IN HER MAJESTY'S CORONER'S COURT
BEFORE THE CHIEF CORONER HHJ LUCRAFT QC

INQUESTS ARISING FROM THE DEATHS
IN THE WESTMINSTER TERROR ATTACK OF 22 MARCH 2017

SUBMISSIONS ON BEHALF OF THE WIDOWS OF
KURT COCHRAN AND PC KEITH PALMER
AS TO DETERMINATIONS TO BE MADE BY THE CORONER

Introduction

1. The author is indebted to the Mr Hough QC and Mr Moss for their industry and their written submissions circulated on 1 October 2018 in respect of which there is substantial agreement.

2. For ease, these submissions will be separated into two sections. The first concerns the submissions of behalf of Melissa Cochran. The second concerns the submissions on behalf of Michelle Palmer, PC Palmer's widow.

Section 1: Kurt Cochran

3. As to Kurt Cochran's death:-

   (a) It is not suggested that the article 2 procedural obligation is engaged in relation to the issues surrounding Kurt's death.
   (b) It is agreed that a short form narrative verdict of unlawful killing coupled with a short narrative is the appropriate conclusion (paragraph 14 CTI's submission).

4. It is submitted that the suggestive narrative ought to record Kurt's bravery and courage. The evidence of Melissa Cochran was to the effect that his decision to push her out of the way of the oncoming vehicle was typical of him[1].

5. In the circumstances, we invite the words set out at paragraph 15(a) of CTI's submissions to be amended so as to read "*Showing no concern for himself, Kurt instinctively and courageously pushed Melissa…*".

6. We have liaised with Mr Patterson QC and the Hogan Lovells team in respect of the words suggested at paragraph 5 above. The two legal teams are agreed that the narrative ought to record words of this nature.

Section 2: PC Keith Palmer

7. CTI's summary of the law at paragraph 6 and 7 of their submissions are agreed. It is to be hoped that there will be no challenge to the submission that the article 2 obligation is engaged (paragraph 11 CTI Submissions). However, despite this hope, we proceed on the basis that it remains in issue.

8. It is anticipated that it will be suggested by the MPS that:-

   (a) As regards the general duty, article 2 is not engaged [despite copious evidence to the contrary]. There was no systemic failure. Any failings in relation to the absence of AFOs at the Carriage Gates at the time of the attack were individual in nature.
   (b) As regards the operational duty, article 2 is not engaged there was no real and immediate risk of death to officers at the Carriage Gates.
   (c) In any event, there is no evidence that the failings (systemic or otherwise) caused the death and thus the Coroner ought not to include within his conclusion reference to failings which it is anticipated that are not a probable cause of death.

9. This submission is directed to these issues.

[1] Day 2

The Law

10. This is not a circumstance where article 2 is engaged automatically. As such, it must be shown that there has been an arguable breach of either the general/systemic duty or the operational duty.

The General Duty

11. We agree that the threshold for an arguable breach of article 2 is low and for these purposes is anything more than fanciful (*R v (AP) HM Coroner for Worcestershire [2011] EWHC 1453 (Admin)* at [60]).

12. The case of *Stoyanovi v Bulgaria App No 42980/04 (ECtHR, 9 November 2010)* sets out in general terms where Article 2 imposes a positive obligation on states to act to prevent harm. See [61]: -

> *"Positive obligations will vary therefore in their application depending on the context … The armed forces, just as doctors in the medical world, routinely engage in activities that potentially could cause harm; it is, in a manner of speaking, part of their essential functioning. Thus, in the present case, parachute training was inherently dangerous but an ordinary part of military duties.* ***Whenever a State undertakes or organises dangerous activities, or authorises them, it must ensure through a system of rules and through sufficient control that the risk is reduced to a reasonable minimum. If nevertheless damage arises, it will only amount to a breach of the State's positive obligations if it was due to insufficient regulations or insufficient control, but not if the damage was caused through the negligent conduct of an individual or the concatenation of unfortunate events.****" (emphasis added)*

13. The principle is clear: a breach of Art 2 can only be established where there were insufficient regulations or insufficient control, rather than isolated instances of

negligence or a '*concatenation of unfortunate events*'. Stoyanovi concerned an army skydiving training exercise. In that case the ECtHR found there had been no breach – there had been a prompt investigation which concluded that the accident was caused by the aircraft's inappropriate speed and poor communication between the crew and paratroopers (see [64]-[68]). The point is that Article 2 does not arise when personnel are exposed to ordinary occupational risk even if inherently dangerous, but it may be engaged if death was caused by insufficient state systems or control.

14. The need for more than individual negligence was emphasised in *R (Long) v Secretary of State for Defence [2015] EWCA Civ 770* at [13]:

> *"… Thirdly, a case which involves no more than an allegation of "negligent conduct of an individual or the concatenation of unfortunate events" (see the Stoyanovi case, para 61) will not engage article 2 . But a case involving dangerous activities undertaken, organised or authorised by the state and which falls within the middle ground may engage article 2 if it is arguable that the death was caused by insufficient state systems, regulations or control."*

15. It is clear that routine acceptance of unsafe practice will engage article 2: see *Long* at [27]-[29]:

> *"[27] The question is whether the failure on 24 June 2003 to equip the RMP platoon with iridium phones should be considered as (i) an individual error in disregard of the system or practice required by the communications order or (ii) a systematic failure of control or the implementation of a different practice or system of communication. Isolated departures from the communications order would not come within the scope of article 2. …*
>
> *[28]* ***In my view, it is clear from the evidence that the failure of the RMP to comply with the communications order was a failure of system or control. It was the result of the introduction (or at least the routine acceptance) of a different practice somewhere in the chain of command. This practice was not occasional or sporadic. It was the normal practice…***

[29] For all these reasons, I do not agree with the assessment of the Divisional Court that article 2 was not engaged because this was a case of individual human error. I accept the submission of Mr Fordham QC that there are clear indications that this is a case of systemic insufficiency of control and not mere negligent control by an individual. ***A <u>one-off failure</u> by a patrol leader to pick up an iridium phone on his way out of the base would probably fall into the latter category. But <u>the normal practice that was adopted here, by which an order came to be routinely disregarded</u>, has all the hallmarks of the former category****." [Emphasis added]*

16. Breaches of article 2 have been found in respect of broader State actions in respect of the general / systemic duty. For example, in *<u>Öneryildiz v Turkey</u> (2005) 41 EHRR 20*, the ECtHR emphasised that the positive, general obligations under Art 2 required a legislative and administrative framework aimed at deterring threats to the right to life in respect of dangerous activities. The applicant and his family lived near a municipal rubbish tip. In 1993 a methane explosion caused a landslide that killed a number of people. Two years earlier, the authorities had been warned of the risks of the explosion, however, even though the operation of household refuse tips and domestic areas were subject to regulations, they were not enforced by the State. The ECtHR stated at [71]:

> "*Art. 2 does not solely concern deaths resulting from the use of force by its agents of the state but also … lays down a positive obligation on states to take appropriate steps to safeguard the lives of those within their jurisdiction. The Court considers that this obligation must be construed as applying in the context of any activity, whether public or not, in which the right to life may be at stake, and a fortiori in the case of industrial activities, which, by their very nature, are dangerous…".*

17. The Court went on to say at:

> "[89] *The positive obligation to take all appropriate steps to safeguard life for the purposes of Article 2 entails above all a primary duty on the State to put in*

place a legislative and administrative framework designed to provide effective deterrence against threats to the right to life …

[90] ***This obligation indisputably applies in the particular context of dangerous activities, where, in addition, special emphasis must be placed on regulations geared to the special features of the activity in question, particularly with regard to the level of the potential risk to human lives. They must govern the licensing, setting up, operation, security and supervision of the activity and must make it compulsory for all those concerned to take practical measures to ensure the effective protection of citizens whose lives might be endangered by the inherent risks****."*

18. More general local authority scenarios are: duty to protect residents from the risks inherent in the operation of a reservoir (*Kolyadenko v Russia (2013) 56 EHRR 2* at [166]); duty to protect the public from falling branches (*Ciechonska v Poland (2011) Application no 19776/04 (unreported)* at [69]).

The Operational Duty

19. In order for the 'operational duty' to be engaged under *Osman* the express duty to protect life arises where the state knows, or ought to know of a real and immediate risk to life. This is a high threshold: *Osman v United Kingdom (2000) 29 EHRR 245* at [116]*:*

> *"…bearing in mind the difficulties involved in policing modern societies, the unpredictability of human conduct, and the operation choices which must be made in terms of priorities and resources, such an obligation [under Art 2] must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities… [W]here there is an allegation that the authorities have violated their positive obligation to protect the right to life in the context of their above-mentioned duty to prevent and suppress offences against the person, it must be established to its satisfaction that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the*

scope of their powers which, judged reasonably, might have been expected to avoid that risk."

20. This approach was confirmed in *Van Colle v Chief Constable of Hertfordshire Police [2008] UKHL 50* [31]:

> "*Art 2 may be invoked where there has been a systemic failure by member states to enact laws or provide procedures reasonably needed to protect the right to life. But the article may also be invoked where, although there has been no systemic failure of that kind, a real and immediate risk to life is demonstrated and individual agents of the state have reprehensibly failed to exercise the powers available to them …*
>
> *[32] The Strasbourg court laid emphasis on what the authorities knew or ought to have known 'at the time'. This is a crucial part of the test, since where (as here) a tragic killing has occurred it is all too easy to interpret the events which preceded it in the light of that knowledge and not as they appeared at the time … The Court should endeavour to place itself in the chair of DC Ridley and assess events as they unfolded through his eyes. But the application of the test depends not only on what the authorities knew, but what they ought to have known. Thus stupidity, lack of imagination and inertia do not afford an excuse to a national authority which reasonably ought, in the light of what it knew or was told, to make further inquiries or investigations …".*

21. For further comment on the threshold test see also *In re Officer L and Ors [2007] UKHL 36* per Lord Carswell at [20]:

> "*…this positive obligation arises only when the risk is 'real and immediate'. The wording of this test has been the subject of some critical discussion, but its meaning has been aptly summarised in Northern Island by Weatherup J in In re W's Application [2004] NIQV 67 at [17] where he said that 'a real risk is one that is objectively verified and an immediate risk is one that is present and*

continuing'. It is in my opinion clear that the criterion is and should be one that is not readily satisfied: in other words, the threshold is high."

22. Where there was a real and immediate risk to life, for a duty of care on the police to arise it is not necessary that the identity of the victim should be known. It was sufficient that the police knew or ought to have known of a real and immediate risk to the life of the victim of violence, and whether they had done all that they reasonably could to prevent the risk occurring (see *Sarjantson v Chief Constable of Humberside [2013] EWCA Civ 1252* at [22]-[25]).

23. See also *In the Matter of an Application by Officers C, D, H and R [2012] NICA 4.* This case arose out of the police shooting of Patrick Jordan in Northern Ireland. The coroner granted some, but not all, officers anonymity. The officers reviewed the decision. It was subsequently quashed on appeal. The Court noted the *Osman* test was a high threshold, but, given the unique context in Northern Ireland, the test was more likely to be satisfied by police officers at risk of attacks by terrorist organisations:

> "[26] … *if there is a risk to life from a well organised and resourced terrorist group which, objectively verified, is neither fanciful nor negligible that is a real risk for the purpose of the Osman test … [27] … there are very limited circumstances in which it will be possible to conclude that the authorities knew or ought to have known of a risk to life. In that sense the test has a high threshold and is not easily satisfied. In Northern Ireland, however, there is a particular context. Police officers have been subject to threats, targeting and attacks by well organise and resourced terrorist organisations using lethal force for many years. It is hardly surprising, therefore, that where the threat emanates from such a group the Osman test should be more frequently satisfied."*

Causation

24. The starting point when considering the issue of causation is the statutory obligation and in particular the matters to be ascertained by the Coroner's investigation. That is

set out in s.5. Section 5(1)(b) Coroners and Justice Act provides that the inquest must determine in what circumstances the deceased came by his death. Where necessary to avoid breach of a convention right this must be read as including the purpose of ascertaining in what circumstances the deceased came by his death (s.5(2) of the Act).

25. This has further been explored in *R (Lewis) v Mid and North Shropshire Coroner [2010] 1 WLR 1836* in which the Claimant sought a judicial review of the Coroner's decision not to put questions to the jury addressing alleged failings arising in the immediate aftermath of a death. The Court of Appeal held there was no duty on a coroner to leave to the jury facts or circumstances which were possible but not probable causes of death, although he had a power to do so. Per Sedley LJ at

> [28]: "…*I see the force of his foundational proposition that the circumstances of a death are not limited to its probable causes: they extend as a matter of plain English to the surrounding facts; and while it is not contended for the present that this allows the jury to pronounce on facts, however close in time, that can have had no bearing at all on the death, it can be intelligibly said that, in a jurisdiction which is not concerned with the allocation of blame, potentially causative circumstances can be just as relevant as actually causative ones.*
> *[29]* ***All of this speaks strongly in favour of a power to take the jury's verdict on such questions. But I am unable to find a reason of principle for making it a duty.*** *It would be quite different if rule 43 were not there, backed as it always is by the supervisory power of the High Court to ensure that it is properly operated. There would then be a significant failure (assuming that no other satisfactory mechanism existed) to implement the investigative requirement of article 2. But it seems to me in the end that the present legislative allocation of functions between coroner and jury, properly interpreted and properly implemented, will fulfil the functions which Mr Owen correctly submits are required by the Convention to be fulfilled."*

26. See also: *R (Allen) v HM Coroner for Inner North London [2009] EWCA Civ 623* at [40]:

"…the coroner was only obliged to investigate those issues which were, or at least appeared arguably to be, central to the cause of the death. I cannot accept the submission of Mr Thomas that causation is irrelevant in an article 2 investigation. He refers to [31] in R (Amin) v Home Secretary [2003] UKHL 51, [2004] 1 AC 653 where Lord Bingham identified the purposes of an article 2 investigation. It is true that there is no reference to causation in that passage, but it does not follow that Lord Bingham considered that causation was irrelevant. The investigation is directed to seeing whether there has been at least an arguable breach of article 2 . It is implicit in such an investigation that what is being investigated caused or may have caused or contributed to the death. Otherwise the link between the investigation and article 2 is severed."

27. In *R (Tainton) v HM Senior Coroner for Preston and West Lancashire [2016] 4 WLR 157* a [strong] Divisional Court indicated held that serious (admitted) failings ought to have formed part of a narrative conclusion given that they formed part of the circumstances of the death even though the jury could not find them to be causative.

28. Finally, in *Van Colle v Chief Constable of Hertfordshire Police [2008] UKHL 50,* the House of Lords held, in respect of causation in Article 2 claims, the Claimant need only show a substantial chance of survival as a result of the state's actions. See [138] of *Van Colle:*

"*It also seems to me to explain why a looser approach to causation is adopted under the Convention than in English tort law. Whereas the latter requires the claimant to establish on the balance of probabilities that, but for the defendant's negligence, he would not have suffered his claimed loss—and so establish under Lord Bingham's proposed liability principle that appropriate police action would probably have kept the victim safe—under the Convention it appears sufficient generally to establish merely that he lost a substantial chance of this".* See also *Osman v United Kingdom (23452/94) [1999] 1 F.L.R. 193* and *Opuz v Turkey (33401/02) (2010) 50 E.H.R.R. 28.*

As to Conclusions

29. CTI submit that any narrative conclusion ought not to be too long or complicated. There is not limit on the length of any conclusion (see e.g. the conclusions in the Inquests into the deaths of the 96 victims of the Hillsborough Stadium Disaster). It submitted that the length any narrative must fit the needs and demands of the case.

30. A narrative conclusion should avoid being 'bland' or 'anodyne', in the sense that it adds 'nothing of significance to anyone's knowledge of the circumstances' surrounding the death: *R (Cash) v HM Coroner for Northamptonshire [2007] EWHC 1354* (Admin) at [49]; [2007] 4 All ER 903. The conclusion ought to address '*disputed factual issues at the heart of the case*' or '*core issues which the inquest raised*'**.**

31. These inquests are now into their fourth week. The public interest in these PC Palmer's inquest has been enormous. The subject of Palace security has attracted an enormous amount of public interest and with good reason. It has undoubtedly been the disputed factual issue at the heart of the case. Any conclusion which fails to grapple properly with the issue would be deficient. The narrative must be appropriately detailed.

Article 2 in these Inquests

The General Duty

32. In our submission it is clear, beyond argument, that article 2 is engaged in this sense.

33. The Post Instruction in force at the date of the attack for Sector 3 stated as follows

> *"…Officers to be positioned in* ***close proximity*** *to the gates when they are open, but not outside.*
>
> *Both officers are to be positioned in line of sight of each other with the ability to respond to Cromwell Green Entrance search point and should include a short patrol into New Palace Yard towards the Cromwell Green Entrance Search point and should include a*

short patrol into New Palace Yard (NPY) towards the exit point of the Cromwell Green Search area" (emphasis added)

34. Commander Usher reiterated in his oral evidence that this instruction ought to have been followed. He accepted that officers in the Colonnade area would not be in close proximity. He indicated that the outer reaches of close proximity was a distance of between 20-25 yards.

35. As we noted in our submission dated 12 September 2018 there was a stark divergence between the description of the duties in the Post Instructions and the statements of PCs Ashby and Sanders. We noted, PC Sanders, In his statement dated 28 August 2018, referred to a map given to him 1 month before the incident:

"*This set of maps given to me 1 month before the attack along with the maps I have already exhibited led me to believe that the whole of New Palace Yard should be covered during our patrol.*

This along with the fact that on the day I had patrolled Sector 3 over a period of 5 years without ever being questioned about my actions or areas of patrol it never occurred to me to adapt my patrol".

36. We also referred to PC Ashby's statement dated 29 June 2018:

"*Sector 3 covers the entire New Palace Yard and Crowell Green Search Point. In my opinion all firearms officers at PoW know this to be the case*"

37. At the time of the attack PCs Ashby and Sanders were in or near the Colonnade. On 12 September 2018 we submitted that in the statements of PCs Ashby and Sanders there was – in no sense – any recognition that they were in the wrong place at the time of this attack. It seemed likely that PCs Ashby and Sanders would say that what they were doing on this day was no different from any other and that nobody informed them that what they were doing was wrong. And in fact, that is precisely what they did say.

38. Thus, the inadequacies of the security arrangements at the Palace of Westminster have been laid bare:-

(a) The Carriage Gates were a place of identified weakness. We cannot improve upon the description in Operation Standfast (set out at paragraph 78 of Commander Usher's first statement) that the gates were a '*clearly identifiable and exploitable weakness*'. Given that the gates represented such a weakness, the importance of armed support at the gates for unarmed officers cannot be understated. The review of Security of the Parliamentary Estate in December 2013 noted that police armed response was '*vital and must be effective and timely*'.

(b) There was no effective or timely armed support at the gates on 22 March 2017. Such support could only be provided if there was AFO support at the gate permanently. There is widespread agreement that officers stationed towards the back of New Palace Yard in the area of the Colonnades could not provide effective support to NFOs at the gates. See photograph DC7989/71. See also PC Glaze who stated that AFO's were probably not able to provide any protection (Day 5 p.183) and PC Ross who agreed that it was a hopeless position from which to provide such support (Day 5 p.133).

(c) Not only were officers not stationed there permanently, the balance of the evidence shows that AFOs were absent from the gates for the majority of the time. In the 108 minutes prior to the attack, the officers were stationed in close proximity to the gates for a maximum period of 14 minutes (i.e. 13% of the time; DC Overall statement). The evidence was that this was typical (allowing for a degree of variance as between one day and the next). See e.g.

i. PC Ashby "*Q. So what we see on the CCTV footage would be typical of any day prior to 22 March? A. Absolutely.*" [Day 7 p. 65].

ii. PC Sanders "Q *And is it right, therefore, to say that that was a typical day for you in terms of where you would 18 patrol? A. Yes, sir*." PC Sanders went on "Q *But what we can be confident of is that you were not at the*

Carriage Gates, or in close proximity to the gates at all times when the gates ere open A. That's correct, sir." (Day 8 p.3)

iii. Mr Ellwood gave evidence to the effect that there were occasions when he passed through an area where the armed presence was not as he would have liked [day 6 p.23].

(d) The reason for the failure of the officers to be present at the gates is clear. The AFOs on duty understood that they were required to patrol the entirety of New Palace Yard as per the map which was displayed in the Base room (WS1633/5).

i. PC Ross described the AFOs as being on a '*roving patrol*' across the whole area of New Palace Yard (Day 5 p.121). PC Ross was not aware of an instruction for AFOs to be at the gates (Day 5 p.137).

ii. PC Glaze stated "*My understanding was that [i.e. NPY] was all part of their patrol area, their sector"* (Day 6 p.160/161).

iii. PC Ashby "*Sector 3 is anywhere within the blue shaded area. My understanding is that when sectors came in part of the reason was to make us more unpredictable to hostile reconnaissance, a terrorist attack. For that reason we were encouraged to be unpredictable in our movements. So long as we were within that area we could stop in a certain area, walk to a certain area. There were no particular timing or any location we had to be.*" This is entirely consistent with both his written statement dated 28 June 2018 and the account attributed to him by Commander Usher.

iv. PC Sanders "*My understanding of the sector 3 was that during our times of being deployed there was to be within that [blue shaded NPY] area and react or deploy to any part of the sector as and when required*". [Day 7 189]. He went on "*Everyone deployed to the Palace at that time completed those sector areas in the same fashion*" (day 7 p.190/1). PC Sanders also gave vivid evidence that not one of anything between 50 to 100 officers with whom he had worked had challenged the way he was performing his sector 3 responsibilities.

v. We know that PC Gerard was also not in close proximity to the gates whilst he was on duty before he was relieved by PC Ashby.

(e) Thus, the evidence clearly establishes that it was (or at the very least ought to have been) obvious that the relevant Post Instruction was not being followed as a matter of routine. AFOs were routinely not in close proximity to the gates. In addition, there was routine non-compliance with the instruction for AFOs not to work specifically as a pair. The wording in the Post Instructions in force since January 2015 required officers on patrol not to work specifically as a pair. Once again, this did not reflect actual practice. They always worked as a pair because that is how they were trained. See e.g:-

i. PC Ashby "*All firearms officers in sector 3 were working as a pair*" (day 7 p.72)

ii. PC Sanders "*Q What did you think you had to do in that regard? A To be as a pair in the area of the sector.*"

(f) The ADAM system was simply not used by the vast majority of AFOs as a means of confirming their post instructions. In the period between December 2015 (when the most recent Post Instruction was issued) and August 2016 only 13% of AFOs accessed the system. That is a lamentable statistic. Commander Usher original evidence that utilisation of this system was of the order of 83-84% was disgraceful. The data on utilisation has the appearance of a system being utilised in the early days after its implementation but thereafter it was largely ignored because no-one enforced its used.

(g) That leaves open the question of whether instructions within the Post Instructions were effectively communicated to AFOs by some other means. It is overwhelmingly clear that they were not. There is not a scrap of credible evidence to suggest the requirements of the Post Instructions were effectively communicated by other means. As to the ring binder in the Base room, the MPS cannot confirm what was within that file at the material time. There is no evidence that the actual post

instruction was physically present in that file. Even if it was, there is no evidence that the ring binder was ever actually utilised by AFOs to confirm their responsibilities. The existence of this binder is not even mentioned in the MM1 (WS5099/1). As for oral briefings, there is no evidence from any person with responsibility for briefing AFOs at Sergeant level to contradict the evidence of PCs Ashby and Sanders concerning what they were told to do – namely to patrol the blue shaded area on the plan WS633/5. Inspector Rose's written evidence as to the scope of the patrol is contradictory to the Post Instructions.

(h) The system of supervision was plainly inadequate because:-

i. PC Ashby confirmed that in his experience of patrolling the yard in the manner described above, he had never been challenged by any officers of a similar or superior rank (Day p.73-74, p.79).

ii. As noted above, PC Sanders was never challenged by his many fellow AFOs.

iii. 'Guest' AFOs were '*without a doubt*' briefed according to the plan on the wall in the Base Room (PC Sanders Day 8 p,13)

iv. The non-compliance with the Post Instructions was not confined to Police Constables. There was no record of compliance with post instructions for the period after February 2016 (Commander Usher, Day 13 p.4-5).

v. The records kept by Inspector Munns which emerged (in most unsatisfactory circumstances) on 24 September 2018 (18 months after the attack) did not indicate that officers were required to be in close proximity to the gates. The one entry which provides any description suggests to the contrary.

vi. CSI Aldworth's evidence to the effect that he was not aware of the routine non-compliance simply underscores the inadequacies.

(i) The fact that the officers did not dedicate their time more effectively to the most vulnerable area was likely to be as a consequence of the failure – on the part of the MPS – to impress upon AFOs the particular vulnerability of the gates. See e.g. PC Ashby day 7 p.81.

(j) The Carriage Gates were effectively left open at all material times – despite a number of reviews which highlighted the risks that this posed. There were numerous opportunities for these arrangements to be changed and improved (such as occurred). In reality, a pair of AFOs on duty in Sector 3 were expected to do an impossible job. They were expected to have eyes on four places within an area with poor visibility. Rather than improve security the changes to the duties of AFOs over the years made the officers at the gates less, not more, safe in their dangerous work.

39. Thus, the list of (systemic) failures is lengthy:-

(a) There was no effective system for ensuring that the content of Post Instructions was communicated to Authorised Firearms Officers. The principal means by which the content of the Post Instructions were distributed was the ADAM system was not actually utilised by the vast majority of AFOs.
(b) There was no effective system for ensuring that AFOs were aware of or actually complying with the content of their Post Instructions.
(c) Routine non-compliance with the Post Instructions was not identified by supervisors.
(d) The Post Instructions were deficient in that they did not clearly establish that officers should be in close proximity to the gates at all times.
(e) Despite numerous opportunities to do so and the rising threat level posed by terrorist attacks, the MPS never recommended to the Palace Authorities that the Gates should be shut. This was an obvious means by which the risk to unarmed officers at the Carriage Gates could be reduced.
(f) In consequence of the above, there was no effective system to protect unarmed officers at the gates.

40. As we observed in our submission on 12 September 2018, at the time of the attack the PCs Ashby and Sanders could scarcely have been further away from that vulnerable location and those stationed at it. They provided PC Palmer with no protection at all. This failure was a daily occurrence. These were not isolated incidents or occasional errors of judgment.

41. The only difference between the 22 March 2017 and every day before is that the threat which those responsible for the security at New Palace Yard knew existed (that is to say the threat of an armed attack) and which they knew they ought to guard against materialised.

Comment on Credibility

42. Extraordinarily, PC Ashby was subject to hostile examination by the MPS during this process. His credibility was put fairly and squarely in issue despite the fact that his account of his duties has been entirely consistent at all times and despite being placed under enormous pressure to recant. It was notable that the same vigorous line was not adopted with other Police Constables who gave evidence which corroborated PC Ashby's account.

43. In so far as it might be suggested that Commander Usher's evidence on the nature of the system in place is to be preferred then the Widow makes these observations on the credibility of Commander Usher. He suggested that there was no reason to think that the Post Instruction was not known to and understood by AFOs. His evidence was, in numerous respects, unsatisfactory:

(a) His evidence to the Court as to when he first became aware of the records kept by Inspector Munns was – to put it neutrally – unsatisfactory. He first told the Court that he could not remember when he was first shown the documents. He later admitted in a witness statement that he had been shown them in the lunch break on very day he was asked about them (perhaps 45 minutes beforehand). If an ordinary witness had given such an account, their credibility would have been seriously damaged. But for such evidence to be given by a Commander in the MPS, this was extraordinary. His explanation for the inconsistency was longwinded and convoluted. His demeanour in the witness box when answering questions on this point was distinctly unimpressive.

(b) A further troubling feature of the emergence of the supervisory records raised above is that Commander Usher [who had – on his own account – given evidence

on countless occasions] saw fit to engage with a colleague midway through his evidence on matters pertaining to the evidence he was giving. He ought to have known better. Again, had an ordinary witness behaved in that fashion he or she could have expected [rightly] to be censured.

(c) Commander Usher sought to portray the utilisation of ADAM in a manner which was neither balanced or fair. Actual utilisation was very modest.

(d) Commander Usher provided evidence that the 2012 Post Instructions had a plan attached to them which provided a more restricted area of blue shading. Counsel for MPS confirmed that this was wrong. This further undermines his credibility as a witness (in that his recall was inaccurate). Despite requests for this plan it was not supplied. MPS could have produced it in order to address the concern raised. They did not. It was never confirmed that a plan which conformed to the description Commander Usher gave even exists.

44. The MPS investigation into the security arrangements at PoW has been narrow and myopic. It has never sought to get to the heart of issue of <u>why</u> PC Ashby and Sanders were not where they ought to have been (as exemplified by the fact that documents were being unearthed 18 months later). Instead they have sought to traduce PC Ashby in particular rather than to seek to investigate fully and take responsibility for its own failings.

Operational Duty

45. The submissions in this regard can be put shortly:-

(a) The threat level for police officers at the time of the attack was severe. This meant that a terrorist attack was regarded as highly likely (WS5103/5).

(b) As noted above, the unarmed officers at the gate were particularly vulnerable because of the attractiveness of the location to a terrorist attack. In addition, by reason of their location and attire they were particularly visible. This is reflected in the e-mail of CI Nicholas Aldworth dated 16 January 2015 (WS5103/5).

(c) The actual implementation of a system which ensured that AFOs was a fundamental to their safety. That is reflected in the January 2015 Post Instruction and the

successor document in December 2015. These Instructions were never actually implemented. The AFOs were, in reality, the only means of protection which was afforded to these officers was the occasional presence of AFOs at the gates. Absent that protection they were defenceless. Providing NFOs with a baton and a spray in respect of a known and highly terrorist threat is no protection at all. Terrorists do not arm themselves in that manner.

(d) In short, the MPS left PC Palmer and, his colleagues at the gate, to fend for themselves and defenceless against a highly likely terrorist threat.

46. It is submitted that these features satisfy the test that there was an objectively verified threat which was immediate in the sense that it was present and continuing from 16 January 2015 until 22 March 2017. To be clear – it is not suggested that all officers on patrol in <u>any</u> location would be at such a threat. However, officers at this location were at such risk.

Causation

47. The question of causation has been the subject of considerable (and at times) heated debate within this process. The question of causation is – in fact – on proper analysis simple. It is clear that the breach of the systemic and operational duties did

(a) AFOs were required to be tethered to the Carriage Gates for a reason, namely, that that was the <u>only</u> location at which they could provide protection to those unarmed officers at the gates. To suggest that their presence at the gates would have made no difference is to ignore the purpose of the posting. Had they been present at the gates, they would have been in a position to do exactly that which they were trained to do and indeed do what they were put there to do: protect officers at the gate like PC Palmer.

(b) The CCTV evidence shows that PCs Ashby and Sanders moved very slowly indeed after the collision between the car and the wall. PC Ashby explained that there was no point in running aimlessly. They needed to identify they threat. Had they been at the gates, there is no reason to think that their approach would have been any different i.e. they would not have moved faster and they would have assessed the

threat. Indeed, in the first 10 seconds after the collision, they had barely moved at all. By that time Masood was out of the vehicle and moving towards the NPY (see NPY compilation 2).

(c) The visibility at the front of NPY to events on Bridge Street is far superior to the view from the rear because the differential in height is reduced.

(d) An officer at the gates would have had a far greater appreciation of the direction from which the threat was coming from the response of the public running away from it.

(e) We note – should it be suggested that the MM1 concluded that compliance with post instructions would not have made a difference that – the officer who prepared the initial assessment into PCs Sanders and Ashby acknowledged that it was '*debatable*' whether PC Palmer's life might have been saved if the officers had been acting in accordance with the Post Instruction. Audrey Shannon stated that "*I support the assertion that the loss of PC Palmer could not necessarily have been avoided had they fully complied with the Post Notes*".

48. There is ample evidence to enable to the Court conclude that the systemic and/or operational failings contributed to the PC Palmer's death or that they these represented a substantial lost opportunity for PC Palmer's life to be saved.

Determination

49. As to the determination, we would invite the Coroner to include within the narrative matters set out in paragraph 39 (as to the nature of the systemic failings), paragraph 46 (as to the operational failings) and paragraph 48 above (as to causation).

Dominic Adamson
Temple Garden Chambers
2 October 2018