remained with
 22 Aysha until 5.20.

23 Dr Colleen Anderson is a medical doctor.
 24 In March 2017 she was based at St Thomas'. She had
 25 qualified for about eight or nine months in clinical

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1 practice. She was in an office overlooking
 2 Westminster Bridge that afternoon. A colleague ran past
 3 her at about 14.30 and said they needed to go out and
 4 help or alert A&E to get things moving.
 5 Her colleague told her that someone had driven along
 6 the bridge. From what he said it didn't sound like
 7 an accident. When she, herself, looked out at the
 8 bridge it was at a standstill and people were attending
 9 to people lying in the road and there was a lot of mess
 10 and the postcard stand. She came to the bus and saw the
 11 body covered in a blanket. It was 14.53.30 when she
 12 arrived there. She made some checks of Aysha. It was
 13 obvious to her that the injuries were incompatible with
 14 life. She then went to aid another with serious
 15 injuries, Police Constable Kris Aves, before returning
 16 to her duties at St Thomas.
 17 Dr Fegan—Earl carried out a post mortem examination
 18 on Aysha on 25 March 2017. When he carried out his
 19 external and internal examinations, he noted significant
 20 head injuries and then a further distribution of
 21 injuries over the body and, in particular, the lower
 22 limbs. There was a catastrophic head injury to the
 23 upper part of the scalp, the top of the skull,
 24 a devastating and unsurvivable head injury.
 25 On the internal examination, he noted multiple

1 fractures of the bones of the face, fractures across the
 2 base of the skull and a major crushing injury to the top
 3 of the skull.
 4 When he examined the cardiovascular system he noted
 5 that the heart had torn away from the major blood vessel
 6 and had been pushed down into the abdominal cavity. In
 7 his opinion, that was a devastating injury in itself.
 8 There were fractures to both right and left—sided ribs
 9 and an injury to the seventh vertebrae which was
 10 disrupted very significantly. That is an injury of
 11 a substantial area of bone which he said required
 12 significant force.
 13 In his opinion, Aysha had died as a consequence of
 14 violence. There were multiple injuries and death would
 15 have been near instantaneous, and in his view without
 16 suffering.
 17 The most crucial injuries were those to the head,
 18 which are entirely consistent with her having been
 19 projected beneath the wheels of a bus. Dr Fegan—Earl
 20 considered the findings of his examination, and the CCTV
 21 material, and said there were features in keeping with
 22 primary impact to an upright individual, probably to the
 23 left side, given the fracture patterns.
 24 He agreed that in the moments before impact she had
 25 been using her phone and appeared to be completely

1 unaware of what was about to occur. The impact caused
 2 Aysha to be violently projected, ultimately beneath the
 3 wheels of a bus. Whilst it was not possible to state
 4 definitively whether Aysha would have suffered fatal
 5 injuries from the impact alone, as it was not possible
 6 to conduct neuropathology, it is, however, his view that
 7 there is a distinct chance of fatality given first of
 8 all the speed of the vehicle that he had viewed,
 9 comparing that type of impact with his experience with
 10 other road traffic collisions which have proved fatal
 11 without the subsequent projection beneath the bus.
 12 He also noted the evidence of contact between the
 13 windscreen of the vehicle and Aysha's head. The formal
 14 cause of death was head injury and chest injury. His
 15 view was that the death was instantaneous and that Aysha
 16 did not suffer. He had a high suspicion she would have
 17 died had she not even been thrown under the bus. It
 18 would have been obvious on even the most cursory view of
 19 Aysha's head injury as she lay under the bus that she
 20 was dead.
 21 Aysha's sister, Michelle, spoke for herself and her
 22 and Aysha's other sister, Silvia, about the loss of
 23 their dear sister. Aysha's husband John also spoke
 24 movingly about the loss of his beautiful wife. His
 25 statement covered the many aspects of Aysha's life and

1 the impact on him and their two daughters of their loss.
 2 As with all of the others on the bridge, her full life
 3 was tragically cut short.
 4 Andreea Cristea. Andreea was on Westminster Bridge
 5 with her boyfriend Andrei Burnaz. They were
 6 sight—seeing. They were walking across
 7 Westminster Bridge. They were a short distance apart
 8 when the Hyundai came towards them. Andreea was
 9 stopping on occasion to take photographs with her phone.
 10 The car hit Andreea, and such was the force of the
 11 impact that she was thrown into the air over the parapet
 12 of the bridge and into the River Thames.
 13 PC Clark put the speed of the Hyundai at that point
 14 of impact, albeit from CCTV footage with a long view, at
 15 between 28 and 36 miles per hour. Andreea entered the
 16 water at 14.40.22. She fell from a height of more than
 17 12.5 metres, that being the distance between the water
 18 level and the top of the balustrade.
 19 The current in the Thames then pulled her along to
 20 the east. A tourist clipper boat, the Millennium
 21 Diamond, was close by. Andreea was carried a distance
 22 of approximately 100 metres and was in the water for
 23 a likely total of little more than five minutes before
 24 she was recovered by a London Fire Brigade boat, the
 25 Fireflash.

1 Michael Brown made a 999 call to report that a woman
2 was in the river and was drowning. Andreea was brought
3 to the side of the Fireflash boat at 14.43.33.

4 Andrei Burnaz explained that he and Andreea were in
5 London on holiday. They had arranged to meet someone at
6 the London Eye at 14.30. They had arrived in
7 Westminster early on and visited the Abbey and then
8 walked across Westminster Bridge towards the south bank.
9 The bridge was quite busy with pedestrians. They
10 stopped to take pictures. He became aware of screaming
11 and noises in front of him. After that he heard a loud
12 bumping and something hit something else.

13 In front of him he saw a car zigzagging between the
14 pavement and the cars that were stopped for traffic. He
15 saw the car come towards them. It was very quick, and
16 he felt a burning sensation on his foot as the car
17 passed over it, and then another banging and the car hit
18 Andreea.

19 At the point of impact there was between 8 to
20 10 metres between him and Andreea. The car was damaged
21 to the front. After the car passed, he looked to his
22 left to find Andreea but couldn't see her. The last
23 time he had seen her, she was to his left, but was now
24 nowhere to be seen. He went to both sides of the bridge
25 and was running about frantically looking for her. He

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1 ran towards the car to see what had happened as he
2 thought she was struck by the car and may be stuck
3 underneath it.

4 As he ran to Parliament Square, he saw people on the
5 pavement, some covered in blood and pools of blood
6 everywhere. He tried to explain to a police officer he
7 saw as to what had happened. The officers were trying
8 to clear the area. He then tried to call Andreea on her
9 phone, and it was ringing and he thought that was
10 a positive sign. He then found her phone and her
11 glasses in a pool of blood. They were close to where
12 they had been standing when the car went past them.

13 He looked again into the river and he then called
14 Andreea's family and spoke to Magda, her sister, and
15 told her what had happened. At one stage he thought
16 about jumping into the river himself, but he continued
17 with his search and with making calls to the family.

18 He spoke to a police officer near to a hotel. He
19 said that the car had hit his girlfriend and that she
20 was in the river, and the officer took his details.
21 This was about 15 minutes after the point of impact. He
22 waited at the south bank hotel for some time. He
23 received a call from Andreea's sister and was told that
24 they had found Andreea and that she was in
25 St Thomas' Hospital. He was taken to King's College

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1 Hospital for his own injury and whilst en route was told
2 that Andreea had been moved to the
3 Royal London Hospital.

4 After he had been treated, he was taken to where
5 Andreea was being cared for. He spoke about some of
6 what he said to others at the time as being a response
7 to being in shock over what had happened.

8 Michael Brown was driving his van across
9 Westminster Bridge at the time of the incident. He was
10 about halfway across the bridge when he heard a loud
11 bang. At first he thought something had hit a bus. He
12 looked towards the direction the sound came from and saw
13 a vehicle driving forwards on the opposite pavement. It
14 was hitting people as it drove along the pavement and
15 people were being flung everywhere across the road.

16 He saw the vehicle hit Andreea. She was thrown
17 about 10 feet into the air and she came down into the
18 Thames. She spun over and over and straight into the
19 water. At first he said he didn't register what had
20 happened, but he did a U-turn, jumped out of his van and
21 was looking over the side of the bridge into the water.
22 He called 999 and, whilst doing so, ran to both sides of
23 the bridge looking for Andreea. His call was made at
24 14.41.

25 On the east side of the bridge he saw Andreea

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1 floating face—down in the water with her arms
2 outstretched. She wasn't moving but the current was
3 carrying her downstream. There was a pool of blood
4 around her. There was a boat to his left just pulling
5 out from the pier, and he began to shout to the man in
6 the front of the boat to get his attention. He was
7 shouting and screaming at those on the boat. His calls
8 were acknowledged. There was a smaller boat too and he
9 saw it had pulled up next to the side of the bigger
10 boat. He thought they were going to save her. He then
11 went to the assistance of others.

12 On his 999 call he had spoken of a number of 20
13 people that had been knocked over.

14 Danny Cooper was the captain at City Cruises. He
15 was the mate on board the Millennium Diamond operated by
16 City Cruises that day. He holds a fully endorsed
17 boatmasters' licence. Gordon Markley, another captain,
18 was also on board and was the captain of the boat that
19 day. There were also three cabin crew aboard.

20 They have a man overboard procedure to be followed
21 in the event of somebody going over the side of a boat.
22 That involved the use of a grab net, or a ladder, so
23 that somebody could climb up to the side of the boat,
24 but there was no specific procedure as to what they do
25 if they found someone in water unconscious.

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1 He had come across such a situation on two or three
2 other occasions. Smaller boats are used. He said he
3 had no experience of getting an unconscious person onto
4 the side of a boat such as this.

5 They were due to leave Westminster Pier at 14.40.
6 When they left, he was unaware of anything untoward.
7 They left the pier and started to turn to port to turn
8 south towards the south bank pier. He was at the helm
9 in the wheelhouse.

10 5 or 10 metres off the pier he noticed what looked
11 like a pile of bags or some garbage coming through the
12 third arch of Westminster Bridge. He and Gordon Markley
13 questioned it, and then they heard and saw Mr Brown
14 looking down at them, waving and screaming. He was
15 shouting there was someone in the water. Initially they
16 still thought it may be debris. They decided they would
17 go and hold onto it or collect it. As they got closer,
18 it was clear it was a body. He was driving the boat and
19 Mr Markley went to get the boat hook. He moved from the
20 wheelhouse to the controls in the open air to get
21 a better visual. There was a call that came out on the
22 radio confirming a body in the water.

23 He saw that Gordon Markley had got hold of the body.
24 This was at or about 14.42.39 that Mr Markley had hooked
25 Andreea's clothing. There was a lot of blood that

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1 filled the water around her. As he looked down he said
2 to Gordon not to move her too much. At the time they
3 didn't know how long she had been in the water. It was
4 physically impossible to pull somebody up with
5 a boat hook, although a natural reaction is to pull
6 and tug, by doing so he was concerned that bits of the
7 body would have been coming up. It was impossible to
8 pull someone up with a boat hook, as there was simply
9 too much of a gap.

10 They also had a lot of people sitting around the
11 edges of the boat and if the body had been in the water
12 for a long time it would not have been very nice for
13 anybody involved, particularly the children sitting
14 downstairs. At that stage it did not occur to him that
15 this body had only just gone into the water.

16 He saw the fire boat coming towards the Millennium
17 Diamond and they manoeuvred to come and collect the
18 body. There was a transfer between the two boat hooks.
19 The transfer took place at 14.44.27. The fire boat was
20 fitted with a Jason's Cradle that can be used to roll
21 something up the side of the boat. The transfer took
22 place in seconds and then the fire boat went fast to the
23 lifeboat station.

24 A police boat then approached them to collect
25 a certificate that Gordon pulled from the water. It had

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1 somebody's name on it and they thought it might help
2 with identification. He did not think it would have
3 been possible to get Andreea out of the water more
4 quickly or more safely in the conditions and
5 circumstances.

6 He had heard Mr Brown calling out from the bridge.
7 There were many voices calling out that could be heard
8 on the CCTV footage from the Millennium Diamond, and
9 that was played in court. Also captured on the
10 recording is Gordon Markley saying he didn't know if it
11 was a wind-up. Mr Cooper explained that it was
12 something they'd had before with people screaming off
13 bridges and it had proved to be nothing.

14 Andreea had been hooked about two minutes after she
15 had gone into the water. He was able, he said, to see
16 a tattoo on the lower back of the person, but he
17 couldn't know that it was obviously a woman at that
18 stage. He reiterated it would have been physically
19 impossible for Mr Markley to have pulled someone up from
20 the distance the body was from the deck. The gap
21 between the deck and the waterline is just over 5 foot.
22 They didn't know what condition the body was in and had
23 Gordon started pulling it, he may have been pulling up a
24 dismembered body.

25 Although the body might only have weighed 11 stone

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1 and the person 5 foot 5 in height, it would not have
2 been possible for one or two of them to have used the
3 15-foot boat hook to lift her out of the water.

4 He had assumed the body had been in the water for
5 a long time because the only bodies he had seen had been
6 face-down and unconscious and in the water for a few
7 days. It did not occur to him that the body had just
8 fallen from the bridge.

9 He explained that the tide pushes bodies up and down
10 all day and nobody sees them and so the initial reaction
11 was that somebody had seen a body on the other side of
12 the bridge, they'd come and tell them on this side. The
13 blood around the body, he said, did not suggest a recent
14 impact to him. He thought it may have been hit by
15 a propeller. He assumed the body had been in the water
16 for a while as it was unresponsive. If someone had just
17 fallen in, there is a lot of noise, but with this, there
18 was nothing. The attempt not to move her out of the
19 water was because they didn't want pieces of the body
20 coming up. There was no way that Gordon could have
21 pulled her up to administer first aid.

22 Both he and Gordon Markley were first aid trained.
23 He knew that the longer someone was immersed in water,
24 the greater the impact it will have on their health, and
25 he had training as to what to do in emergency situations

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1 such as when someone goes overboard and needs to be
2 brought back onto the vessel. Again he repeated it
3 would not have been possible to get her onto the vessel.
4 Had they been able to do so, they could have given
5 her resuscitation. The man overboard situation set out
6 in the City Cruises manual was based, he said, on a
7 conscious casualty that wants to get out of the water,
8 the person can pull themselves up to a grab net or the
9 man overboard ladder. What they had done here was to
10 stop, he said, the body disappearing.

11 Mr Hough, I'm going to pause there and we will
12 resume at 2.05 pm.

13 MR HOUGH: Yes, sir.

14 (1.04 pm)

(The Luncheon Adjournment)

16 (2.05 pm)

17 THE CHIEF CORONER: Gordon Markley has been a captain on the
18 Thames for over 20 years, and also holds a boatman's
19 licence. He knew of the company procedures for someone
20 going overboard. They had a rope net which could be
21 lowered over the side of the vessel, which will enable
22 a person to cling to it, and a ladder which you could
23 hang over the side supported onto the boat which you
24 could assemble yourself and go down to the water level
25 to retrieve a person. They had both items on board on

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1 22 March. He was the senior captain of the vessel that
2 day.

3 As Danny was manoeuvring the vessel from the pier he
4 heard a person shouting from the bridge. Their
5 attention was drawn to something and then they realised
6 there was someone in the river and they jumped into
7 action. He ran down to grab the hitcher, a boat hook,
8 to try and get hold of the body in the water and to give
9 assistance. A boat hook two-thirds of the actual one
10 was brought to court so that I could handle it to gauge
11 the weight of it.

12 Mr Markley saw the body coming through the bridge.
13 He was unaware of the situation that had arisen on the
14 bridge and presumed it was a body in the river. His
15 first instinct was to get hold of the body rather than
16 it floating off with the tide. There were no signs of
17 life.

18 Coming across bodies in the river is not something
19 they see every day, but he had experience of it many
20 times. He had been fortunate to save lives, but in
21 those cases they have seen movement and given
22 assistance, thrown lifebelts to people, but in this case
23 there was no sign of life until the body had got quite
24 close to him, and he was able to grab hold of some of
25 the material and could see there was a lot of blood

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1 coming from part of the body. This is when he realised
2 there was something more on there but still, he said, no
3 signs of life. There was no indication that the person
4 was alive.

5 With the hitcher he grabbed part of the clothing to
6 hold the body near to the boat. He and Mr Cooper were
7 trying to manoeuvre the body away from the propellers of
8 the boat. The tide was pushing the boat away from the
9 body and so Mr Cooper had to manoeuvre the boat to get
10 near to the body so that he could get a hold on it and
11 with a vessel of that size he said Mr Cooper did a great
12 job. The vessel was some 33 metres long and 14 metres
13 wide.

14 He hitched part of a rucksack he could see Andreea
15 was wearing. He then pulled her to the side of the
16 boat, awaiting assistance. He had not considered the
17 possibility of using the boat hook to lift her body out
18 of the water and bringing her onto the boat. His
19 opinion was to leave her there in that position rather
20 than causing any further injuries. Lifting the weight
21 of a body might cause a spinal or neck injury. He was
22 still presuming it was a dead body, but as it got
23 closer, there was a vast amount of blood swirling
24 around, which he thought was unusual, but he said this
25 was all over in about a minute.

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1 Although he began to harbour doubts about whether
2 this was a dead body and whether it might be someone who
3 was alive, there was no way in his position with the
4 boat hook that he could have got the person onto the
5 boat safely. The clothing might have torn or the piece
6 of strapping on the rucksack may have torn. If he had
7 lifted the body from the water onto the side of the boat
8 it is approximately a metre and a half lift and to pick
9 a body of that weight up that far he thought would have
10 caused more damage.

11 With the boat hook he would not have been able to
12 lift an 11-stone body with a person wearing water-logged
13 clothing. He saw assistance coming immediately. He saw
14 a police launch and then a fire launch within seconds.
15 Both vessels approached and they ushered the fire launch
16 to them. He walked the body to the front of the boat,
17 keeping it clear of the propellers and then handed the
18 body to those on the fire launch. It was about 20
19 seconds from him releasing the boat hook to the fire
20 launch using the cradle and getting the body on board.
21 The launch then moved immediately to the pier to hand
22 the body to the emergency services.

23 He was just about to release Andreea, pass her to
24 the fire launch, when it looked as if a certificate had
25 come out of her rucksack. He quickly released her,

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1 harpooned the certificate , flicked it onto the deck and
2 still had time to get back hold of the rucksack strap
3 and pass her body to the fire launch.

4 In a report he filed later he set out the person was
5 probably not alive as there were no signs of life that
6 he could see. He had also put on the report that
7 a reason they had not retrieved the body was as it
8 appeared dead, bloodied, and they had a boat full of
9 children. To bring the body on the boat with that
10 amount of passengers on board would have been
11 distressing. Trying to retrieve the body with a boat
12 hook on his own whilst another crew member was
13 manoeuvring the boat would be endangering his own life
14 and if something had happened to him, if he went into
15 the water, then he would be leaving the boat with his
16 colleague alone.

17 He hooked Andreea at about 14.42.39. About a minute
18 later the Fireflash was in view. At 14.43.48 he had
19 used the boat hook to retrieve the certificate , and at
20 14.44.28 he was transferring Andreea to the Fireflash .
21 He didn't think they could have done that manoeuvre and
22 the transfer any quicker.

23 Mr Markley was asked about a statement he had made
24 to his employers on the day of the events. He had given
25 explanations about why he had not pulled the body on

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1 board. He had not included the explanation about his
2 fear of injuring Andreea. He explained that when he had
3 written that statement he had presumed the body was
4 a dead body. It wasn't until later on that he had been
5 informed that Andreea had been taken to hospital and was
6 still alive .

7 He agreed with Mr Patterson that the voices calling
8 from the bridge had a sense of urgency to them, but he
9 had not considered getting the man overboard ladder as
10 that would have been quite time consuming. By the time
11 he had got the ladder, the body would have floated away.
12 He would have needed to put the ladder into position,
13 and it was not for him to go down to, but for someone to
14 assist themselves out of the water. Again, he said had
15 he seen signs of life , he would have gone down a few
16 steps towards water level. Had there been no other
17 assistance with them around in the sense of smaller
18 boats, then he would have taken other steps. But with
19 the emergency services there on hand, what did get
20 carried out was far quicker than anything else .

21 He accepted that with the benefit of hindsight that
22 he would have loved to have been able to have gone down
23 into the water and tried at least to raise her face to
24 see what state she was in and whether she might have
25 started breathing. He said that what he had done at the

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1 time he thought was appropriate.

2 Thomas Wolfe was the watch manager of the white
3 Watch at Kensington with the London Fire Brigade on
4 22 March. He was on the Lambeth Fireflash. For him it
5 was the first time on a fire boat. They had just passed
6 under Westminster Bridge when they got an emergency call
7 to a person in the river. The crew turned the boat
8 around immediately and went towards Westminster Bridge.
9 It took just three minutes to get there.

10 He saw Mr Markley with a boat hook holding something
11 in the water. As they got closer he saw it was
12 a female, motionless, not showing any signs of life in
13 the water. Her arms were out and legs were going down
14 into the water. The body was transferred to them.

15 There were a lot of children on the Millennium
16 Diamond filming it and watching. The casualty was
17 retrieved from the water using the cradle. It was
18 a very quick process, under a minute, and perhaps 30
19 seconds. As soon as the cradle came up and the body
20 rolled over he saw signs of life . He and the crew set
21 to work immediately. He had an emergency care pack. As
22 she was turned from face-down to face-up there was
23 a short cough and a spurt of water came out. He noted
24 that Andreea had a large head injury on her left side.
25 She was not conscious. He removed her upper clothes so

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1 that they could put the defibrillator on and start using
2 oxygen.

3 Although he could not hear the commands from the
4 defibrillator , that did not hinder the administration of
5 first aid. They checked her airway, her breathing and
6 circulation . He found a pulse and so they didn't
7 actually need to use the defibrillator . Although the
8 pulse was weak, as they moved it was gradually getting
9 stronger. Her eyes were open and he noted one pupil was
10 a lot larger than the other. He estimated it was about
11 five minutes to the Tower Pier RNLI station, but it may
12 have been only two. It was all happening very quickly.
13 They were talking to her and trying to get a response,
14 letting her know that they were doing the best they
15 could for her. He saw her eyes moving. She started
16 breathing more and as the pulse got better, her eyes
17 opened up and he could see her eyes moving around.
18 Andreea was then handed over to the ambulance staff.

19 Joanne Fant is an ambulance technician. She was
20 contracted to the East of England Ambulance Service
21 in March 2017. She and a colleague had transferred
22 a patient from Basildon Hospital to the Chelsea and
23 Westminster Hospital and had been assigned to another
24 job in Chelmsford and so they were making their way
25 there through Central London when a fireman flagged them

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1 down. She was told they had got a body out of the
2 water. He told her more of what had been going on. She
3 asked for as much detail as she could about the body and
4 how long the person had been in the water.

5 She contacted her controller to make contact with
6 the East of England and also to ask for more back-up.
7 She then went to the jetty. She was briefed by those
8 with her and they could see a serious head injury. The
9 packing on the head wound was very bloodied. The left
10 pupil was dilated because of the injury. Her face was
11 very distorted from the impact, which may have indicated
12 a blown eye socket. Andreea was put in the ambulance
13 and she continued to make observations and to provide
14 care for her.

15 Andreea was wrapped in foil blankets to restore her
16 temperature and they were looking at putting in
17 an airway but she started choking. There were two other
18 paramedics with her on the ambulance and they travelled
19 to the Whitechapel hospital. As they did so, her
20 condition was deteriorating because of the amount of
21 blood and fluid she was bringing up. Both pupils had
22 dilated by this stage and from the volume of fluid that
23 was coming up, they thought she had been in the water
24 quite some time.

25 Andreea was given oxygen and an ECG was being used

1 to monitor her heart. The head injury required constant
2 rebandaging. At the hospital Andreea was taken to the
3 resuscitation area. Some blood Andreea coughed up went
4 into her eye, and so Ms Fant was admitted to A&E
5 herself.

6 Dr Samy Sadek is a consultant in emergency medicine
7 based at the Royal London Hospital. He had overseen the
8 care of Andreea after she was brought in by ambulance.
9 They were given a full history of the incident and
10 a full handover. It was clear on the immediate initial
11 assessment that Andreea had a significant head injury.
12 She had a facial injury, bleeding from both the head and
13 face, she was pale, she was in respiratory distress, she
14 was struggling.

15 Although Andreea was breathing for herself and
16 generating occasionally good or adequate oxygen levels,
17 she was working very hard to achieve that. The first
18 critical intervention was to assess and look after her
19 airway. They thought there was a primary lung injury
20 which they later found out was likely due to water
21 submersion.

22 Andreea was an extremely complex patient. She had a
23 number of very, very severe injuries and issues at play,
24 one of which, that she was hypothermic and that she had
25 lost a lot of blood. A neurological assessment was

1 made. Her Glasgow Coma Scale reading was 3, the lowest
2 possible score. A chest x-ray showed quite diffuse long
3 shadowing on both lung fields through her lungs. They
4 intubated and ventilated Andreea. A set of CT scans
5 were also carried out. Andreea's skull was fractured.
6 It was quite an extensive skull fracture, extending from
7 the side down to the base. There were quite complex and
8 severe facial bone fractures.

9 She had the appearances of an injured brain. Scans
10 led to a series of interventions. They had difficulty
11 in maintaining ventilation to achieve good oxygen and
12 carbon dioxide levels. They got to the stage where it
13 as felt the only option was to put her on a lung and
14 heart bypass machine. That decision might involve
15 a move to Bart's Hospital, but the emergency ECMO team
16 came from Barts to them as Andreea was too unwell and
17 too unstable to be moved.

18 At 18.40 on 22 March, the intensive care team and
19 the ECMO team took over her care.

20 Dr Anthony Bastin is a consultant in critical care
21 based at Bart's. Andreea was transferred to Bart's on
22 23 March and Dr Bastin was involved in her care from
23 then through to 6 April 2017. It was hoped that the
24 ECMO support may be able to improve the oxygen levels
25 and improve her carbon dioxide levels to improve the

1 conditions in an attempt to improve her recovery overall
2 and specifically from her brain injuries.

3 Andreea underwent a neurosurgical procedure to
4 remove blood from around the brain at the Royal London
5 and was then transferred so that the ECMO support could
6 be carried out at Bart's, which has the appropriate
7 input to do so.

8 Over the period from 23 March to 6 April, there were
9 some positive signs as well as some negative signs.
10 Dr Bastin said it was clear to all from the outset that
11 Andreea's injuries were very severe — the extent of the
12 intracranial injuries and the degree of injury to her
13 lungs and the fact that she was requiring a lot of
14 support in the intensive care unit to keep her alive.
15 They were in no doubt about the likelihood of her
16 surviving the injuries was low, but nevertheless at the
17 early stage, and certainly in the first few days, they
18 could not be certain of the impact of the injuries on
19 her life later on, which is why they continued at that
20 stage.

21 Despite the concerns about the poor prognosis, they
22 were doing all they could to ensure that if Andreea did
23 survive, she would have had as few ill effects as
24 possible.

25 Andreea's condition deteriorated in early April and

1 following a detailed review by Professor Uff,
2 a neurosurgeon, it was decided that as her condition had
3 deteriorated to the point that it was no longer likely
4 that she would survive the injuries, they should switch
5 from an active approach to an approach aimed at
6 palliating her condition and providing comfort and care.

7 On 6 April, brainstem death testing was carried out
8 which confirmed brainstem death and the family who had
9 been updated throughout the process and who were there
10 with her throughout that day and were at her bedside,
11 all other support was withdrawn and she died at 15.11 on
12 6 April 2017.

13 Dr Bastin made clear that the overriding cause of
14 death was the brain injuries. The problems from
15 immersion in water and the lungs contributed. Whether 2
16 minutes or 6 minutes in the water would have made any
17 difference to Andreea's outcome, he thought it unlikely,
18 but he couldn't be sure. It certainly would not have
19 worsened things.

20 Dr Fegan—Earl conducted a post mortem examination on
21 Andreea on 10 April 2017. In both his external and
22 internal examinations, he noted evidence of head injury
23 and lower limb injury. He noted double black eyes, not
24 from direct injury, but as a consequence of major
25 fractures to the base of the skull. There was an injury

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1 to the left side of the skull. There were multiple
2 other injuries to shoulder and upper arm, the front of
3 the chest, pelvis, lower part of the abdominal wall,
4 lower limbs and right buttock. The internal examination
5 showed evidence of fractures passing across the base of
6 the skull. That is a thickened area of bone and so the
7 fracture is evidence of application of high levels of
8 force. This was Andreea's only bony injury. From
9 a neuropathological examination, Andreea was said to
10 have suffered a severe traumatic brain injury amounting
11 to diffuse axonal injury, the same injury he had
12 observed in Leslie Rhodes.

13 Dr Fegan—Earl's examination continued to the
14 respiratory system where he noted evidence of pneumonia
15 which he said is an extremely common terminal finding in
16 patients who have suffered from a significant head
17 injury. In Andreea's case, she was further vulnerable
18 to pneumonia on account of the time she spent underwater
19 and the water which she accordingly inhaled.

20 In conclusion, Dr Fegan—Earl gave evidence that
21 Andreea died as a consequence of an act of violence.
22 She sustained serious head injuries, a conclusion he
23 reached based on the neuropathology and a review of
24 Andreea's medical notes.

25 That head injury rendered her immediately

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1 unconscious. The skull injuries were most consistent
2 with the impact from a vehicle, which Dr Fegan—Earl
3 contrasted with injuries that might have been caused by
4 one falling into water from a height.

5 He concluded that it's highly likely that Andreea
6 would have died irrespective of whether she had entered
7 the River Thames. The injury is likely to have rendered
8 Andreea unconscious which subsequently made her more
9 vulnerable to the inhalation of water, having been
10 thrown into the river, then being unable to swim. The
11 combination of prolonged increases in intracranial
12 pressure and changes in the lungs due to her immersion
13 in the river caused her major organs to fail.

14 The pathologist was asked a number of questions
15 relating to the survivability of Andreea's injuries in
16 various hypothetical situations. He suspected that she
17 would not have survived had she been recovered from the
18 water 2 or 3 minutes earlier. Likewise, had Andreea
19 been attended to by a more specialist team, such as
20 HEMS, the pathologist did not consider that this would
21 have given Andreea a chance of survival. The
22 pathologist supported these opinions by reference to
23 Andreea's diffuse axonal injury. The cause of death was
24 given as 1(a) multiple organ failure due to 1(b) head
25 injury (operated) and immersion.

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1 A recording was played in court setting out the
2 detail of Andreea's life. The narrator on the recording
3 was Magdalena Toi. The recording traced Andreea's life
4 in Bucharest, through to her interest in fashion, her
5 meeting Andrei and their travels together, including
6 this visit to London. As I've said before, but repeat
7 here, another young life cut tragically short.

8 I am grateful for those who organised the link from
9 this courtroom to the British Embassy in Bucharest for
10 some days of these Inquests so that Andreea's family
11 have been able to follow these proceedings.

12 Keith Palmer. After Masood's vehicle had struck
13 Andreea and those near her, it drove back onto
14 the roadway before it went into the pavement for a short
15 distance, manoeuvred around a set of traffic lights and
16 then back onto the road. At that point, hostile vehicle
17 mitigation barriers are in place and so the car drove
18 around those before it was driven straight into the wall
19 surrounding the Palace of Westminster. It struck the
20 wall at 14.40.38. There was a group of pedestrians in
21 the road at that point. The car struck a number of the
22 pedestrians and the car sustained heavy front impact
23 damage.

24 Masood remained in the car for approximately
25 10 seconds, then the driver's door opened, Masood came

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1 out armed with two knives. He then ran around the
 2 perimeter of the Palace and encountered police officers
 3 at the north of the two vehicle Carriage Gates entrance
 4 to New Palace Yard. There were pedestrians on the
 5 pavement as Masood was running along. They were all
 6 running to keep out of his path.

7 PC Keith Palmer was one of the police officers on
 8 duty in New Palace Yard that afternoon. He was
 9 stationed on the north of the two sets of Carriage
 10 Gates. As Masood went through the gates, PC Palmer went
 11 forward to challenge him. It was an extremely brave
 12 thing for him to do. It was clear that he was
 13 fulfilling his job of protecting the Palace and those
 14 within it. Masood attacked PC Palmer, driving him
 15 towards the low wall around the grassed area in the
 16 yard. As Keith is stumbling, Masood continues to stab
 17 at him.

18 Another officer came forward and the distraction
 19 meant that Keith was able to get to his feet and away
 20 from the attack. Keith and the other officers run
 21 through the vehicles barrier in New Palace Yard, pursued
 22 by Masood. Masood passes a car on its way out from
 23 New Palace Yard and is then confronted and shot.

24 The attack on PC Palmer was ferocious. Masood
 25 stabbed Keith with two knives, one in each hand, causing

1 numerous stab wounds. There were multiple strikes at
 2 a time when PC Palmer was in an exposed position. It is
 3 clear to me that PC Keith Palmer acted with bravery. He
 4 did not shrink from his task of protecting those within
 5 the Palace of Westminster.

6 Carl Knight was on a 159 bus sitting upstairs. He
 7 saw Masood emerge from the Hyundai after it crashed. He
 8 saw a male pedestrian go to Masood and ask him what he
 9 was doing. Masood responded by saying "Fuck off, you
 10 don't want to mess with me". This was shouted
 11 aggressively and dominantly. As he shouted this, he
 12 raised his hands, showing a knife in each hand. The
 13 pedestrian immediately backed off, slipped off the kerb
 14 into the cycle lane, and ran away in the direction he
 15 came.

16 A little later, Mr Knight observed people motionless
 17 on the ground by the car. As Masood made his way to
 18 Parliament Square, Mr Knight also noticed a woman and
 19 child who said "Please don't kill me". Masood appeared
 20 to ignore her and his walk became a run. He ran past 15
 21 or 20 people and continued to the gates.

22 Mr Knight described it as follows:
 23 "It was as if there were no guards on the gate as
 24 the African male ran, still wielding the knives, into
 25 the garden area of the Palace. He made it 20 metres in,

1 approximately, running to his left. I then remember
 2 seeing a high visibility police officer. I'm not sure
 3 if he challenged the African male or exactly what he
 4 did, but they both began grabbing each other and then
 5 tumbling to the floor."

6 Mr Knight thought PC Keith Palmer was stabbed about
 7 five times before he managed to get away.

8 John Campbell was on a number 88 bus. He saw three
 9 or four stabs to PC Palmer by Masood. He described the
 10 knife having a very large blade of between 10 inches and
 11 a foot long.

12 Antonia Kerridge, then working as a senior
 13 parliamentary aide, working in the office on the third
 14 floor of Portcullis House, had an unobstructed view out
 15 to the Palace of Westminster and into Parliament Square.
 16 Just before 15.00 she heard a loud crashing sound.
 17 Although the windows are quite sound-insulated, it was
 18 loud enough that the crash could be heard in the office.
 19 She then heard what she thought initially was the sound
 20 of people cheering. She thought there had been
 21 a protest outside, but when she and colleagues went to
 22 the window they could see that the Hyundai had crashed
 23 into one of the pillars between the railings that go
 24 round New Palace Yard. There was a person under the
 25 vehicle, and another person lying on the pavement to the

1 right of where the car was, who was not moving and was
 2 bleeding. The driver's door was open.

3 She then realised that the cheering sound was people
 4 screaming. A colleague said there was a man with
 5 a knife in the street. Her attention was then diverted
 6 to the man with the knife. When she first saw Masood,
 7 he was by the corner before turning left. She could see
 8 that he was holding a knife downwards. He was moving
 9 quickly, but not sprinting. There were a lot of people
 10 in front of him running away from him to Parliament
 11 Square. He was lumbering, moving around and looking.
 12 He was waving the knife around.

13 When she looked back to the car, she could see that
 14 people were attending to the casualties around it.

15 She lost sight of Masood at the point of the
 16 confrontation by the gates. It was all happening very
 17 quickly. She next saw him at the Carriage Gates
 18 entrance. The police officers who had been at the gates
 19 had dispersed and he was chasing them into the area
 20 where cars would normally drive. She saw the police
 21 officer run forwards and then towards the left, and then
 22 the police officer collapsed just next to the barrier.
 23 She saw the attacker, Masood, went over the policeman,
 24 Keith Palmer, and started to stab him on the ground.
 25 She saw Masood raise the knife quite high and stab. She

1 couldn't say exactly how many stabs there were. She
2 mentioned three or four times. From where she was
3 stood, the blows seemed to be on the upper body and the
4 area of the yellow jacket he was wearing.

5 It came to an end when Masood moved away from Keith
6 on the ground and then turned and ran back towards the
7 right. Masood, having disengaged from Keith, still with
8 the knife in his hand, was looking around a lot, moving
9 quite quickly and looking for where to go next, heading
10 towards where the barrier is in front of Westminster
11 Hall.

12 She then saw a man in a grey suit run from the
13 restricted area where ministers would be dropped, draw
14 a gun and go towards the attacker. The attacker was
15 still moving forwards with the knife, waving the knife,
16 and the man in the suit then shot him two or three times
17 and the attacker fell to the ground.

18 The attack she had seen was violent and at times she
19 had looked away. Had Masood made it to the members'
20 entrance, he would have to pass through a number of
21 corridors and rooms before you could make your way
22 eventually to the chamber of the House. There are
23 a number of doors and people that would have been in the
24 path between the entrance and the chamber. The Prime
25 Minister and cabinet ministers have offices in the

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1 building and Prime Minister's Questions had taken place
2 that day at noon.

3 James West was attending an event in Portcullis
4 House. He was in room Q on the first floor. He was
5 stood close to the window that looked out onto
6 New Palace Yard. He saw the Hyundai crashed into the
7 railings on the pavement. There was a body on the
8 bonnet and a body on the pavement. A number of people
9 were stood around it and there was a cyclist, and he
10 initially thought there had been an accident with the
11 cyclist. He took a photograph of what he could see.

12 When he first viewed the scene, people seemed to be
13 going towards the vehicle to help the victims, but that
14 all changed quickly and they started running in the
15 opposite direction, at which point he noticed a man with
16 a knife. This man, Masood, was close to the car, moving
17 towards Parliament Square. He assumed he had come from
18 the car. He was trying to run, but was not the most
19 athletic of people and was lumbering, holding a large
20 kitchen knife, with a long, straight, silver blade in
21 his right hand, pointing it downwards towards the
22 ground. He went towards Parliament Square.

23 There was a big crowd of people, some waiting to
24 cross the road, some taking pictures of Big Ben,
25 tourists in general, and he ran straight towards them.

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1 Mr West then lost sight of Masood, partly because of the
2 number of people and partly because of what was going on
3 by the car.

4 He next saw Masood when he was running through the
5 vehicle gate of New Palace Yard. The police officers
6 were running from the gates. There were a couple,
7 probably two officers, in high-visibility jackets and
8 then a number just in white shirts and black trousers,
9 the sort of standard police or security attire. He
10 wasn't sure how many, perhaps five or six. All of the
11 officers, bar one, ran towards Westminster Hall. He
12 appeared to trip or stumble on a kerb where the ground
13 is cobbled and fell, at which point the assailant
14 started attacking the officer on the ground. He had
15 not noticed anything at the gate.

16 The officer was on the ground and was curled up to
17 make himself small. The attacker was bent or knelt over
18 him and appeared to have one hand to support himself and
19 hold the officer in place whilst the other was
20 repeatedly stabbing the officer. He saw quite a few
21 stabbing motions, between 8 and 10. The stabbing was
22 downwards and he described it as something you would see
23 in a horror film. All of the stabs were to the upper
24 body. It was repeated and constant rather than
25 frenzied.

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1 The officer somehow managed to escape from under the
2 weight of the attacker, started running in the direction
3 of Westminster Hall where the other officers had
4 originally run to. He was amazed, he said, that the
5 officer had managed to get up. The attacker followed.
6 A colleague of his suggested they should move away from
7 the window as there could be a bomb in the car. It
8 seemed like a sensible suggestion and so he moved away
9 too. His colleague was a little slower to move than he
10 was and they said "They've taken him down", by which he
11 took to mean that the attacker had been shot.

12 Mr West said that he would have thought it was
13 obvious to the attacker that the person he was attacking
14 was a police officer and he described the attack as one
15 of being callous and calculated.

16 Police Constable James Ross is an officer with the
17 Parliamentary and Diplomatic Protection. He was on duty
18 on 22 March and he had worked in the Palace grounds for
19 about eight years by 2017. He was on post 8P, the
20 pedestrian entrance off Parliament Square. It is
21 an entrance used by passholders and Members of
22 Parliament. Police Constables Stephen Marsh and
23 Doug Glaze were on the south gate and Police Constables
24 Keith Palmer and Kevin Tipple on the north gate. The
25 equipment he and his colleagues each had that day

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1 comprised handcuffs, an extendable baton or an asp, some
 2 incapacitant CS spray and a police radio. The radio
 3 would have been tuned to the channel for the
 4 Palace of Westminster police and security staff. They
 5 were also all wearing police body armour.

6 The vehicle gates were then kept open from 7.00 in
 7 the morning until 10.00 at night. The outer movable
 8 crowd control barriers would be opened and closed by
 9 officers inside as and when vehicles entered or left.
 10 The large gates, he said, were often hard to open and
 11 close as they were very heavy. The right-hand gate on
 12 the north side came in two parts and it almost took two
 13 people to close that. The barriers could be wheeled
 14 around to act as a barrier and had a metal catch thrown
 15 across the top. They could be opened or closed as and
 16 when vehicles or cyclists had to enter the premises or
 17 if there was a vote in the Parliament. If there was a
 18 vote the gates had to be open for at least eight minutes
 19 so you could not impede any MP or member of the Lords
 20 coming in to vote.

21 He was at his post just after 14.30 on 22 March.
 22 The main vehicle gates were open and the barriers were
 23 also open as there was a division. He was engaged in
 24 a conversation with his two colleagues on the south
 25 gate. He was not aware where the two armed officers on

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1 duty in New Palace Yard were. He himself had been an
 2 armed officer before at the Palace, and from his
 3 recollection and memory of doing the armed role five
 4 years before this, it was a roving patrol and so you
 5 could be at the gates or down by the colonnades, down by
 6 the members' entrance; it was not static at any one
 7 point.

8 When he was undertaking the armed role they were to
 9 be aware of certain situations where if you've got
 10 people coming in and out, because a lot of people get
 11 dropped off by the members' entrance, you would be aware
 12 of those in and around there and mindful of that. There
 13 was no instruction to be in a particular place when the
 14 vehicle gates were open. It was not the practice of any
 15 of his colleagues to be at the vehicle gates when they
 16 were open.

17 What first drew his attention on 22 March was a very
 18 loud bang and crash on Bridge Street. He thought it was
 19 a car crash but was not certain. Straightaway there was
 20 screaming and he didn't know if it was some sort of
 21 demonstration, but there were people running, screaming,
 22 and they were coming around the corner and turning left
 23 towards the gates.

24 He was aware that PC Glaze was using the radio.
 25 What PC Glaze said and what he recalled, he said, were

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1 two different things. He thought PC Glaze had put up
 2 saying it was a car crash. He has since heard that he
 3 said he thought it was an IED, ie a bomb. There were
 4 then people running fast, screaming and running past the
 5 entrance. He went to the entrance of the gate to stop
 6 people trying to get into the gated area. A couple had
 7 tried to run in and he barred their entrance, as he
 8 didn't know who they were.

9 Someone shouted in his face "There's a man with
 10 bloody big knives running this way". He stepped back
 11 and closed the gate. He then heard some noise to his
 12 right and he saw PC Palmer on the floor on his back up
 13 against the metal barrier of the down ramp, and standing
 14 right over him was the suspect, Masood. Masood had
 15 a knife in each hand, blades about a foot long, and he
 16 was stabbing Keith in and around the head area, hitting
 17 him with such force he said the blades were bending on
 18 impact.

19 There were two officers in front of him with asps
 20 drawn. He went behind them and he thought he could use
 21 his CS spray and was trying to get it from his belt.
 22 Then things changed. When he next looked up he was
 23 distracted by a car that was leaving the estate and when
 24 he looked back, Keith and the other officers had gone,
 25 managed to run around in an arc towards the members'

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1 entrance, past the car. The attacker was moving towards
 2 him and he could see that he was still carrying the two
 3 knives. Then he saw a plain-clothes officer with a
 4 Glock drawn challenging Masood. He shouted at Masood
 5 "Armed police". Masood continued towards him with his
 6 knives in his hands, and then the officer shot Masood
 7 who fell down in front of him.

8 His time as an AFO ended in about 2013 and he had
 9 undertaken the role in the Palace for about three and
 10 a half years. There had been a fixed post at the
 11 Carriage Gates about eight or nine years ago, but then
 12 it was deemed to give more of a reaction gap they were
 13 moved further away from the gates and it became a roving
 14 patrol. The fixed post was a single post, Glock-only
 15 then the post moved back to give a reactionary gap, as
 16 he phrased it. There were always unarmed officers at
 17 the gates because they were opening and closing the
 18 gates, but the armed officers were moved back. It gave
 19 time to react. On all posts, officers were always
 20 issued with post instructions. He was shown the
 21 post instructions for the Palace of Westminster,
 22 modified on 16 January 2015, and in particular, those
 23 covering sector 3. It reads:

24 "Both officers are to work together, working within
 25 close proximity of each other but not specifically as

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1 a pair. Officers to be positioned in close proximity of
 2 the gates when they are open but not outside.”
 3 He believed that to be quite similar to the
 4 instruction he had when he was an AFO, save that he
 5 thought you were allowed to be as a pair. In an AFO
 6 working relationship you do actually work as a pair as
 7 opposed to separately, but the area wasn’t just Carriage
 8 Gates; it was the whole area. You were not required to
 9 be in close proximity to the two of them all the time.
 10 It was routine to patrol the entire area of
 11 New Palace Yard. The blue area on the ranger sector 3
 12 map was the patrol area.

13 As an unarmed officer at the gate, he would not have
 14 expected armed officers to be present in close proximity
 15 of the gate regularly. It would be every now and then
 16 that he might see them passing by. They had quite
 17 a large area to cover. As he would have his back to
 18 them, he would be watching the gate and he wouldn’t
 19 really focus on what was happening behind him.

20 Police Constable Douglas Glaze also on duty on that
 21 day. He was on the south gate at the Carriage Gates.
 22 He had been on the unarmed side of the Palace of
 23 Westminster policing since 2004 and prior to that, had
 24 been an armed officer in what was then known as the
 25 Diplomatic Protection Group at the

1 Palace of Westminster. He was with PC Marsh.
 2 When he was an AFO and stationed at New Palace Yard
 3 the post was a static one. At Carriage Gates it would
 4 have been two officers and they would have been
 5 positioned behind the unarmed officers. He stopped
 6 being an AFO in 2012.
 7 He joined SO17 in April or May of 2014. He was
 8 aware that the AFOs were patrolling in a different way
 9 at some time, but he wasn’t sure when. In March 2017 he
 10 knew that, depending on what time it was, and if the
 11 House was sitting, that the AFOs would be in a certain
 12 area within a certain sector. He understood that area
 13 covered the area down to the colonnades.

14 When the attack started, he was at the south gate.
 15 He heard a noise that he could only describe at the time
 16 as an explosion. He now knew it was a car crashing.
 17 The noise was coming from over his right-hand side in
 18 Bridge Street in the Portcullis House direction. At
 19 14.40 he sent a message:

20 "Patriot, Carriage Gates, just had some sort of
 21 explosion ... down near Portcullis House".

22 There was then a very eerie millisecond of silence,
 23 and then screaming from the area of the explosion. He
 24 couldn’t see anything obvious, and he started moving
 25 backwards, trying to see what had happened, and then he

1 just remembered screaming and shouting, coming round
 2 past Carriage Gates, lots of people, hysterical,
 3 shouting and crying and screaming. There was a mass of
 4 people running round the corner from Bridge Street into
 5 Parliament Square and towards the gates.

6 He then heard PC Marsh shouting "What’s happening?"
 7 and he recalled shouting something similar "What’s going
 8 on?" Then he heard something that he said he will never
 9 forget. It was a female voice shouting "They’re
 10 throwing grenades". This was coming from more or less
 11 directly beside the south gate. People were running
 12 past the gates. It was just too fast for him to take
 13 in, to comprehend what was happening at the time.

14 He thought he then started to move backwards towards
 15 the gates and thinking they needed to shut the gates and
 16 he looked over his right shoulder and saw who he now
 17 knows to be Masood inside the grounds. He noted that he
 18 was a very large man with two extremely large knives,
 19 one in each hand, walking like a robot with his arms
 20 moving up and down, swinging his arms in exaggerated
 21 movements. At the time he didn’t think it was
 22 a solitary attacker; he thought it was multiple
 23 attackers in a Mumbai-style attack.

24 He sent a further message about 12 seconds after the
 25 end of the first one which stated:

1 "Knives attacking, people with knives attacking".
 2 He thought they were going to die because they were
 3 under multiple threats. He could recall shouting
 4 "Firearms". He was being pursued backwards into the
 5 estate. He could see Masood with the knives, but not
 6 what he was doing.

7 He then saw PC Carlisle and possibly PC Marsh
 8 running in the direction of Masood, and then Masood
 9 started chasing PC Carlisle. They move towards the
 10 lamppost beyond the car barrier and he then saw
 11 a protection officer coming from the direction of
 12 members’ entrance and then he heard the shots.

13 He saw that PC Palmer fell and when he went over
 14 towards him that he was injured. He called for first
 15 aid kits and they started to survey Keith to see where
 16 the injuries were. He was joined by others to look
 17 after Keith and was calling out for a paramedic and that
 18 they needed ambulances. When the HEMS team arrived, he
 19 led them to Keith.

20 Police Constable Nick Carlisle was stationed in
 21 New Palace Yard on Carriage Gates north at the time of
 22 the attack. He was unarmed and had never carried
 23 a firearm in the Metropolitan Police. At the time of
 24 the attack, PC Carlisle had just been relieved by
 25 PC Tipple and was preparing to head to the mess room for

1 a break. Therefore, there was one extra unarmed officer
2 at the north gate compared to the usual staffing level.
3 PC Carlisle heard a loud bang from Bridge Street.
4 It appeared to come from the area opposite Tesco which
5 was on the ground floor of Portcullis House, facing
6 towards New Palace Yard. PC Carlisle heard PC Glaze use
7 his radio to report a possible explosion. PC Carlisle
8 was able to see a grey 4x4 vehicle from his position and
9 could see that it had collided with the wall and the
10 railings at Bridge Street. He could see thin smoke
11 floating into New Palace Yard and he inferred that there
12 had been a high-speed collision, although he could not
13 be certain.

14 PC Carlisle believes that the sight line he had of
15 the vehicle was better than the sight line would have
16 been from the back of New Palace Yard by the colonnades
17 and the construction site.

18 The next thing he remembers is shouting and
19 screaming from that location. It seemed to begin
20 immediately after the loud bang. There was no
21 noticeable delay. PC Carlisle decided to see and
22 investigate what had occurred and stepped out of the
23 gates towards the street. Before he made it onto the
24 street, a man wearing a suit shouted a warning to him
25 that there were men with knives stabbing people. That

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1 man was 5 metres away from him. As soon as he heard
2 those words, PC Carlisle saw Masood. PC Carlisle was
3 not the only police officer in the mouth of the gate,
4 but was accompanied by PC Palmer and PC Tipple.

5 The first thing PC Carlisle noticed were Masood's
6 two large knives. Masood was running through the crowd,
7 the knives were held at eye level. Masood was looking
8 directly at the three police officers in the gates,
9 ignoring the members of the public around him.
10 PC Tipple shouted to shut the gates. PC Palmer was
11 a yard or two in front of PC Carlisle, encouraging
12 members of the public to come into the Palace. It all
13 happened very quickly. PC Carlisle didn't remember
14 particularly the radio transmissions that followed.

15 Seeing Masood, PC Carlisle and PC Tipple tried to
16 create distance between them and the knifeman.
17 PC Carlisle lost sight of PC Palmer. PC Carlisle backed
18 off at least 10 metres. He could then see that
19 PC Palmer was being driven back, his arms up, attempting
20 to defend himself from the knife, parrying off the
21 blows.

22 PC Carlisle then remembers running forwards with the
23 intention of rugby-tackling Masood. That was a brave
24 act on his part, seeing a colleague being attacked and
25 a man intent on attacking others, but nonetheless, he

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1 did what he did.

2 By this point, PC Palmer had stumbled backwards.
3 Masood saw PC Carlisle and turned to face him. This
4 allowed PC Palmer to get to his feet. Masood came at
5 PC Carlisle with the knives and he realised it was
6 impossible to carry out the rugby tackle that he had
7 planned. Instead, he veered to the side and ran along
8 with PC Palmer.

9 PC Palmer was shouting for armed support. He
10 couldn't see the AFOs who were supposed to be patrolling
11 New Palace Yard. He did see two plain-clothed
12 protection officers with handguns already drawn. They
13 were running up the cobbles towards the exit gate at
14 a run. PC Carlisle immediately got out of the line of
15 fire and indicated towards Masood. PC Carlisle
16 described these officers shooting Masood. He then
17 witnessed the first aiders' efforts for both Masood and
18 PC Keith Palmer.

19 The Right Honourable Tobias Ellwood MP was a
20 minister at the Foreign Office in March 2017. He had
21 had a career in the British Army before going into
22 politics and had annual training in first aid, including
23 battlefield casualty training and cardiac pulmonary
24 resuscitation training, CPR. He was at a meeting with
25 the permanent secretary in his office as Minister for

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1 the Middle East and North Africa when the division bell
2 sounded. That meant he had eight minutes to get into
3 the chamber and into the lobbies. His route took him
4 across Parliament Street, along Derby Gate, down
5 Canon Row and into Portcullis House. Normally he would
6 have gone down Parliament Street which he said was
7 a quicker route.

8 That was something he said he now regrets. Had he
9 gone the usual way, he would have seen the crash, he
10 would have been behind the terrorist, and although he
11 made no speculation about whether he could have changed
12 anything, he admitted he could perhaps have made things
13 worse, but he could have stepped forward and he
14 regretted not having that opportunity.

15 As he was about to go up some steps near to
16 Portcullis House he heard a significant crash followed
17 by screams. His interpretation was that the screams
18 were one of shock. The sounds were coming from
19 Bridge Street. In Portcullis House he went down the
20 escalators that connected into Parliament. There were
21 two waves of people running towards him. In a division
22 bell, both escalators used to be turned to go down so
23 that Members of Parliament could get in promptly. The
24 police were desperately trying to get one of those or
25 both reversed. He continued down and ran into a group

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1 of people shouting and screaming with panic in their
2 eyes about an incident unfolding. They were shouting
3 "Go, go, go, go", and there were "Shots fired, go back,
4 go back".

5 After a second wave of Members of Parliament and
6 others running towards him, he went through the
7 colonnades and it was barren. There was nobody there
8 apart from a number of officers who were crouched
9 looking towards the Carriage Gates which told him that's
10 where the concern was.

11 His first observation was the numbers of armed
12 police officers pointing their weapons towards Carriage
13 Gates. He said he had never seen so many armed officers
14 with their weapons out in the Houses of Parliament. He
15 could see there were two bodies lying on the ground, the
16 nearest one clearly a police officer, Keith Palmer, with
17 other officers attempting to give him support. Masood
18 was also having medical attention and there were also
19 people there with weapons pointed at him.

20 Mr Ellwood could see that those tending to Keith
21 could do with some help and assistance and he ran
22 forward. He made clear who he was so as not to compound
23 the situation. He said that he was medically trained
24 and one of those there asked him to tell him what to do.
25 He started going through the drills to provide first aid

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1 support. He was aware that he was putting his own
2 safety at risk and that there was a risk of a secondary
3 attack, and he spoke about his own brother who was
4 killed by a secondary attack in Bali.

5 He assumed that the terrorist, Masood, would have
6 liked to have taken the vehicle through the Carriage
7 Gates so had there been an IED on it, there could have
8 been some form of follow-up attack.

9 There was a puddle of blood around Keith. He had
10 lost a lot of blood and was still conscious. He checked
11 the pulse and found one, which he thought to be good
12 news for CPR. The lacerations on Keith's arm, whilst
13 significant, had not breached any major artery. It was
14 the stab wound near the armpit area that he later
15 recognised as piercing into the lung that was a huge
16 concern, a critical injury.

17 He wanted to explore more of the status of the
18 injuries and asked for some heavy-duty scissors to cut
19 off the flak jacket and other garments. Keith was
20 unconscious and pale, his eyes were dilated. He was
21 told that an ambulance was on its way. The wound under
22 the arm was continuing to bleed and he applied direct
23 pressure to it. He considered a tourniquet but there
24 was no point as the lacerations on the arm, whilst down
25 to the bone, were not causing significant loss of blood.

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1 Keith had lost a huge amount of blood. His heart
2 stopped, as did his breathing, and so he commenced CPR.
3 They had to ensure that pressure was maintained on that
4 and they had to go through the CPR process. Someone
5 else asked if they could help and he checked that they
6 knew what they were doing. Although one might normally
7 alternate with compression and breathing, Mr Ellwood
8 explained that he was competent and strong enough to
9 continue and did so; he didn't want to break the
10 pattern. He continued with chest compressions and the
11 other person dealt with the breathing.

12 The paramedic team and he continued with the CPR.
13 He explained what he and the others had been doing and
14 they advanced into putting in drips, injections and
15 other things. The HEMS team also arrived.

16 Mr Ellwood said it was very silent in Westminster,
17 so the noise of the helicopter landing made a lot of
18 noise. The HEMS team also asked him continue. Within
19 a number of minutes, they had assessed that unless
20 dramatic action was taken, they would lose Keith. The
21 HEMS doctor gave the instruction to move Keith from the
22 wall to give more space. The doctor, Dr Anthony Hudson,
23 made two insertions on either side of the ribcage, took
24 a large, sharp pair of scissors and proceeded to cut
25 open the ribcage across the top, before then placing

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1 a clamp-type device in the incision and using a crank
2 device to open up the torso to reveal the internal
3 organs. The procedure took about 35 seconds.

4 A valve had been placed in Keith's mouth and he was
5 operating the air ball providing air to the lungs. The
6 right lung was going up and down and the other severely
7 lacerated, and the doctors pulled the lung back and
8 tried to suture out the pool of blood that had collected
9 beneath it.

10 At this stage it was very critical and one of the
11 doctors started to squeeze the blood through the system
12 in his arm and the doctor grabbed the heart directly and
13 started squeezing it. Mr Ellwood stated that he had
14 unfortunately seen some horrific injuries, some that had
15 failed and some that had been successful, and he was
16 going to continue until told otherwise. The sheer loss
17 of blood was proving significant and there were no
18 indications of an improvement. It was clear that Keith
19 was not responding.

20 The doctors felt they had done everything to try and
21 keep Keith alive. Mr Elwood looked at the doctor and
22 said:

23 "Sir, you're going to have to tell me to stop, you
24 must order me to stop and you need to make that
25 decision".

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1 The doctor replied:
 2 "Sir, you've done your best but you need to stop.
 3 There is nothing more we can do."
 4 The doctor pronounced death at 15.15.
 5 Mr Ellwood said that in his capacity as an MP, he
 6 had given thought to the adequacy of the security
 7 arrangements on the gate. He had visited many
 8 parliaments around the world and in the UK we have
 9 an unusual set up of the tourist attraction, the
 10 front-of-house of what Parliament is being the same
 11 location as our functional and principal entrance for
 12 members of the House of Commons, and that had always
 13 worried him. There is a sense of vulnerability because
 14 it is slow getting through, but accepted the police have
 15 to do their checks. Mr Ellwood paid tribute to the work
 16 they do in having to make difficult decisions with
 17 tourists who want to have their pictures taken and are
 18 simply friendly, to dealing with agitators and other
 19 things and worst case situations like this of somebody
 20 wanting to cause harm.
 21 He accepted that everyone recognised there was
 22 a particular vulnerability. It is an iconic symbol of
 23 democracy across the world. Its openness, its
 24 transparency is key to the work Parliament does, and
 25 that's why they continued and didn't shut down the day

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1 after the attack. There is also the practical challenge
 2 in the movement of Members of Parliament and the public
 3 wanting to visit and keeping out those who wish harm.
 4 Mr Ellwood explained that there is a significant
 5 armed presence on the estate and there had been
 6 occasions when he had come through the gates where
 7 there's not been the armed presence that he would like
 8 to see. He was not involved in security arrangements at
 9 the Palace of Westminster and he would not have known
 10 what the deployment of armed officers was on that day.
 11 He also expressed the view that he believed those
 12 working on the estate should be protected, but that they
 13 must also continue the transparency for the public. He
 14 added that we must not become so risk averse and so
 15 reliant on our security forces that that encourages and
 16 almost allows these events to take place. He felt it
 17 important that all of us as individuals, although the
 18 official advice is to step back and report it, that we
 19 counter that somewhat because if more step forwards, as
 20 happened with the Manchester attacks or London Bridge
 21 and, indeed, at Westminster, the message will get
 22 through, he said, that no terrorist is going to win. No
 23 matter what they do, they will not succeed, they will
 24 not change our way of life, they will not challenge our
 25 values. His worry was that the more we become a tower

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1 of protection, it changes the face of what Parliament is
 2 all about, what we are about, and the terrorist may
 3 ultimately die on the day, but then wins as they have
 4 affected who we are.

5 Anthony Davis was visiting the Palace of Westminster
 6 for an event to promote charity work associated with
 7 boxing. After the event he was leaving through a route
 8 that let into New Palace Yard. He'd started to film
 9 using his phone in the Grand Hall. He put his phone
 10 away when he heard an altercation. Things happened very
 11 quickly. After seeing people running, the mood changed
 12 and he saw a black man enter the gates and start
 13 attacking one of the policemen. That man was carrying
 14 the two knives.

15 He must have put his phone in a pocket with it still
 16 recording. He saw the police running away in his
 17 direction. They were shouting "Run, run, they've got
 18 knives." He jumped over the fence and tried to help as
 19 best he could.

20 He then saw a man who he thought at the time was
 21 a marksman put three rounds into Masood, then he saw
 22 Keith fall to the ground. He too had some first aid
 23 training. He tried to turn Keith to assess the
 24 situation he was in and he saw a large head wound that
 25 was bleeding profusely and applied pressure to that. He

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1 checked Keith's airway. His eyes were open and he was
 2 breathing. The carotid pulse seemed weak. He asked an
 3 officer to get a medic and others were there very
 4 quickly. He was trying to reassure Keith. He then
 5 noted blood on the cobbles on the ground and wondered
 6 where that was coming from. He moved Keith's arm and
 7 then saw the wound. He had tried to apply pressure to
 8 that too. He said that Mr Ellwood was soon on the scene
 9 and those all around Keith worked as a team, trying to
 10 tend to him whilst they waited for an ambulance.

11 Keith's condition deteriorated over time and he was
 12 trying to inject some urgency into what they were doing.
 13 They started CPR before the HEMS team arrived. He
 14 described Dr Hudson, the HEMS doctor, as "One
 15 switched-on cookie" who gave clear leadership and
 16 carried out surgery after they had moved Keith a short
 17 distance.

18 Dr Hudson was a registrar in pre-hospital emergency
 19 medicine working for HEMS. A doctor/paramedic team is
 20 available 24 hours a day across London. One team is
 21 always available at any given time and he said a third
 22 member of the team sits in the ambulance control
 23 screening all calls made to the ambulance service and
 24 it's their job to interrogate those calls and make
 25 a decision as to whether the HEMS team would benefit the

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1 case. The criteria depended on the severity of the
2 injury and their ability to recognise the need of those
3 additional resources. The HEMS team is based on the
4 helipad on the roof of the Royal London Hospital.

5 He said there is a standard operating procedure in
6 place to mobilise more teams should they be required.
7 The first stage for that to happen would be a
8 declaration of a major incident and then it would be
9 dependent on the time it takes for other teams to
10 assemble at the helipad and that would depend on the
11 time of day.

12 Within a 24-hour period the average number of jobs
13 the HEMS team is dispatched to is between three and
14 five. The flight time from helipad to Westminster would
15 only be a couple of minutes. The decision as to where
16 they can land is a matter for the pilot, but there are
17 restrictions based on the size of the landing area
18 required. They landed in Parliament Square that day.

19 When they got the call, he saw on the instructions
20 they were going to a road traffic collision on
21 Westminster Bridge. When they got to the aircraft
22 a second message came, saying that the number of
23 casualties had increased and the number of patients
24 estimated to be 20.

25 As a team, they appreciated they were going to

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1 something more significant than simply a person
2 unfortunately hit by a vehicle and en route they started
3 to discuss amongst themselves what they might do. He
4 thought the initial call came at 14.43. They were at
5 the scene very quickly, but they couldn't land
6 immediately. The area is very highly built up, highly
7 populated with people going about their activities, and
8 there was a need to sanction a landing at a site like
9 Parliament Square. But also they were trying to gather
10 as much information from the air as to what it was that
11 was happening on the ground.

12 They were using the time above the bridge to get
13 a sense of the scale of the incident and the number of
14 patients. They could see from the air a number of
15 grounds of people being tended to on the ground. The
16 helicopter landed at 14.56. Police then escorted them
17 to the Palace of Westminster. They had a discussion
18 that there were a number of casualties on the bridge,
19 but given the geography of the scene, those at the
20 Palace of Westminster were not fully aware of the extent
21 of the incident, stretching back to the south side of
22 Westminster Bridge.

23 Those at the Palace were aware of a small number of
24 casualties where the vehicle had come to a stop against
25 the fence on the Palace of Westminster, but he was told

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1 they had only minor injuries.

2 A decision had to be made as to whether they would
3 deploy the wider scene across the bridge or those in the
4 Palace. As they were presented with two patients in
5 traumatic cardiac arrest in the Palace, the decision was
6 that they were best served by attending to them. As
7 they came through they could see two patients on the
8 floor and he went to Keith Palmer. He was advised that
9 he was the patient with greatest need. Patients in
10 cardiac arrest having received a stab wound are more
11 likely to be resuscitated successfully than someone who
12 has received a gunshot.

13 He made an assessment of the injuries Keith had
14 sustained and his condition. He asked that the CPR stop
15 momentarily and noted that Keith had a weak central
16 carotid pulse and was taking some agonal gasps. There
17 were some signs of life at that point. The
18 resuscitation efforts being performed were of good
19 quality. They were going to replace the blood lost with
20 a transfusion and whilst doing that Keith returned to
21 cardiac arrest and so a plan for surgical intervention
22 was made. He carried out a thoracotomy.

23 He also tried to perform a hilar twist, where the
24 lung is mobilised, twisted on its pedicle, to try and
25 reduce blood loss, and he also attempted to put a clamp

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1 across the hilum to further reduce blood loss and
2 massage the heart directly, attempting to restore its
3 filling and pumping. The heart was not filling with
4 blood and he formed the view there was no chance of
5 resuscitation.

6 Even in the setting of a theatre or an emergency
7 department, it would be an extremely rare event to
8 successfully resuscitate anyone from the position that
9 Keith was in, and he instructed the team to stop.

10 Dr Robert Chapman, a Home Office pathologist,
11 carried out the post mortem examination on Keith Palmer
12 on 24 March 2017. He noted a cutting wound to the back
13 of the head, 9.6 centimetres in length, passing forward
14 from Keith's right side to his left. This wound went
15 through the full thickness of the skull and was so deep
16 as to score the skull underneath. He recorded a second
17 stab wound to the upper mid-line of Keith's back of 1.9
18 centimetres in length with a depth of about
19 1 centimetre, but this did not penetrate the chest
20 cavity.

21 There was a larger stab wound of 8.5 centimetres in
22 length to the left side of Keith's back, passing from
23 Keith's left side to the right and slightly upwards,
24 through the rib space beneath the left third rib,
25 fracturing the left fourth rib and continuing into the

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1 chest cavity to strike the upper lobe of the left lung.
 2 That same wound then continued through a branch of the
 3 pulmonary artery, one of the major blood vessels within
 4 the lung, and some of the airways of the lung. The
 5 track then continued further to strike part of the left
 6 atrium, the upper chamber of the heart on the left side
 7 of the heart, penetrating through the heart,
 8 a 1.5 centimetre-wide track. The wound had a depth of
 9 18 centimetres.

10 A fourth wound was a cutting wound to the upper part
 11 of the right shoulder measuring 5 by 2 centimetres. The
 12 fifth and sixth wounds were both smaller, both passing
 13 into the muscle of the chest wall, but not penetrating
 14 into the chest cavity and both about 1 centimetre deep.

15 The next stab wound was to the mid-left upper arm,
 16 about 11 centimetres in length on the surface and
 17 11 centimetres deep, passing straight through Keith's
 18 arm. The pathologist also noticed reddened abrasions to
 19 Keith's left wrist and a superficial cut on the palm of
 20 the left hand. On the back of the right hand Keith
 21 suffered a cutting wound about 2.5 centimetres in
 22 length, alongside a blunt force injury to the back of
 23 the hand.

24 There was also bruising to the back of the left
 25 hand. Keith had a graze on his right elbow. He had

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1 a stab wound on the front of his left lower thigh,
 2 penetrating to a depth of about 1 centimetre.

3 The wound which passed through Keith's arm was
 4 caused by moderate force, in the pathologist's opinion.
 5 The 18 centimetre wound was caused, said the
 6 pathologist, by a severe force, given the damage which
 7 it caused the fourth rib. Some but not all of Keith's
 8 injuries were indicative of being caused whilst
 9 defending himself. Although the post mortem showed some
 10 cerebral swelling, Dr Chapman gave evidence that it was
 11 not a significant finding and was incidental to the
 12 other injuries.

13 Dr Chapman gave the cause of death as haemorrhage as
 14 a result of a stab wound to the chest, the fatal wound
 15 having caused immediate and profuse blood loss. Keith's
 16 collapse would have been rapid and his injury was not
 17 survivable.

18 Paul Fenne, the principal engineer in the Physical
 19 Protection Group for the Metropolitan Police, examined
 20 the body armour worn by PC Palmer. What was clear from
 21 his examination is that where the body armour covered
 22 the area where Keith was stabbed, the wire mesh within
 23 the armour prevented either of the two knives from
 24 penetrating through to the skin. One of the two knives
 25 had been bent out of its normal shape. Even with the

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1 level of force required for that to happen, the blade
 2 would not have penetrated the body armour.

3 There were a number of marks to the front and back
 4 of the armour consistent with a knife attack. The area
 5 where the fatal wound was inflicted was not covered by
 6 the armour.

7 Mr Fenne demonstrated that no armour then, or
 8 currently available, would provide protection for this
 9 area, save for some body armour designed for use by the
 10 army in Afghanistan, known as Kestrel, but that armour
 11 would not be suitable for the work being undertaken by a
 12 police officer in the position of PC Palmer as it would
 13 prevent him moving his arms through much of their range
 14 of movement. He dealt with the balance between
 15 wearability and the protection requirements of body
 16 armour.

17 Keith's sister, Angela, read a moving tribute. She
 18 set out his life away from his work, his wish to become
 19 a policeman, and the importance to him of the job that
 20 he did. She also set out the picture of Keith as
 21 a family man and the impact on all his family of his
 22 loss.

23 Chief Inspector Sawyer also spoke about Keith, the
 24 policeman, from his own perspective, and from two close
 25 colleagues, PCs Sean Wright and Nick Carlisle. In the

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1 course of these Inquests, I have met both of Keith's
 2 sisters.

3 New Palace Yard. There were two AFOs on duty
 4 covering New Palace Yard, Police Constables Lee Ashby
 5 and Nicholas Sanders. By March 2017, PC Ashby had been
 6 a police officer for about 20 years, and an AFO for 13
 7 of those years. He had spent much of those 13 years
 8 working at the Palace of Westminster and was on
 9 a permanent team there for about six of those years.

10 On 22 March, PC Ashby was tri-armed, carrying
 11 a Heckler and Koch G36 carbine, a Glock 17 pistol and
 12 a taser. He believes that he was using the PaPD
 13 dispatch 1 radio channel deployed to sector 3.

14 PC Ashby referred to a set of laminated maps of the
 15 sectors on the wall of the base control room in the car
 16 park beneath New Palace Yard. PC Ashby relied upon the
 17 blue shading as showing sector 3, depicting the
 18 approximately rectangular area of New Palace Yard,
 19 stretching from Carriage Gates to the colonnades. He
 20 said that every other AFO shared this understanding.
 21 Save for on Wednesdays, the days on which there were
 22 an unusually high number of high profile Members of
 23 Parliament around the area of members' entrance,
 24 PC Ashby said there were no particular areas of
 25 New Palace Yard which the AFOs were instructed to patrol

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1 at particular times.
 2 He explained that AFOs were, until 18 months or two
 3 years before the attack, on a fixed post near to
 4 Carriage Gates, standing behind the armed officers.
 5 PC Ashby carried a very similar blue highlighted map
 6 in his patrol uniform at all times to remind him of the
 7 sectors. When he subsequently spoke to Commander Usher
 8 some months after the attack, he produced a laminated
 9 copy of this map dated 25 July 2012 to support his
 10 understanding.
 11 PC Ashby was not aware of any post instructions or
 12 post notes. In his words:
 13 "As far as I'm aware, my post instructions are what
 14 we can see on the screen here."
 15 Referring to the map with the blue highlighting on
 16 the base room wall.
 17 When asked whether he was aware of the January 2015
 18 and December 2015 post notes which both describe that
 19 officers were to work in close proximity of one another
 20 and be in close proximity to Carriage Gates when the
 21 gates were open, PC Ashby was clear that he was not.
 22 The Parliamentary and Diplomatic Protection Command,
 23 PaPD, maintains a computer system referred to as ADAM,
 24 standing for Armed Deployment Authorities Management
 25 system. It serves a number of purposes, one of which is

1 to contain the definitive version of post notes.
 2 PC Ashby accepted that he had not accessed ADAM since
 3 29 June 2015, but explained he was never asked to do so.
 4 At the time of the attack, PC Nicholas Sanders had
 5 been a police constable for approximately 15 years and
 6 had more than five years as an AFO. Four of those have
 7 been at the Palace of Westminster. Like PC Ashby, he
 8 was tri-armed, but carried an MP5 carbine rifle in place
 9 of PC Ashby's G36. PC Sanders cited the same blue
 10 highlighted laminated map as the source of his post
 11 instructions as to the limits of sector 3. His
 12 understanding was that AFOs were expected to be
 13 unpredictable in their movements so as to avoid hostile
 14 reconnaissance and to be available to deploy anywhere
 15 within the sector. He did not believe there was any
 16 expectation to be at the Carriage Gates at any specific
 17 time, and as with PC Ashby, was not aware of either of
 18 the 2015 iterations of the post notes.
 19 He justified this understanding by relying on the
 20 fact that the Palace of Westminster was the only place
 21 on the PaPD command where one patrolled in sectors.
 22 PC Sanders was aware of the ADAM system and accepted
 23 that he was aware that he was under an obligation to
 24 access the system from time to time. Despite there
 25 being a record to the contrary, PC Sanders believed he

1 had used the ADAM system before 22 March 2017. He
 2 accepted, though, that he had not used it in relation to
 3 duties at the Palace of Westminster. This is because,
 4 to his mind, his post instructions for the
 5 Palace of Westminster were entirely clear and they were
 6 as posted on the wall of the base room. PC Sanders
 7 accepted that had he logged onto the system it would
 8 have been straightforward to locate the post notes.
 9 Both PC Ashby and PC Sanders recognised the
 10 vulnerability of Carriage Gates and knew that by being
 11 on a roaming patrol, they would be out of sight of the
 12 gates at times. PC Sanders recalled a briefing sent by
 13 email and subsequently given orally by Superintendent
 14 Simon Causer and Superintendent Amanda Dellar
 15 in February 2017 which reaffirmed his understanding of
 16 sector 3. He produced a copy of a map received at that
 17 briefing to substantiate his understanding.
 18 In short, PC Ashby and PC Sanders both believed that
 19 their orders on 22 March 2017, as on any other day on
 20 which they were protecting sector 3, was to conduct
 21 a patrol throughout the entire sector. In contrast, the
 22 most recent post notes, produced on 14 December 2005,
 23 required officers to remain at Carriage Gates whilst the
 24 gates were open and only ever conducting a short patrol
 25 into New Palace Yard.

1 When asked whether they accepted that the blue
 2 highlighted map was not a patrol map but an alarm map
 3 showing the location of alarms within the sector, both
 4 officers denied this to be their understanding.
 5 CCTV shows the movements of PC Ashby and PC Sanders
 6 before the attack. It also shows PC Gerard, with whom
 7 PC Sanders patrolled until PC Ashby came on duty at
 8 around 14.00 hours. There is a short period of time,
 9 14 minutes, during which PC Gerard and PC Sanders stand
 10 near Carriage Gates in the hours before the attack, but
 11 after 2.00 pm, PC Sanders and PC Ashby do not go near
 12 the gates. Instead, the CCTV shows them standing in the
 13 colonnades for most of the time until the time of the
 14 attack.
 15 During that time it is known that they spoke with
 16 Acting Commissioner Craig Mackey who was leaving after
 17 a meeting at the Palace of Westminster. PC Sanders says
 18 they spent their time under the colonnades because it
 19 was busier than normal in that area with cabinet
 20 ministers and MPs. Similarly, PC Ashby said it was
 21 likely because there was likely to be higher profile
 22 individuals in that area than in other areas at that
 23 time.
 24 When the car collided with the wall, PC Ashby and
 25 PC Sanders both describe hearing a sound which they

1 initially believed to be an explosion. They moved
 2 towards the sound, stopping at the top of the ramp which
 3 connects New Palace Yard to the underground car park.
 4 They used the ramp as cover, not knowing the threat
 5 which they faced. They subsequently heard the sound of
 6 shots being fired.

7 PC Sanders told PC Ashby that the sound was coming
 8 from behind them, and together they began to move around
 9 New Palace Yard clockwise to the point at which Masood
 10 had been shot. They didn't move straight to the point
 11 of the shooting, but again, went into the colonnades.
 12 PC Sanders says that from all the noise and confusion he
 13 understood that there may be an armed terrorist in the
 14 colonnades.

15 PC Ashby could see it was unusually busy near the
 16 members' entrance. Their training is immediately to
 17 confront and contain a deadly threat.

18 Upon realising what had in fact occurred the two
 19 AFOs walked towards the locations at which Masood and
 20 PC Palmer were lying on the ground.

21 When moving from the ramps to the point at which the
 22 shots had been fired, it is clear from the CCTV that
 23 PC Ashby and PC Sanders moved at walking pace.
 24 PC Sanders gave evidence that this was because he was
 25 undertaking a continuous threat assessment, not knowing

1 what had occurred, and whether any threat was extant.
 2 At no point before the attack did either PC Ashby or PC
 3 Sanders hear any relevant radio transmission.

4 PC Sanders accepted that his areas of patrol on that
 5 day were typical of his actions when on sector 3. When
 6 asked whether he accepted that his actions did not
 7 constitute a short patrol, within the wording of
 8 the December 2015 post notes, PC Sanders agreed, though
 9 of course emphasising he had not seen those notes.

10 PC Sanders was aware of a binder of documents in the
 11 base room containing documents as to the AFO daily
 12 duties. He referred to this as the duty binder. Asked
 13 whether had the officers been positioned at the gates
 14 they would have taken a shot at Masood, they both agreed
 15 they would in certain circumstances.

16 Mr Hough, I'm going to suggest we break there.
 17 I'm conscious that I have been speaking for some time.
 18 We'll just have a short break, and certainly to give the
 19 shorthand writers a break too.

20 MR HOUGH: Yes, sir.

21 (3.18 pm)

(A short break)

23 (3.32 pm)

24 THE CHIEF CORONER: Commander Usher is the protection
 25 commander with strategic responsibility for the Royalty

1 and Specialist Protection Command and the Parliamentary
 2 and Diplomatic Protection Command. He has held that
 3 role since April 2016.

4 He has never, himself, been an AFO, or acted as
 5 a firearms commander. However, he is trained as
 6 a firearms commander. He has a responsibility to
 7 provide protective security to the
 8 Palace of Westminster, among other roles. His
 9 department works alongside the Parliamentary Security
 10 Department under a civilian Director of Security,
 11 Eric Hepburn. Operational decisions at the
 12 Palace of Westminster are informed by tactical
 13 assessments carried out by a security coordinator from
 14 the Metropolitan Police Service.

15 Commander Usher referred to the desire of Parliament
 16 that Carriage Gates are open as far as possible, being
 17 symbolic of an open and democratic Parliament. The
 18 ornate metal gates were left open during sitting hours
 19 and external crowd control barriers were opened and
 20 closed to allow vehicles to enter through the gates.

21 During a division, for those eight minutes, the
 22 barriers remained open. The barriers were first
 23 installed as a temporary measure and at the time of the
 24 attack it was intended that they would be replaced in
 25 time with a structural and permanent barrier. The

1 ornate metal gates were too heavy to open and close with
 2 ease and any frequency. They have since been replaced
 3 with a modernised version.

4 Inspector Stephenson completed a tactical planning
 5 review dated November 2014. At that time, the review
 6 stated that there were two AFOs on Carriage Gates, one
 7 of whom would perform a short foot patrol around the
 8 yard, whilst the second remained at the gates. The post
 9 notes, based on that review dated January 2015, stated
 10 that officers are to be positioned in close proximity to
 11 the gates when they are open, but not outside. The post
 12 notes did not mention the occasional short patrol by one
 13 of the two officers.

14 In January 2015, the national threat level was
 15 raised to severe in respect of the threat to officers.
 16 A second tactical review was carried out in June 2015.
 17 This review recognised that the gates, when opened,
 18 represented one of the weakest points in the physical
 19 perimeter of the estate. The same recommendation as to
 20 a short patrol was made.

21 The 14 December 2015 post notes following this
 22 review stated that:

23 "Officers are to work together, working with
 24 proximity of each other, but not specifically as a pair.
 25 Officers are to be positioned in close proximity to the

1 gates when they are open, but not outside. Both
 2 officers are to be positioned in line of sight of each
 3 other, with the ability to respond to Cromwell Green
 4 entrance search point and should include a short patrol
 5 into New Palace Yard towards the exit point of the
 6 Cromwell Green estate.”

7 Those notes remained in force on 22 March 2017.

8 Commander Usher accepted that even a failure to have
 9 an armed officer at the gates for 10, 20 or 30 per cent
 10 of the time would be a weakness in security
 11 arrangements. He said that following the 2015 review,
 12 that would be a problem.

13 Commander Usher was asked about older post notes,
 14 including the 2012 post notes, which referred to
 15 a patrol of the sector shown on the highlighted map.
 16 That map was not attached to the post notes, and it was
 17 not clear to which map it referred.

18 Commander Usher said that the highlighted map was
 19 not the same blue highlighted map as on the wall of the
 20 base room and in PC Ashby’s pocket. Instead,
 21 Commander Usher believed that the 2012 map had made
 22 reference to a shaded area which was between Carriage
 23 Gates and the vehicle search point as opposed to
 24 extending to the back of the yard.

25 Commander Usher accepted that the 2014 post notes

1 did include patrols on both sides of New Palace Yard
 2 with the officers walking on either side of the central
 3 grassy area.

4 He also gave evidence about a parliamentary security
 5 report from 2004, which made reference to the risk of
 6 officers on the gates being rushed by an attacker. He
 7 gave evidence about Operation Standfast, a covert
 8 penetration testing exercise that took place some years
 9 before the attack, highlighting the deterrent and
 10 disruptive effect of armed police officers, and
 11 identifying the gates as a very busy entrance point onto
 12 the estate.

13 A 2013 report had noted that pedestrian entrances
 14 remained vulnerable to a determined and hostile attack
 15 and recommended that armed officers should be in
 16 positions set back from the outer physical protective
 17 security boundary. There was a 2015 review specifically
 18 of security at Carriage Gates, identifying a risk to
 19 officers stationed there.

20 I heard evidence of a number of concerns that were
 21 raised by and to senior officers, including an email
 22 chain with Chief Inspector Nick Aldworth, as he was
 23 then, that issues with officers’ patrols were becoming
 24 “a bit too frequent for our liking” in February 2015.

25 Commander Usher had himself visited the Palace of

1 Westminster on a number of occasions before
 2 22 March 2017. He could not recall where he had seen
 3 officers positioned. Whatever the meaning of “short
 4 patrol”, Commander Usher accepted it would not include
 5 a patrol to the back of New Palace Yard by the
 6 colonnades. He was clear that the post instructions
 7 were mandatory, not advisory.

8 Evidence was given about the consideration of arming
 9 officers with tasers. This was raised as an option in
 10 a 2015 report. There was not the sufficient training
 11 capacity for this to be possible. The decision was not
 12 made to arm unarmed officers with tasers, but that AFOs
 13 would continue to carry taser.

14 He was asked about the ADAM system. He said that
 15 officers were told to access it regularly, but he was
 16 not aware of any definition of “regularly”.

17 After the attack, he met with PC Ashby and
 18 PC Sanders for, he says, a review of occupational health
 19 procedures. In the course of the meeting he asked about
 20 their locations on the day of the attack and, having
 21 recently read the post notes, realised they were not
 22 acting in accordance with the notes. There are no notes
 23 of the meeting, and nobody else was in attendance.

24 Early on in the meeting, Commander Usher recalls
 25 PC Ashby producing a copy of a laminated map from his

1 pocket and explaining that he always carried it as
 2 an aide-memoire. Commander Usher spoke frankly and
 3 explained that he believes that PC Ashby was probably
 4 aware before that meeting that there was a potential
 5 problem as to where he had been patrolling.
 6 Commander Usher found it unusual that PC Ashby claims to
 7 have been told every day before patrolling to patrol in
 8 accordance with the highlighted map. He found it
 9 unusual that PC Ashby produced the map so quickly in the
 10 meeting.

11 Commander Usher reported the two AFOs to the
 12 Department of Professional Standards to conduct
 13 a review. The DPS concluded that the officers were in
 14 the wrong positions, but that their beliefs were
 15 reflective of a wider misunderstanding amongst AFOs. It
 16 was found that there were a number of officers who had
 17 not registered for the ADAM system. I know from seeing
 18 further evidence disclosed by the MPS after
 19 Commander Usher’s evidence, that only 13 per cent of
 20 officers in the PaPD had logged into ADAM
 21 between December 2015 and 1 August 2016. PC Ashby had
 22 not used the system since 2015; PC Sanders had never
 23 used it. Commander Usher said that officers who had not
 24 logged onto ADAM might have seen post notes in hard copy
 25 instead. I had no evidence from any PCs who had viewed

1 the notes in hard copy. The investigation resulted in
2 organisational learning, but no sanctions in respect of
3 the two AFOs.

4 Inspector Stuart Rose was a deputy inspector in the
5 Diplomatic Protection Group stationed at the
6 Palace of Westminster between November 2015 and
7 May 2017. He was a trained AFO. He's now an inspector
8 in the Holborn custody suite. During Inspector Rose's
9 time at the Palace he understood sector 3 to be a sector
10 patrol which involved a short patrol within the area of
11 the sector, but with a large focus of the attention on
12 Carriage Gates. He would have expected AFOs to patrol
13 the area around Carriage Gates, as well as the barriers
14 at the vehicle search area. He would also expect the
15 AFOs to be mindful of the point where the subway enters
16 into the colonnades, but would not expect them to patrol
17 in the colonnades. He would not have expected AFOs to
18 be static at any point, but to be on a moving patrol
19 around the yard. He recognised that by carrying out
20 a patrol in this way, officers would at times have a far
21 from perfect view of Carriage Gates.

22 Inspector Rose had a copy of the post notes in
23 a binder in the supervisor's office. He also knew they
24 were on the ADAM system. He doesn't know whether there
25 was a similar binder in the officers' base room, but he

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1 knows that PCs were expected to check the post notes on
2 ADAM.

3 He also recalls that whenever there was
4 a substantive change to post notes, it would be conveyed
5 at the next parade briefing, and he expects that emails
6 would be sent to all officers. Inspector Rose was aware
7 of the December 2015 post notes. He was aware of the
8 phrase "short patrol". In his view, the post notes were
9 open to a degree of interpretation. The inspector does
10 not remember the detail of the laminated map that's on
11 the wall of the base room, but recalls there was
12 a laminated map there.

13 When asked to consider the map in his evidence, he
14 said that it appears to show the patrol area for
15 sector 3. He accepted the shading appeared to suggest
16 the patrol should be the entirety of the area.

17 Chief Inspector Aldworth gave evidence on two
18 distinct topics of relevance to different victims of
19 Masood's attack. He is currently a chief superintendent
20 working for the National Counter Terrorism Policing
21 Headquarters. He was previously the OCU Commander at
22 Protective Security Operations, which is
23 a Metropolitan Police service unit.

24 Because of that role, he was able to give relevant
25 evidence concerning barriers on the bridge on

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1 22 March 2017. However, he had previously held the role
2 of Chief Inspector for Operations at the
3 Palace of Westminster from March 2014 to December 2015.
4 He was, therefore, also able to give evidence about
5 security procedures in New Palace Yard, as well as
6 specifically the posting of armed officers.

7 Chief Superintendent Aldworth had responsibility for
8 security across the estate, including New Palace Yard.
9 He did not recall patrolling instructions which were
10 given to armed officers in sector 3 when he was first
11 posted to the Palace. On 16 January 2015, when the
12 threat assessment increased in respect of individual
13 officers, Chief Superintendent Aldworth sent an email to
14 various colleagues saying it was necessary to change the
15 positioning of armed officers in order to provide better
16 protection to staff and visitors. He wished to have
17 armed officers closer to the Carriage Gates. He sent
18 a document containing interim measures to supervisors.
19 This included an expectation that patrols would be
20 carried out by supervisors to ensure compliance with the
21 amended posting at least twice every shift.

22 He set up a way for records of these to be checked,
23 to be retained on CAD, although no records have been
24 located for disclosure by the Metropolitan Police
25 Service.

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1 The officer was asked about a series of emails
2 concerning officers failing to comply with post notes.
3 In one email in February 2015, Chief Superintendent
4 Aldworth said that such complaints are becoming too
5 frequent for his liking. He said in evidence that he
6 would have considered it a serious problem if officers
7 were not in the correct positions given the raised
8 threat level.

9 He was asked about the review of security at
10 Carriage Gates which he commissioned in May 2015. One
11 of the recommendations of that review was that armed
12 officers should be deployed behind unarmed officers at
13 Carriage Gates, but he didn't remember details about the
14 specific recommendation.

15 Chief Superintendent Aldworth was asked about
16 a disagreement he had with an unarmed police constable.
17 A meeting followed and Chief Superintendent Aldworth
18 accepts, to his embarrassment, that he lost his temper
19 and used inappropriate language. I didn't receive
20 detailed evidence as to the substance of this
21 disagreement which led to this meeting, although
22 I understood it to be said to relate to
23 post instructions at St Stephen's entrance.

24 As to the issue of barriers on the bridge, Chief
25 Superintendent Aldworth described the Centre for

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1 Protection of National Infrastructure, CPNI, sets the
2 engineering standard for protective measures and the
3 technical standard for practice. Those measures are
4 then fed through to the NaCTSO which feeds the relevant
5 professional developments and standards into the counter
6 terrorism security network. The CT security advisors
7 are then employed locally by police forces. There are
8 around 200 such advisors across the country. They give
9 guidance to government and industry regarding crowded
10 places, amongst other roles.

11 Chief Superintendent Aldworth was asked about
12 a definition of crowded place:

13 "Crowded places are locations where a terrorist
14 attack may cause many deaths and casualties, and/or
15 sites which offer the prospect of an impact beyond loss
16 of life alone. They are designated following an
17 assessment against a specified criteria and are commonly
18 privately owned places to which the public have access.
19 The criteria, and the national list, sit at a high
20 security classification."

21 NaCTSO maintains a list of crowded places and works
22 alongside the Office for Security and Counter Terrorism,
23 a department of the Home Office, in maintaining the
24 list, and the criteria for meeting the definition.

25 Chief Superintendent Aldworth did not have the power

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1 to mandate any specific protective security measures be
2 put in a specific place. His mandate is to give advice
3 to the owner of the structure of the public authority
4 owning the highway or location. Where his advice is
5 rejected, he has no way to oblige the step to be taken.

6 The hostile vehicle mitigation barriers around
7 Parliament at the end of Bridge Street are specifically
8 there to protect the building and were not constructed
9 to protect pedestrians. In Westminster, Chief
10 Superintendent Aldworth described there being something
11 like 1,900 roads. In relation to a small number of
12 specific areas Chief Superintendent Aldworth had been
13 pushing for redevelopment for reasons of counter
14 terrorism.

15 In relation to bridges, Chief Superintendent
16 Aldworth said there had been no appreciation that might
17 be the focus of terrorist threats. No consideration had
18 been given to putting barriers on Westminster Bridge
19 specifically, and Westminster Bridge did not meet the
20 definition of a crowded place.

21 Some bridges, indeed, could not support appropriate
22 hostile vehicle mitigation measures and barriers. After
23 the London Bridge attack, barriers were installed across
24 bridges within eight or nine days. The combination of
25 Westminster Bridge and the London Bridge attacks was the

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1 catalyst for this action.

2 Eric Hepburn is the Director of Security for
3 Parliament. He took up that post on 1 September 2016.
4 He is responsible for the operational security of
5 Parliament. The Parliamentary Security Department, PSD,
6 first came into existence on 1 January 2016 following
7 a review on security by Sir Paul Jenkins QC. Security
8 is provided by a combination of police officers and
9 security staff. The police contingent fall into the
10 Parliamentary and Diplomatic Protection division under
11 Chief Superintendent Johnson and she reports to
12 Commander Usher.

13 The responsibility for security in Parliament is his
14 responsibility on a day-to-day basis, but is undertaken
15 in partnership with the Metropolitan Police. In the
16 event of an emergency at the Palace, operational control
17 passes to the Metropolitan Police. There are periodic
18 meetings between him and the police to consider risks
19 that might be posed to security and the safety of
20 Parliament.

21 There are also meetings to discuss strategic issues.
22 On a daily basis, briefings are provided to his staff
23 and to the police about what meetings are taking place,
24 whether there are any particular people coming to the
25 Palace, and what kinds of cars they would need to be

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1 aware of.

2 Armed police are the responsibility of the
3 Metropolitan Police. They rely on them to give advice
4 and guidance. If he or his staff strongly believe that
5 armed officers were needed in a particular area, or to
6 be moved from one place to another, it is something they
7 would bring to the attention of the police, but it is
8 not something they would seek to interfere with. He was
9 aware that armed police on the Palace estate worked in
10 accordance with post notes. He did not have access to
11 the post notes. His team would have their own post
12 notes.

13 A balance had to be struck between openness and
14 security. It is an important democratic right for
15 people to be able to come to Parliament, to meet with
16 their Member of Parliament and to visit the
17 organisation. The Palace, he said, has more than
18 a million visitors a year. No advance permission is
19 needed for visiting and the only ticketing is for Prime
20 Minister's Questions.

21 Mr Hepburn dealt with the physical security barriers
22 in and around the estate. The hostile vehicle
23 mitigation barriers at the base of the Elizabeth Tower
24 on Bridge Street were installed to guard against
25 assessed infrastructure risks to the Parliamentary

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1 estate. They were not intended as a barrier to protect
2 pedestrians.

3 As at March 2017, both sets of vehicle gates at
4 Carriage Gates, north and south, were open and left open
5 whilst the House of Commons was sitting. The external
6 crowd control barriers were closed, except when vehicles
7 were entering and leaving, and also during divisions.
8 Had anyone wanted to express concern about the practice
9 of leaving the crowd control barriers open during the
10 divisions, it could have been raised with his department
11 and, if necessary, they would have taken it through the
12 House.

13 For crowd control barriers it would have been
14 a decision taken in the Parliamentary Security
15 Department, but no one had expressed concern about it as
16 a security matter. With the gates being open or closed,
17 that could have been raised by the Metropolitan Police
18 with his department, and it would have been put to both
19 speakers of the Houses to make a decision.

20 On 22 March there were three security officers from
21 his department in New Palace Yard and a doorkeeper at
22 the members' entrance. His officers wear body armour
23 and are issued with personal radios. The radios are
24 turned to a channel shared with the police officers at
25 the Palace.

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1 He was aware in March 2017 that Carriage Gates had
2 been identified by the police in tactical assessments
3 and security views as a particularly vulnerable entry
4 point for any attacker onto the estate. He was very
5 comfortable with the recommendations from the police to
6 put armed police at the perimeter of the estate,
7 including New Palace Yard, but he would not know where
8 the armed officers would actually be posted, nor would
9 he or anyone from his department monitor where they were
10 deployed.

11 Chief Superintendent Dawn Morris is now in charge of
12 protective security operations for the
13 Metropolitan Police. For four years to June 2018, she
14 was part of the Public Order and Resources Command and
15 led on the Prepare strand of the Government's
16 anti-terrorist CONTEST strategy for the Met Police.

17 In her evidence she set out the training given to
18 Met officers in the period running up to March 2017.
19 There is a document called the MPS Response to Terrorist
20 Attack Guidance, so as to ensure there is a coordinated
21 multi-agency response should there be such an attack.
22 The document was first produced in January 2016 and has
23 been revised on a number of occasions.

24 Versions of the document predating March 2017
25 considered marauding firearms attacks and knife attacks.

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1 Such an attack would be a multi-seated marauding attack
2 or an ambiguous attack. She said that an ambiguous
3 attack would include firearms, knives, vehicles or
4 explosive devices. The document used scenarios based on
5 the Paris attacks from November 2015 and the Nice attack
6 in 2016.

7 Training carried out included training for the
8 command structure used where there is a significant
9 event. There is a trained cadre of people that can take
10 on the roles of "gold" strategic lead, "silver" tactical
11 lead, and bronze on-the-ground command in such
12 eventualities. There have been a number of large-scale
13 exercises conducted to test and enhance preparedness for
14 attacks. One such exercise was carried out in March, on
15 19 March 2017, to test the capability to respond to
16 a threat on the River Thames. That exercise tested not
17 just the command and control structure, but also the
18 armed officer response.

19 She spoke about a number of other specific exercises
20 and need to check how the approach worked with other
21 agencies and how their response would be coordinated.
22 She also spoke about the Hydra training where large
23 teams are presented with a range of audio, video and
24 different text-based materials in order to immerse
25 themselves into a scenario and work through a decision

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1 process, and Operation Plato, which is the national
2 codename used to activate an enhanced multi-agency
3 response to a terror attack. The Westminster Bridge
4 attack was the subject of an Operation Plato declaration
5 at 14.55 on 22 March.

6 Masood. Detective Chief Inspector Dan Brown is the
7 deputy senior investigating officer on
8 Operation Classific. One area of his responsibility has
9 been the life and background of Masood. He also led the
10 investigation into the planning and preparation for the
11 attack on 22 March. Masood was born on
12 25 December 1964. His birth was registered in the name
13 of Adrian Russell Elms, his mother is Janet Ajao and he
14 was known either as Adrian Elms or Adrian Ajao until
15 2004. He formally changed his name to Khalid Masood in
16 2005.

17 Masood went to secondary school initially in
18 Lewisham and then the family moved to Tunbridge Wells.
19 Janet Ajao tried to get him into a local grammar school
20 but those efforts failed and he went to Huntley Boys'
21 Comprehensive School.

22 Age 14, he first came to the attention of the police
23 when he was arrested and later cautioned for
24 shoplifting. Although Masood's mother described him as
25 displaying normal boisterous behaviour in his school

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1 years, his brothers suggested he was a violent but
2 clever person who would not back down from an argument.
3 He left school at 16 and went to Tunbridge College of
4 Further Education and undertook a BTEC course in
5 business studies.

6 Detective Chief Inspector Brown and his team then
7 traced the life the Masood onwards and the other
8 occasions on which he came to the attention of the
9 police. In 1992, he formed his first serious
10 relationship with Jane Harvey and they had two children,
11 in 1992 and 1998. Jane Harvey described Masood as
12 intelligent, powerful and persuasive, with a charming
13 personality. However, she also said she would regularly
14 go out drinking and call for her help when he returned.

15 Masood did a three-year degree course at Falmer
16 University in Brighton. Most notable of his scrapes
17 with the police was a prosecution for wounding in 2000
18 which led to him serving a sentence of imprisonment, and
19 then in 2003 where an extremely serious incident of
20 violence occurred. There had been a number of other
21 reports of incidents of violence in the police system in
22 the interim, which Detective Chief Inspector Brown dealt
23 with.

24 The incident in 2003 led to Masood being charged
25 with attempted murder. The details of the offence are

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1 extremely serious. The victim sustained the most
2 horrific injuries. Masood stood trial, the issue was
3 self-defence. Ultimately he was acquitted of the most
4 serious charges.

5 Evidence on this offence was also called from
6 Detective Constable Stuart Black from Sussex Police. He
7 said that the injuries sustained by the victim in that
8 case are some of the worst he has ever seen. The knife
9 had been used on the victim with sufficient force that
10 it had gone through the upper mouth plate and into the
11 lower jawbone where the tip broke off and remained
12 embedded in the jaw after the attack.

13 The periods Masood served in prison, serving
14 a sentence in 2000 and then on remand in 2003, are of
15 some significance. The prison records show that when
16 Masood left prison on the second occasion, his religion
17 was given as Muslim. He clearly developed his interest
18 in the religion whilst there, even though, whilst there,
19 there was nothing to show that he formed or expressed
20 extremist views.

21 Masood went to work in Saudi Arabia after leaving
22 prison in 2003. He married Farzana Malik in 2004, but
23 that marriage did not last long. He went to Saudi
24 Arabia again in 2005, the same year that he changed his
25 name by deed poll.

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1 In 2006, he met and subsequently married
2 Rohey Hydara. They lived in Luton initially and Masood
3 returned to work in Saudi Arabia. When he returned,
4 they moved to Chadwell Heath. Whilst there, Rohey had
5 a recollection of Masood meeting a friend in a park,
6 somebody he told her was wearing a tag in relation to
7 a terrorism offence, and where he would not take his
8 mobile phone.

9 Masood returned to Saudi Arabia in 2008 through to
10 2009, and on his return, they moved to Luton, and Masood
11 worked for ELAS. Whilst there, he met Craig O'Donaghue.
12 Craig O'Donaghue's recollection was that Masood wanted
13 to convert him to Islam. It is at this stage that
14 Masood started to use the gym and began to use steroids.
15 He had anger issues and their marriage -- this is the
16 marriage to Rohey Hydara -- had its problems.

17 In 2012 Masood went to live in Birmingham, where he
18 set up an English language teaching business. He and
19 Rohey separated and she returned to London. At this
20 time Masood used an Islamic dating site called Pure
21 Matrimony and exchanged emails with a woman in which he
22 described various parts of his life.

23 In 2015 he was making plans for a return to Saudi
24 Arabia. In 2016 he received a job offer from
25 a university there. In early 2017, he was living in

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1 Birmingham and the family were in London.

2 He met a man called Ahmed El Farsi, a Moroccan man,
3 who had a home in Morocco. Masood expressed an interest
4 in travelling to Morocco. A text recovered from Masood
5 to El Farsi speaks about a trip on 26 March 2017.

6 On 7 March 2017 Masood sent an email to his mother.
7 A number of topics are covered in that communication,
8 including a business opportunity in Morocco.

9 Detective Chief Inspector Brown and his team
10 investigated Masood's finances. Masood was struggling
11 for money and was in debt at the time of his death.
12 An application for a loan in December 2016 had been
13 refused.

14 They made extensive investigation of Masood's
15 periods in custody. Part of those records showed his
16 conversion to Islam in 2000, but that he really accepted
17 the religion in the course of his second term in prison.

18 On 8 March 2017, Masood had carried out internet
19 research on 4x4 vehicles, including Hyundai vehicles,
20 and he then reserved a car through Enterprise cars in
21 Birmingham. The period of hire was from 16 to
22 20 March 2017. He emailed his mother about visiting her
23 on 16 March.

24 On 9 March 2017, he went to a Tesco store local to
25 him in Birmingham and bought two knives, one of which is

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1 believed to have been used in the attack. He also made
2 inquiries about Calor Gas consistent with the potential
3 use of a canister as a weapon.

4 On 14 March 2017, his eldest daughter contacted her
5 sister, saying that their father was leaving the country
6 and a reference to their grandfather, Masood's
7 stepfather, who was in hospital.

8 Also on 14 March, Masood was making internet
9 searches about speed tests and crash tests for the
10 Hyundai Tucson, and on 15 March, he sent between his two
11 email addresses the document entitled "Jihad".

12 On 16 March he visited Enterprise car hire,
13 collected the car he had booked online, and then drove
14 from Birmingham to Wales to meet his mother and
15 stepfather. In conversation with his mother he
16 mentioned that he was thinking of moving to a Muslim
17 country, but he couldn't go back to Saudi Arabia because
18 of his criminal record, and a friend in Morocco with
19 a property was a possibility. As he left, he said:

20 "They'll say I'm a terrorist. I'm not."

21 On 17 March he went to Brighton and checked into the
22 Preston Park Hotel.

23 On 18 March he drove to London, and at 12.44 that
24 day was crossing over Westminster Bridge in the Hyundai.
25 He crossed back over that bridge at 12.52. This was

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1 clearly a reconnaissance for 22 March.

2 He then drove to Cobham and checked into the
3 Days Inn. He extended his stay and on the 20 March he
4 watched a number of videos about terrorist attacks. On
5 21 March he extended the hire of the car for a second
6 time, checked out of the Days Inn and went back to the
7 Preston Park Hotel in Brighton.

8 On 21 March, he had a video call with his wife and
9 young children, as well as a call with his eldest
10 daughter. She thought he was going to Morocco.

11 On 22 March, Masood was searching on the internet
12 for Prime Minister's Questions and vehicle-borne
13 improvised explosive devices. He checked out of the
14 hotel and drove back to London. He travelled across
15 Westminster Bridge from south to north, and then across
16 Parliament Square and down Victoria Street. He turned
17 around and then went down Whitehall and then back to
18 Parliament Square before crossing south over
19 Westminster Bridge. This was at about 10.30 am, and
20 appears to be further reconnaissance.

21 His car is seen at 11.18 on the A3 travelling south.
22 The next time his car is picked up on the CCTV is at
23 13.52 when it is travelling north. The car is seen
24 parked in a car park in St Thomas' Hospital until about
25 14.36 when Masood drives out of the car park towards the

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1 approach to Westminster Bridge.

2 Masood sent texts and other messages at 14.26 and
3 14.29 with the "Jihad" document attached. Amongst other
4 people it went to was his wife, Rohey. She sent a text
5 at 14.32 saying she needed to speak to him urgently, and
6 at 14.51 asking what it is that he had sent her. At
7 14.38 he is in the bus lane before he sets off on his
8 murderous attack.

9 In the course of questions from Mr Patterson,
10 Detective Chief Inspector Brown was asked about the
11 radicalisation of Masood, the information from prisons,
12 from those who knew him and from materials he had looked
13 at online and the books in his possession. Detective
14 Chief Inspector Brown was also asked about the links
15 between Masood and others of concern in the Crawley
16 area, particularly those with links to ALM.
17 Mr Patterson explored areas where Masood had been
18 involved in seeking to convert others. The material on
19 the internet in hard copy form and on the memory stick
20 was also explored in the course of these Inquests.

21 Mr Patterson also questioned Detective Chief
22 Inspector Brown about the links between terrorists and
23 previous disposition to serious violence. Detective
24 Chief Inspector Brown was asked about other terror
25 incidents also involving the use of hire vehicles, as

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1 well as the use of WhatsApp for the sending messages
2 that presents serious difficulties for those involved in
3 law enforcement. The questions and topics for Detective
4 Chief Inspector Brown were wide-ranging and throughout
5 it seems to me he gave clear and candid answers to all
6 the important topics raised by Mr Patterson and then
7 Mr Adamson about the background of Masood, the details
8 of the planning and the preparation of this atrocious
9 attack.

10 Janet Ajao is the mother of Khalid Masood. She gave
11 evidence about his childhood and schooling. She
12 recalled that he was arrested for shoplifting at 14.
13 Janet continued describing her son's life, including his
14 time in prison and his partners. She was aware that he
15 took up the Islamic faith upon leaving prison, some time
16 after 2003.

17 In detail she explained the extent to which Masood
18 would often want to talk about nothing but religion,
19 describing that she could put down the telephone, go and
20 make a cup of tea, come back and find that he was still
21 in the course of a monologue. She did not recall him
22 ever expressing hostility or hatred towards the West or
23 other religions or on views in support of terrorist
24 violence. Nor did she recall any associations he had
25 with people with extremist views.

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1 Janet understood that Masood had moved to Crawley in
2 2004 because a man whom he had met in prison had told
3 him to go and live somewhere near a large Muslim
4 community. Janet was shown emails which Masood had sent
5 to her, one in May 2013. In that email, he complained
6 about his mother not seeing his children and complained
7 about his life having been blighted by being sent to
8 a comprehensive school. Janet said this had deeply
9 upset her.

10 During his last visit to see her, Masood made his
11 mother repeat a number of religious phrases to the
12 effect that Allah was the one true God and Mohammed the
13 Prophet. She understood that he was then travelling to
14 London, assuming that it was to be see his wife and
15 children. The next morning, shortly before he left
16 Janet's home, Masood spent time looking at a large road
17 map on the kitchen table, which Janet said was similar
18 to the map on which we know Masood made a series of
19 handwritten notes.

20 As he was leaving, he said to her "They'll say
21 I'm a terrorist, but I'm not". Janet did not say
22 anything in response, not understanding what he meant.
23 It did not cross her mind that he was planning
24 a terrorist attack. She was very clear about what she
25 would have done had she understood this to be the

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1 meaning. In her words:

2 "I'd have done anything, believe me. I think
3 I would have phoned directly on 999 and someone would
4 have come out to me".

5 Rohey Hydera is the widow of Khalid Masood. They
6 met in 2006 and married soon after their meeting.
7 Masood was more strongly religious than she was: he was
8 stricter in his dress sense and in eating halal food
9 than she was. At times in their marriage Masood worked
10 in Saudi Arabia. They had lived in various locations,
11 including Chadwell Heath, Luton and Birmingham. When
12 they married Masood had told her that he had been in
13 trouble and had been to prison. She knew that he had
14 been to prison for as long as two years and he had told
15 her of his acquittal.

16 As to his conversion to Islam he spoke about someone
17 he met in prison who was there on drugs charges and that
18 that person gave him the message of Islam. He told her
19 he became more religious when he went to Saudi Arabia.
20 Masood was loving towards their children, but otherwise
21 he had an angry and controlling temperament. This would
22 get very bad when he was on steroids. He would rant and
23 complain over every little thing.

24 They had separated on a number of times in the
25 course of their marriage. The reason was his temper.

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1 On a number of times he went as far as to speak the
2 Islamic formula to divorce. On one occasion it was
3 because he had asked her to stop wearing trousers. On
4 another occasion it was because she had asked him to
5 stop using steroids and he refused.

6 Rohey said she was never aware of Masood associating
7 with anybody who was a member of an extremist group.
8 She did not recall him ever discussing the 9/11 attack
9 on New York. As far as she was concerned, Masood was
10 polite to people of other religions and those of no
11 faith.

12 Some years before the attack she covertly recorded a
13 number of conversations she had with Masood. In one of
14 those conversations he can be heard speaking vehemently
15 about the importance of him being the head of the
16 household and being obeyed. When he was using steroids,
17 as during that recording, his tone was different to when
18 he was not using any drugs.

19 Masood kept a hammer and pocketknife at the side of
20 the bed, saying he needed those to protect himself
21 against a burglar. He had a knife in the boot of the
22 car. He had a knife in a backpack on another occasion.

23 Rohey moved to London in November 2016. She
24 understood that Masood was preparing to move to
25 Saudi Arabia to take up a job offer. When he had

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1 difficulties with a visa application, he became
2 frustrated. Rohey was aware that Masood was settling
3 a number of debts, although money was tight. He paid
4 an outstanding electricity bill and a second bill from
5 Birmingham Council. In the last few months of his life
6 he prayed more often and was more focused upon religion.

7 Rohey spoke to Masood by FaceTime on the night of
8 21 March. She said that apparently he told her he was
9 going to spend the night in prayer. His face was
10 visibly reddened. On the morning of 22 March, Rohey
11 received text messages from Masood which she considered
12 to be relatively normal, but perhaps more loving than
13 usual. Then at about 2.30 received a message with
14 the document "Jihad". She messaged Masood and received
15 no response. She then began to receive automatic news
16 notifications that there had been an attack in London.
17 She was immediately worried. As soon as she saw
18 a photograph of the London attacker lying on the ground,
19 she realised that it was her husband.

20 When asked her opinion of what he did on 22 March,
21 Rohey spoke succinctly and forcefully, "It was evil".
22 When it was suggested that she knew more about his
23 radical beliefs than she is now willing to admit, she
24 firmly denied this, saying:

25 "I knew I was living with a man that had anger

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1 issues, but I didn't know he would do something like
2 this. If I did, I would have told the police, just like
3 I did when I realised it was him, I called the police."

4 Professor Cowan is a professor of pharmaceutical
5 toxicology. Samples were taken from Khalid Masood
6 post-mortem and those samples were analysed. Analysis
7 shows that nandrolone, an anabolic steroid, had been
8 taken by Masood within a week before his death. It is
9 a steroid that is effective when given by injection.
10 Professor Cowan wasn't able to say that it had been used
11 over a period of time from the hair sample taken from
12 Masood. However, from a document where the handwriting
13 is attributed to Masood that lists a number of
14 substances, and where two were of particular interest:
15 one preparation containing testosterone, and the other
16 nandrolone, as the document sets out sums of money
17 involved and some regularity of orders, he had concluded
18 that Masood was a steroid user over a period of time,
19 albeit not a particularly heavy user.

20 He had looked at evidence from people who knew
21 Masood as well as from various analyses and, based on
22 all of that material, he didn't see any note that
23 suggested when Masood was using steroids he became
24 aggressive and that when he was off them he was
25 depressed. He said in large doses steroid use can cause

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1 aggression. Anabolic steroids come within the Misuse of
2 Drugs Act and specifically Schedule 4 as a class C drug.
3 To sell them without a medical prescription he said
4 would be an offence.

5 Dr Chisholm is a consultant clinical psychologist.
6 He gave evidence of a psychological profile he had
7 undertaken on Masood. In carrying out his assessments,
8 he had looked at a collection of witness statements,
9 some recordings of Masood made by his wife, as well as
10 material about Masood's offending. His opinion is that
11 Masood was not suffering from a psychotic illness or
12 from any psychotic symptoms. Masood met criteria
13 sufficient for anti-social personality disorder, and
14 that it was probable, although he was less confident,
15 that Masood also met the criteria for narcissistic
16 personality disorder. At the time of the attack Masood
17 was able to think logically and rationally.

18 Detective Chief Superintendent Peter Holdcroft was
19 Head of Operations and part of SO15 as at March 2017.
20 He led the proactive response of SO15 units. They were
21 looking to see if there was a wider threat from other
22 suspects linked to Masood to see if there was anyone
23 else involved in the commission, preparation or
24 instigation of the attack and to take steps in order to
25 mitigate any further threat.

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1 They arrested Rohey Hydera but she was released
2 after interview and after inquiry showed there was no
3 evidence to implicate her. They had arrested six
4 individuals at addresses connected to Masood, or to the
5 details given on the car hire document, but again there
6 was shown to be no connection and no involvement in the
7 attack.

8 Ahmed El Farsi was arrested and interviewed on the
9 basis of the links in February 2017. That interview and
10 further investigation showed no evidence implicating him
11 as being involved in the attack.

12 Yusuf Kumar was arrested and interviewed. Extensive
13 inquiries were made into him but, as with the other
14 individuals arrested and interviewed, there was nothing
15 to implicate any of them. The extensive investigation
16 showed that Masood acted alone in this attack.

17 Witness L has been with MI5 since 1991. He is the
18 Deputy Director for International Counter Terrorism
19 responsible for policy, strategy and capability. His
20 job involved looking at the challenges the country faces
21 in international counter terrorism and considering the
22 strategic changes that might be made to address them.
23 He gave evidence in the London bombing Inquests
24 in February 2011 before Lady Justice Hallett. He set
25 out the functions of MI5 and the legal framework in

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1 which it acts. He also set out the investigative
2 processes adopted by MI5, including the approach to
3 subjects of interest and the tiers applied to such
4 people.

5 He dealt with a number of reviews undertaken by MI5
6 following the Westminster Bridge attack: the post-attack
7 review; an Operational Improvement Review, and
8 an insurance process conducted by David Anderson QC, as
9 he then was.

10 A particular focus of the Operational Improvement
11 Review was the assessment of Subjects of Interest, or
12 SOIs. MI5 had around 3,000 SOIs in March 2017 with
13 around 500 investigations being pursued into individuals
14 and groups linked to Islamic terrorism. There were
15 approximately 20,000 closed SOIs. The scale of the
16 work, he said, was unprecedented.

17 David Anderson in his report had endorsed as
18 appropriate the processes followed by the review teams.
19 He had praised MI5 staff as frank and open to criticism
20 in meetings.

21 Masood first came to the attention of MI5
22 in April 2014, when his telephone number was found in
23 the contact list of another SOI. This was part of
24 Operation Crevice, known commonly as the fertiliser bomb
25 plot. Masood has never been identified as having any

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1 connection to the plot, and it would have been
2 straightforward to identify Masood from his telephone
3 number, but Witness L was clear it would not have been
4 proportionate.

5 Later, a long standing associate of Masood's was
6 investigated as an SOI between 2004 and 2009. During
7 this time Masood's personal contact details came up in
8 that investigation. Some of those contact details were
9 attributed to Masood at that stage and some were not.

10 The information on Masood did not suggest he was
11 involved in the activity under investigation. Again, it
12 would have been practical to identify Masood but not
13 proportionate to do so, there being no evidence that
14 he was involved in any activities of concern.

15 In 2009 and 2010, a person called Khalid Masood was
16 thought to be in a position to assist in travel to the
17 FATA, an extremist in Saudi Arabia. MI5 thought that
18 this might be the Khalid Masood with whom this Inquest
19 was concerned, but he was ruled out as a suspect.
20 Masood was given a holding code during this
21 investigation as an SOI. When it was ruled out that
22 he was the person facilitating trouble, his holding code
23 was downgraded. That was in March 2010. Masood's
24 identity had not been established at that time with any
25 confidence.

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1 By December 2010 MI5 completed a full identification
2 of Masood and had his PNC record. There was no evidence
3 that he was involved in any form of extremism. Although
4 his PNC record showed violent offending, Witness L does
5 not think this would have weighed heavily in
6 an investigator's mind, being about seven years before
7 that date.

8 Masood was closed as an SOI, the decision being
9 taken in December 2010, although he wasn't formally
10 closed until October 2012. Between those dates there
11 was some intelligence indicating that he was involved
12 with other SOIs, but this was only on the margins of
13 extremism. There was absolutely no evidence of direct
14 involvement in extremism or attack planning, but there
15 was an indication that he consumed extremist material.
16 That, he said, is not enough to keep somebody as an SOI.
17 If it were, there would simply be an unmanageable number
18 of SOIs.

19 Between 2012 and 2016 Masood did continue to appear
20 on MI5's radar. He appeared intermittently as a contact
21 of a number of SOIs. There was never any evidence that
22 he was a member of ALM. There was never any
23 intelligence that he might be directly involved in
24 extremist activity. This did not reach the threshold
25 for further investigation into Masood.

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1 In 2013 specific intelligence was received that
2 Masood had expressed contentment with the violent
3 actions such as the World Trade Centre attack on 9/11
4 had attracted people to Islam. Such sentiments,
5 he said, are depressingly common. It was not enough to
6 make Masood an SOI once again.

7 Looking back at all of the factors of which MI5 was
8 aware, Witness L maintains MI5's view that there was no
9 reason to reopen the investigation into Masood. Because
10 Masood appears to have planned the attack on his own,
11 Witness L thinks it very unlikely the plot would have
12 been noticed by MI5, even had he been reopened as
13 an SOI. Even with hindsight Witness L did not believe
14 there was anything which MI5 could practicably have done
15 to prevent this type of attack by a person with Masood's
16 record and background.

17 The reasons for a decision to close an SOI did not
18 get recorded by MI5. Witness L gave evidence that this
19 is appropriate because it would be an inappropriate use
20 of resources to do otherwise. Instead reasons were
21 given when a positive decision is made to do something
22 intrusive. This process has since changed and more
23 records are kept.

24 Siwan Hayward is the Director of Compliance,
25 Policing and On-Street Services for Transport for

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1 London, or TfL. She is responsible for managing TfL's
2 relationship with its policing and enforcement partners.

3 TfL has a duty to maintain GLA, Greater London
4 Authority, roads and a power to effect appropriate
5 improvements. It has a specific power to provide and
6 maintain rails, fences, barriers and so on. It has
7 a further right to take steps to keep the traffic
8 flowing. The Westminster Bridge Road is such a road.
9 TfL is both the highway authority and the traffic
10 authority for it.

11 TfL is the decision-maker for changes to the roadway
12 but would typically consult with the neighbouring local
13 authorities. TfL would often ask for advice from CTSAs,
14 Counter Terrorism Security Advisors, as described by
15 Chief Superintendent Aldworth. TfL has a duty to take
16 all reasonable measures to reduce the risk of crime,
17 including terrorism. Ms Hayward said that bridges in
18 general, and Westminster Bridge in particular, were not
19 identified by TfL as particularly vulnerable to
20 a terrorist attack.

21 TfL received guidance documents through police
22 channels about the terrorist attacks in Nice and Berlin
23 in 2016. The first guidance resulted in TfL reviewing
24 how large crowds at public events are protected and to
25 work alongside the police in that respect. As to the

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1 Berlin guidance, which suggested using pedestrian
2 barriers as a slowing mechanism, TfL did not regard that
3 to be specifically relevant to them in respect of crowds
4 on bridges.

5 TfL did not undertake any subsequent review of
6 hostile vehicle mitigation on roads and bridges.
7 Ms Hayward was clear that pedestrian guardrails that
8 existed on other bridges at the time were not
9 appropriate as hostile vehicle mitigation device, but
10 were to keep pedestrians out of the carriageway.

11 Ms Hayward was also asked questions regarding
12 heights of the balustrade on Westminster Bridge. The
13 balustrade in places is approximately 99 centimetres,
14 she was told. Ms Hayward said that the recommended
15 height was a minimum of 100 centimetres and this small
16 discrepancy would not have been sufficient to trigger
17 any remedial work.

18 That concludes my summary of the evidence that's
19 been called in the course of these Inquests. In
20 relation to the Article 2 questions, my decision is
21 this.

22 It is common ground, and I agree, that Article 2 is
23 not engaged in any of the Inquests concerning the
24 victims on the bridge, but in respect of
25 PC Keith Palmer, my decision is that Article 2 is

1 engaged, and I will provide full reasons for that
2 decision in due course.

3 I need, then, to make a formal determination in
4 respect of each person.

5 So turning first of all to Kurt William Cochran.
6 The date and time of his death was 22 March 2017 at
7 17.34 hours on Lower South Bank Walk, London, near
8 Westminster Bridge. The medical cause of his death was
9 multiple injuries.

10 Then, turning to the determinations. Kurt Cochran
11 was unlawfully killed. On 22 March 2017 Kurt Cochran
12 was on a visit to London. He had been walking with his
13 wife, Melissa, across Westminster Bridge. They had
14 reached a point near the south bank side when a Hyundai
15 vehicle was driven deliberately into the pavement where
16 they stood. This was part of a terrorist attack.

17 Showing no concern for himself, Kurt instinctively
18 and courageously pushed Melissa away from the path of
19 the vehicle and as a result, was struck with full force
20 by the vehicle. He was thrown over the parapet of the
21 bridge to the embankment below, falling from a height of
22 5.12 metres. In the fall he sustained a serious head
23 injury which was not survivable. Despite early medical
24 attention from a nurse, an ambulance crew and a hospital
25 doctor, he died at the scene.

1 Leslie Arthur Rhodes. His date and place of death
2 was 23 March 2017 at 20.44, and that was at King's
3 College Hospital, London. The medical cause of death in
4 his case is also head injury.

5 Turning to the determination in his case,
6 Leslie Rhodes was unlawfully killed. On 22 March 2017
7 Leslie Rhodes was walking from the south bank side of
8 Westminster Bridge towards the north bank side. He was
9 struck from behind by a Hyundai vehicle which had been
10 deliberately driven into the pavement where he was
11 walking. This was part of a terrorist attack.

12 Leslie was carried along into the carriageway
13 a distance of 33 metres. As a result of the impact, he
14 suffered a devastating brain injury which was not
15 survivable. He was unconscious from the time of the
16 impact until his death. Despite early medical
17 intervention, attention from a hospital doctor and
18 paramedics at the scene, and despite proper treatment at
19 King's College Hospital, Leslie died on 23 March 2017 in
20 hospital.

21 Aysha Frade. The date and place of her death was
22 22 March 2017 at 15.08 on Westminster Bridge. The
23 medical cause of death in her case was head and chest
24 injuries.

25 Aysha Frade was unlawfully killed. On

1 22 March 2017, Aysha Frade was walking across
2 Westminster Bridge towards Parliament Square on her way
3 home from work. While walking on the pavement, she was
4 struck from behind by a Hyundai vehicle which had been
5 deliberately driven towards her. This was part of a
6 terrorist attack.

7 Aysha was thrown into the air and into the path of
8 the nearside rear wheels of a bus. Those wheels passed
9 over her, inflicting injuries which were immediately
10 fatal. Aysha would not have suffered. She was assessed
11 as dead at the scene by a paramedic and by a doctor.

12 Andreea Cristea. The date and place and time of her
13 death was 6 April 2017 at 15.11 at St Bartholomew's
14 Hospital. The medical cause of death in her case, 1(a)
15 multiple organ failure, 2, head injury (operated) and
16 immersion.

17 The determination in her case. Again,
18 Andreea Cristea was unlawfully killed. On
19 22 March 2017, Andreea Cristea was walking across
20 Westminster Bridge with her boyfriend, Andrei Burnaz, on
21 the Parliament Square side. She was stopping at times
22 to take photographs with her mobile phone. Whilst on
23 the pavement, she was struck by a Hyundai vehicle which
24 was being deliberately driven towards pedestrians on the
25 pavement. This was part of a terrorist attack.

1 Andreea was thrown into the air and over the parapet
 2 of Westminster Bridge, landing in the River Thames
 3 below. She was carried by the current a distance of
 4 100 metres and was in the water for around 5 minutes
 5 before she was recovered by the London Fire Brigade
 6 boat. She was treated by fire officers and then by
 7 an ambulance crew and paramedics before being taken by
 8 ambulance to hospital.

9 Whilst in hospital she received extensive and
 10 complex medical care over the following days. Despite
 11 the best efforts of clinicians, she died on
 12 6 April 2017.

13 Keith David Palmer. The date and place of his
 14 death, 22 March 2017 at 15.15, at the
 15 Palace of Westminster in London. The medical cause of
 16 death in his case is, 1(a) haemorrhage, 2, stab wound to
 17 the chest.

18 Turning to the conclusions as to death,
 19 determination. PC Keith Palmer was unlawfully killed.
 20 On 22 March 2017, PC Keith Palmer was on duty as
 21 an unarmed police officer stationed at the Carriage
 22 Gates entrance from Parliament Square into the
 23 Palace of Westminster estate.

24 An attacker who had driven his vehicle into multiple
 25 pedestrians on Westminster Bridge entered the gates.

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1 PC Palmer stepped forward to challenge him. He
 2 immediately began attacking PC Palmer with knives,
 3 driving him back into the New Palace Yard area.
 4 PC Palmer stumbled against a low wall and the attacker
 5 continued his assault. In the attack, PC Palmer
 6 suffered a number of injuries, one of which was
 7 a serious stab wound to the chest. Although he was able
 8 to move away from the attacker, PC Palmer collapsed
 9 shortly afterwards. Despite prompt and capable medical
 10 attention at the scene, he suffered a cardiac arrest and
 11 could not be saved.

12 Before the start of the attack, the armed officers
 13 stationed at New Palace Yard had not been in close
 14 proximity to the Carriage Gates entrance. They had been
 15 some distance away and out of view of the entrance
 16 because they had understood their duty to involve
 17 a roving patrol around the yard.

18 In fact, tactical advice and written instructions
 19 stated that armed officers should be stationed close to
 20 the Carriage Gates entrance so as to protect those in
 21 the estate and their unarmed colleagues. Due to
 22 shortcomings in the security system at New Palace Yard,
 23 including the supervision of those engaged in such
 24 duties, the armed officers were not aware of
 25 a requirement to remain in close proximity to the gates.

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1 Had they been stationed there, it is possible that
 2 they may have been able to prevent PC Palmer suffering
 3 fatal injuries.

4 I should make clear that the determination sheets
 5 will be posted on the website and made available to the
 6 press.

7 In terms of the Prevention of Future Death Reports,
 8 the directions I make are as follows: that any
 9 interested person wishing to propose points to be made
 10 in any Prevention of Future Death Report beyond those
 11 set out already in the submissions should file those
 12 submissions with the solicitors to the Inquest by
 13 4.00 pm on 12 October this year, identifying the points
 14 to be made and the proposed addressees of any report.
 15 And, secondly, that any interested person wishing to
 16 respond to those proposals or others for points to be
 17 made in any Prevention of Future Death Report, should
 18 file submissions with solicitors to the Inquests by
 19 4.00 pm on 9 November 2018.

20 After considering those submissions, I will produce
 21 a report, if necessary, and circulate it to all
 22 interested persons, as well as sending it to the
 23 appropriate addressees.

24 It would be wrong for me not to say a few other
 25 words of thanks. Can I simply repeat what I have said

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1 a number of times: to thank all of those representing
 2 the interested persons in the course of these Inquests.
 3 You have each helped me enormously in the difficult
 4 tasks that I have faced, and I thank you all very much
 5 for your oral and written submissions.

6 Can I also, please, thank those who have been
 7 looking after the witnesses who have come from the
 8 witness care team and the coroners' court support
 9 services at this court.

10 I would particularly like to express my sincere
 11 thanks and appreciation for all the painstaking work
 12 that's been undertaken by the Metropolitan Police
 13 counter terrorism team over the many months since these
 14 awful attacks, led by the senior investigating officer,
 15 Detective Superintendent Crossley, and his deputy,
 16 Detective Chief Inspector Brown, but also Detective
 17 Inspector Eastwood and their team of approximately 40
 18 officers who have investigated these events on 22 March,
 19 and then have acted in effect as my coronial officers in
 20 providing disclosure and investigating matters at the
 21 request of the Inquests team.

22 I would like to specifically mention the
 23 contributions to the coronial investigation by Detective
 24 Sergeant Walker, Detective Constable Osland, Detective
 25 Constable Needham and Detective Constable Overall, as

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1 well as the work of all of those in the family liaison
 2 team, the family liaison officers and, as I've
 3 indicated, the witness support teams.
 4 Mr Hough, that concludes these Inquests. We move,
 5 tomorrow morning, to start the Inquest in relation to
 6 Masood. That, in fact, I think will be listed in this
 7 court at 10.45 tomorrow morning.
 8 MR HOUGH: Sir, yes. Before I finish, may I say on behalf
 9 of your team how impressed we have been by the dignity
 10 of the bereaved families and their representatives, to
 11 thank them for that, and to express our sincere
 12 condolences to them once again.
 13 THE CHIEF CORONER: Yes. Mr Hough, right at the very first
 14 review hearing that I carried out, I expressed my
 15 condolences to the families, and I repeat them. I have
 16 had, as I have indicated, the opportunity of meeting not
 17 all but many of the families in this process, and it has
 18 been an important part of the process for me to do so.
 19 I know that words can never really cover what has
 20 happened, but they certainly have my sincere
 21 condolences.
 22 MR PATTERSON: Sir, I wonder before we rise may I, on that
 23 theme, echo what you say, sir, about the families. As
 24 counsel instructed to represent some of the families of
 25 those killed on 22 March, it would be wrong to conclude

1 without my making mention of those who have been at the
 2 heart of this whole process. As you have very
 3 thoughtfully observed already, they have shown dignity
 4 throughout, sir, despite facing evidence that has been
 5 upsetting and harrowing at times for them and regular
 6 reminders of what happened. They have attended
 7 conferences with us, the lawyers, they have assisted us
 8 and in the process been assisting you in the Inquest
 9 hearings, and as their representative I would like to
 10 recognise publicly their dignified approach and express
 11 our appreciation for their input.
 12 Could I also take this opportunity, sir, in relation
 13 to eyewitnesses who have come to court --
 14 THE CHIEF CORONER: Yes.
 15 MR PATTERSON: -- who have had to relive at times what must
 16 be difficult for them to relive, what they saw. As you
 17 know, sir, where particular thanks were appropriate for
 18 the assistance that they gave on the day, this has been
 19 expressed by the representatives of the families, and in
 20 expressing the families' gratitude to those individuals,
 21 those words of gratitude were very sincerely meant.
 22 Finally, sir, could I also take this opportunity to
 23 thank you, sir, for the sensitive way that you have
 24 presided over these hearings. From first to last you
 25 have shown sensitivity to the families. You have wanted

1 to know more about the loved ones who lost their lives.
 2 You asked for evidence about each of the deceased in
 3 order to ensure that they weren't just treated as
 4 persons about whom we know little beyond their name and
 5 age, but as real people with distinct personalities and
 6 interests and families and friends.
 7 You met with family members where you could, and
 8 that really helped, and I know that that assisted the
 9 families considerably, and I thank you for that, sir.
 10 You took steps to set up a video link to assist some
 11 family members to follow your proceedings from afar, and
 12 that was gratefully received. You ensured that their
 13 concerns were explored in evidence and their questions
 14 answered, and when we consider, sir, the recent reforms
 15 to coronial law that were made with the intention of
 16 putting the needs of the bereaved at the heart of the
 17 system, we would submit, sir, that these Inquests have
 18 sought to do just that.
 19 So on behalf of the families, could I express our
 20 gratitude and appreciation for the care and humanity and
 21 sensitivity that you have shown to them.
 22 THE CHIEF CORONER: Thank you very much, Mr Patterson.
 23 MR ADAMSON: Sir, I also wish to express on behalf of my
 24 clients their thanks to you. It is clear from your
 25 detailed summing-up that you have heard and listened to

1 all of the evidence that has been put before you.
 2 I would also like to pay tribute to the families for the
 3 way in which they have conducted themselves throughout
 4 this process. They have, as all have said, behaved with
 5 impeccable dignity when they find themselves in the
 6 cruellest of spotlights.
 7 THE CHIEF CORONER: Thank you.
 8 MS STEVENS: Sir, can I add my words to those that have just
 9 been advanced by my learned friends. The dignity and
 10 the strength of Police Constable Palmer's family
 11 throughout has been remarkable, and mirrors the
 12 qualities of Keith Palmer himself.
 13 It would be impossible not to have been humbled by
 14 the dignity and strength of all the families. May I too
 15 offer my condolences to all.
 16 THE CHIEF CORONER: Thank you. I'll rise.
 17 (4.39 pm)
 18 (The court adjourned until 10.45 am on
 19 Thursday, 4 October 2018)
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