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 METROPOLITAN POLICE SERVICE

IN RELATION TO CONCLUSIONS AND FINDINGS

Introduction

1. PC Palmer was a dedicated and highly valued Metropolitan Police officer, whose conspicuous bravery and ultimate sacrifice in the course of duty is plain. He gave his life courageously confronting a terrorist whilst protecting those inside Parliament. His sacrifice has been openly and repeatedly acknowledged by the MPS, which stated at the beginning of these proceedings that it recognised that PC Palmer's family had been caused immense anguish. PC Palmer's MPS colleagues and superiors in the MPS of course share in that anguish, and it would be utterly wrong to suggest otherwise. By way of a single example, the court is reminded of Chief Superintendent Aldworth's genuine and heartfelt conclusion to his evidence.

2. Notwithstanding the stated belief of PC Palmer's sisters and parents (through the press), and the contention of their counsel, that there has been an insufficient inquiry and inadequate disclosure in relation to the terrible events of 22 March 2017 and, in particular, the issue of Parliamentary security, there can be no doubt whatsoever that there has in fact been a full and fearless coronial investigation into the death of PC Palmer.

3. For that reason, but also on account of its legal obligations, the MPS has responded appropriately to multiple requests from the inquest team for further information, and has provided a significant number of further statements and documents in order to assist the Chief Coroner. The Chief Coroner is particularly asked to note that no request from the inquest team, routed either by way of SO15 or the Directorate of Legal Services, has gone unmet.

4. The inquest has heard extensive evidence from the AFOs on duty in Sector 3 that afternoon, from three of the unarmed officers at Carriage gates, and from Chief Superintendent Aldworth and Commander Usher. The court has also been provided with a significant number of documents following requests from its inquests team. Largely as a result of the oral evidence

of PCs Ashby and Sanders, the issue of post instructions and whether AFOs were generally aware of the nature of their obligations to patrol in close proximity to Carriage Gates has assumed a greatly enhanced significance in the course of the hearing, and the focus of the inquest has accordingly altered.

5. The evidence before the inquest has been rigorously examined (in the case of Chief Supt Aldworth and Commander Usher, over many hours). It establishes beyond any doubt that Masood's attack on PC Palmer was completely unexpected, and brutal in its implacability, speed and violence. Overwhelmed by the ferocity of the attack, PC Palmer had no option but to try and get away, and was thereafter unable to defend himself. No other officer had any time at all to react[1]. The CCTV proves that just 5 seconds elapsed between Masood entering through Carriage Gates (14.41.10) and his main attack on PC Palmer (14.41.15).

6. The rapidity of the attack was such that any proposition to the effect that his murder might have been prevented had PCs Ashby and Sanders been in close proximity to Carriage Gates is completely speculative. Indeed, in this case, a determination that such shortcomings as there were in the system of supervision were causatively linked to PC Palmer's murder would, in our submission, be unjustified. Police systems did not kill PC Palmer. Masood killed PC Palmer.

7. Counsel to the inquests have properly recognised that the issue of whether PC Palmer's chance of survival may have been improved by better supervisory systems is a 'challenging question which involves a good deal of speculation' (para 11(i)). Given the multiple levels of

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[1] **PC Glaze:**

Before Masood entered (transcript day 5 p164):
"….people were running past the gate across Parliament Square, congregating round the north gate as well. It was just chaos, and the speed, it was just too fast for me to take in, to comprehend what was happening at that time….I think I started moving back towards the gate and I'm thinking: we've got to shut the gate. And as I looked over my right shoulder, I saw who I now know to be Masood was inside, not just approaching was inside, already in the grounds.

(transcript day 5 p165):

I don't remember making [radio transmissions] I remember trying to make – everything just happened so quickly.

(transcript day 5 p195):

Q. This terrible attack lasted but three seconds or so before PC Palmer was being stabbed up against the low barriers, wasn't it?
A. Sure.
Q. And no officer was able to use their asp, or CS spray to stop Masood before he deliberately and dreadfully stabbed PC Palmer?
A. No, sir , he was on as I say, he was in and on top before I knew, at that point, what was happening.
Q. No officer on that gate, however observant, and I'm sure you were very observant, had a chance to stop him because it was just too quick?
A. Sir.
Q. Isn't that right?
A. Sir.
Q. You were able to make your first report on the radio at, just four seconds after Masood came through the gate, a second after he was already beginning to attack PC Palmer, who was falling to the floor . But the speed with which he came through the open gate meant that you had no chance to stop him, did you?
A. No, sir

informed guess work and inherent difficulties at every stage of the factual timeline, identified by them, it is quite impermissible to conclude that PC Palmer's chance of survival *might* have improved. What is suggested, in effect, is a conclusion drawn from multiple and compounded hypothetical scenarios. As counsel to the inquests again recognise (paragraph 6(b)), the tracing back of separate chains of events and causes often gives rise to difficult questions of judgment.

8. Even on the basis that PCs Ashby and Sanders were unaware of the requirement to be in close proximity to Carriage Gates, it is not at all clear that their understanding was the result of a failure in supervision (there being no evidence that, even if more thoroughly supervised, they would necessarily have been in close proximity to Carriage Gates, as opposed to being elsewhere in NPY, perhaps by the exit to the Cromwell Green search point or by the Members' entrance). Even then, the evidence overwhelming establishes that, had they been in close proximity to Carriage Gates, they would have been drawn away to the explosive noise in Bridge Street, which they could not reasonably have ignored. Further, even had they positively ignored their duties, and remained in the close proximity of Carriage Gates, there is no evidence at all to support the proposition that Masood could have been shot and either disabled or killed before the fatal attack on PC Palmer.

9. The Chief Coroner, in his 16 September 2018 ruling rejecting the application under section 7 Coroners and Justice Act 2009 made by PC Palmer's sisters, noted at para 45 that it was 'somewhat speculative' to suggest that PCs Ashby and Sanders could have saved PC Palmer's life even if they had been standing in close proximity to Carriage Gates when the attack began. He further said "They might have moved away from their post in response to the sound of the vehicle colliding with the north wall of NPY. Even if they had not done so, they would have had seconds to react and any attempt to take a shot would have been complicated by the attacker's close proximity to Keith Palmer and other unarmed officers". Whilst the court's understanding of the AFO supervisory system is now plainly greater than it was as at 16 September, in light of the actual evidence, the position concerning these breaks in the chain of causation remains evidentially unchanged.

10. Given the evidence adduced in this inquest, the MPS properly argues (and, by the advancing of such arguments, no disrespect is meant to PC Palmer's family) that the procedural or adjectival obligation in Article 2 to hold an Article 2 complaint inquest is not engaged in PC Palmer's inquest as it is not arguable that there was a breach of the state's general duty to safeguard life. This is because:

    i. Such shortcomings as contributed to PC Ashby and Sanders' failure to be in the close proximity of Carriage Gates were operational, and not systemic.

    ii. In any event, the shortcomings were causatively too remote from PC Palmer's murder as to give rise to a 'real prospect' that his death might have been prevented. In common law terms, such shortcomings were not 'possibly', let alone 'probably', causative of his death.

11. Accordingly, the italicised section of the proposed determination, prefaced at paragraph 17(c) of counsel to the inquests' submissions, should instead read:

"*The armed officers did not appreciate, as they should have done, that there was a requirement to remain in close proximity to the Carriage Gates. However, even had they been in close proximity to the Gates at the moment of Masood's attack, it cannot be said they would have been able to prevent PC Palmer from suffering fatal injuries.*"

Article 2

12. The positive substantive obligation under Article 2 to protect life may be breached where there has been a systemic failure to enact laws or provide procedures reasonably needed to protect the right to life: Van Colle v Chief Constable of the Hertfordshire Police [2008] UKHL 50; [2009] 1 AC 225, para 30, per Lord Bingham.

13. In Osman v United Kingdom 29 EHRR 245, para 115, the European Court of Human Rights identified the 'primary duty' of a state under the article as being 'to secure the right to life by putting in place effective criminal law provisions to deter the commission of offences against the person backed up by law-enforcement machinery for the prevention, suppression and sanctioning of breaches of such provisions'.

14. Article 2 may accordingly imply in certain well-defined circumstances a positive operational obligation on the authorities to take preventive measures to protect an individual or to whom a responsibility is assumed whose life is at risk from the criminal acts of another individual: Osman (supra); Savage v South Essex NHS Foundation Trust [2009] 1 AC 681 at para 19; R(Kent County Council) v HM Coroner for Kent [2012] EWHC 2768, para 41; R(Medihani) v HM Coroner for Inner South London [2012] EWHC 1104, para 29.

15. The ECtHR has put the 'operational' obligation in this way: Article 2 may be breached where 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, but failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk: Osman v UK (2000) 29 EHRR 245, paras 115, 116.

16. Although the test in Osman was phrased in terms of risk to an *identified* individual from the criminal acts of a third party, the ECtHR has itself since recognised that the risk is not restricted to identified individuals, but may include unidentified members of the public at large: Mastromatteo v Italy (App No 37703/97), para 68, 74.

17. A number of points must be made about the nature of the positive Article 2 obligation in the context of a real and immediate risk to life.

a. The threshold is a high one, and the test of 'real and immediate risk' is not easily satisfied: *In re* Officer L [2007] UKHL 36; [2007] 1 W.L.R. 2135 at para 20, per Lord Carswell ("*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*"); Van Colle v Chief Constable of the Hertfordshire Police [2008] UKHL 50; [2009] 1 A.C. 225, para 69 per Lord Hope ("*…the very high threshold that was laid down in Osman"*); per Lord Brown at para 115 (*"The test…..is clearly a stringent one which will not easily be satisfied"*).

b. The ECtHR in Osman recognised that an impossible or disproportionate burden must not be imposed on authorities: *'For the Court, and bearing in mind the difficulties involved in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources, such an obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. Accordingly, not every claimed risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising*': para 116. This observation has particular resonance in this case, in which any assessment of the risk of a terrorist attack was hindered by the unpredictability of any such attack, and the procedures adopted to meet the risk gave rise to difficult operational choices in terms of means of response, the availability of resources and the particular requirements of the Palace of Westminster.

c. The standard accordingly is based on reasonableness, requiring consideration of the circumstances of the case, the ease or difficulty of taking precautions and the resources available: *In re* Officer L (supra) at para 21: "*The standard accordingly is based on reasonableness, which brings in consideration of the circumstances of the case, the ease or difficulty of taking precautions and the resources available. In this way the state is not expected to undertake an unduly burdensome obligation: it is not obliged to satisfy an absolute standard requiring the risk to be averted, regardless of all other considerations…*"

d. In Van Colle v UK (2013) 56 EHRR 23 (13 November 2012), the ECtHR reiterated the test identified in Osman at para 116, namely that the applicant has to show that the authorities failed to do all that was reasonably required of them to avoid the risk to life. The ECtHR emphasised that '*Not every deemed risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising'*: para 88. The ECtHR in Mastromatteo v Italy also emphasised that there is no obligation to prevent every possibility of violence: para 68.

e. The relevant act does not have to amount to gross negligence or wilful disregard of the duty to protect life. The House of Lords in Van Colle (supra), at para 30, noted that the submission to the contrary had been rejected in Osman.

f. Guard should be taken against the dangers of hindsight. The court must try to put itself in the same position as those who were criticised were in as events unfolded for them, subject to the obligation to carry out further inquiries had due diligence so demanded:

Mitchell v Glasgow City Council [2009] 1 AC 874, para 33; Medihani (supra), at paras 3, 44, 45.

g. A real risk is one that is objectively verified and an immediate risk is one that is present and continuing: *In re* Officer L (supra) at para 20; Rabone v Pennine Care NHS Foundation Trust [2012] 2 WLR 381, para 39. In the context of the risk of a terrorist attack, whilst of course the risk of such an attack at Parliament was continuing, the means and time of any attack was necessarily unknown.

h. In relation to causation, the ECtHR rejected in Van Colle (supra) any suggestion that the appropriate test of causation within Osman was one of a 'but for' test of state responsibility: para 104. In Pearson v UK (2012) 54 EHRR SE11, an admissibility decision, at para 72, the ECtHR stated: '*However, it is recalled that "a mere condition sine qua non does not suffice to engage the responsibility of the State under the Convention" (Mastromatteo v Italy at [74] where the applicant's son was murdered by prisoners who had been provisionally released by the prison authorities). Accordingly, even if it could be said that but for her erroneous arrest Kelly Pearson would not have later died in London, this would not necessarily be sufficient to engage the responsibility of the state under that article*.'. The test[2] is whether there was a failure to take reasonable measures which could have had a real prospect of avoiding the deaths: R(Long) v Secretary of State for Defence (infra) at para 32.

18. The standard in Article 2 is constant and not variable with the type of act in contemplation, although the crucial question is one which can only be answered in the light of all the circumstances of any particular case: Van Colle (supra) at para 35 per Lord Bingham. However, in R v Secretary of State for Defence ex parte Smith [2010] UKSC 29; [2011] 1 AC 1, at para 210, Lord Mance identified certain categories of case in which the substantive right in Article 2 may potentially be engaged:

a. Killings by state agents;
b. Deaths in custody;
c. Conscripts;
d. Mental health detainees;
e. Other situations where the state has a positive substantive obligation to take steps to safeguard life: '*Such situations exist not only where the right to life is inherently at risk, but also where the state is on notice of a specific threat to someone's life against which protective steps could be taken: Osman v United Kingdom (1998) 29 EHRR 245 ; Öneryildiz v Turkey (2004) 41 EHRR 325 (state allegedly tolerated and, for political reasons, encouraged slum settlements close to a huge uncontrolled rubbish tip, without making*

[2]In an Article 2 inquest, the coroner has, in any event, a further *discretion*, though not a duty, to make findings in relation to matters that were possibly and not probably causative: R. (Lewis) v. HM Coroner for the Mid and North Division of the County of Shropshire [2010] 1 WLR 1836, CA, per Sedley LJ at [28]. In a non-Article 2 inquest the coroner's findings should be confined to matters which are probably causative. The position is reflected in the Chief Coroner's guidance document (No. 17), at paragraph 50.

any effort to inform the settlers of dangers posed by the tip, which in the event exploded, killing some 39 residents).

19. In each of these categories, including 'Osman' cases, it is clear that there is some special link between state and victim: either because the deceased was in the special care or custody of state, or in a position of vulnerability, in which additional responsibilities arose; or was a soldier; or was in hospital. In each case, the state is taken to have assumed some responsibility towards the person whose death is in issue, on account of vulnerability, either factual or presumed, borne out of the deceased's status, position or location, or on account of specific knowledge on the part of the state. The nature of that responsibility is directly relevant to the nature of the positive obligation imposed by Article 2.

20. Accordingly, in the context of death of a person under the care and responsibility of health professionals, the ECtHR has noted that '*where a contracting state has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, it cannot accept that matters such as errors of judgment on the part of a health professional or negligent co-ordination among health professionals in the treatment of a particular patient are sufficient of themselves to call a contracting state to account from the standpoint of its positive obligations under article 2 of the Convention to protect life*': Powell v UK 30 EHRR CD 362.

21. The Court of Appeal in R(Takoushis) v Inner London Coroner [2005] EWCA Civ 1440, endorsing Richards J's analysis in R(Goodson) v Bedfordshire and Luton Coroner [2006] 1 WLR 432, noted that '*The position is or may be different in a case in which gross negligence or manslaughter is alleged: see, e g, R (Khan) v Secretary of State for Health [2004] 1 WLR 971 . By gross negligence we mean the kind of negligence which would be sufficient to sustain a charge of manslaughter*': para 96.

22. In R(Humberstone) v Legal Services Commission [2011] 1 WLR 1460, also in the context of health care, the Court of Appeal held that only systemic failures by the state could give rise to arguable breaches of Article 2. Allegations of individual negligence would not suffice: '*By implication, the judge accepted that the state's substantive (he called it primary) duty under article 2 would not encompass responsibility to protect patients from a simple act of negligence by a health professional. There can be no doubt that that is the law: see, for example, Savage v South Essex Partnership NHS Foundation Trust (MIND intervening) [2009] AC 681, paras 69–70, per Lord Rodger of Earlsferry*': para 53, per Smith LJ. And at para 58: '*Those limited circumstances arise where the death occurs while the deceased is in the custody of the state or, in the context of allegations against hospital authorities, where the allegations are of a systemic nature such as the failure to provide suitable facilities or adequate staff or appropriate systems of operation. They do not include cases where the only allegations are of "ordinary" medical negligence*'… .

23. In R(Parkinson) v Kent Senior Coroner [2018] EWHC 1501 (Admin); [2018] 4 W.L.R. 106 the High Court (Singh LJ; Foskett J; HHJ Lucraft QC) stated:

"**86** The enhanced duty of investigation, which falls upon the state itself to initiate an effective and independent investigation, will only arise in medical cases in limited circumstances, where there is an arguable breach of the state's own substantive obligations under article 2 .

87 Where the state has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, matters such as an error of judgment on the part of a health professional or negligent co-ordination among health professionals in the treatment of a particular patient are not sufficient of themselves to call the state to account under article 2 .

88 However, there may be exceptional cases which go beyond mere error or medical negligence, in which medical staff, in breach of their professional obligations, fail to provide emergency medical treatment despite being fully aware that a person's life would be put at risk if that treatment is not given. In such a case the failure will result from a dysfunction in the hospital's services and this will be a structural issue linked to the deficiencies in the regulatory framework.

89 At the risk of over-simplification, the crucial distinction is between a case where there is reason to believe that there may have been a breach which is a "systemic failure", in contrast to an "ordinary" case of medical negligence."

24. In the context of military service, the ECtHR has similarly limited the impact of the substantive positive obligation under Article 2. In Stoyanovi v Bulgaria (App No 42989/04) 9 October 2010. It stated:

'**61**. Positive obligations will vary therefore in their application depending on the context. It is primarily the task of the domestic systems to investigate the cause of fatal accidents and to establish facts and responsibility. In the present case, which concerns an accident during a military training exercise, the Court notes that while it may indeed be considered that the armed forces' activities pose a risk to life, this is a situation which differs from those "dangerous" situations of specific threat to life which arise exceptionally from risks posed by violent, unlawful acts of others or man-made or natural hazards. 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 (see, for comparison, *Kalender v. Turkey*, no. 4314/02, §§ 43-47, 15 December 2009).'

25. The 'concatenation of unfortunate events' has been interpreted as meaning no more than a combination of events over which the state has no control and for which it cannot be held responsible: R(Long) v Secretary of State for Defence [2015] EWCA Civ 770, para 15.

26. To similar effect, the Supreme Court in Susan Smith v MOD [2013] UKSC 41; [2014] AC 52, the Supreme Court held that the extent to which the substantive duty under the article might be applied to military operations would, given their unpredictability, vary according to the context; that an unrealistic or disproportionate positive obligation under Article 2.1, in connection with planning or conducting military operations in armed conflict, should not be imposed on the state, but effect should be given to the obligation under article 2.1 where it was reasonable to expect an individual to be afforded protection; that allegations relating to matters of procurement, training or the conduct of operations linked to the exercise of political judgment or issues of policy, or to acts or omissions occurring during actual operational engagements, would be beyond the reach of Article 2.

27. The present case is not to be assessed as an example of the situation in which the state has failed to take reasonable measures to mitigate the risk posed by a specific individual on account of his or her unlawful or criminal violent action. The organisation of protective measures to address the threat of terrorist attack, and the risks posed to individual police officers in the course of defending property or persons against attack, is more akin to the types of 'dangerous' activity identified in Stoyanovi and Susan Smith.

28. Accordingly, Article 2 may be breached where the death was caused by insufficient state systems, regulations or control, in other words a system failure, but not where the death resulted from individual operational failings, such as individual failings of understanding or individual failings of compliance: R(Scarfe) v Governor of HMP Woodhill [2017] EWHC 1194 at paras 54-56, or from an individual's failure to operate properly within the system provided by the state. The Chief Coroner is reminded that it is important that allegations of individual negligence are not dressed up as systemic failures: R(Humberstone) v Legal Services Commission [2011] 1 WLR 1460, at para 71, per Smith LJ.

Submissions

Introduction

29. The submissions from counsel to the inquests imply, rightly, that no breach arises from any alleged failing on the part of the MPS to respond to the general terrorist threat, or to respond to specific intelligence suggesting terrorism-related activity in or near Carriage Gates. The evidence from witness L on behalf of the Security Service was that there was nothing that could or should have alerted the authorities to Masood's intentions. DCI Brown's evidence was that there was nothing revealed in the exhaustive investigation conducted after Masood's attack that could or should have alerted the police to his intentions (transcript day 9 p97). No contrary position could seriously be advanced.

30. Moreover, there is nothing whatever to indicate that the general Palace of Westminster security arrangements were deficient, whether strategically or tactically, in a way relevant to PC Palmer's inquest. The evidence is that the security of politicians, police officers and the public was constantly under review by the MPS. It is important that, amidst the scrutiny that has been placed upon perceived shortcomings in the AFO supervisory arrangements, the court does not lose sight of the extensive and professional anti-terrorist measures put in place by the MPS.

31. The evidence is that the MPS had a team of specialist tactical firearms advisers who constantly reviewed and sought to improve the security arrangements at Parliament generally and at Carriage Gates in particular. The security arrangements, including in relation to the deployment of armed officers, were elaborate and under constant review, as the numerous and detailed reports referred to in the Usher 1 statement readily demonstrate. In particular, the endless dichotomy between mobility, which might lead to AFO's not being in the precise location of an emerging threat, and fixed patrols, which might lead to predictability and vulnerability, was under constant examination. The history of MPS tactical consideration of this dichotomy establishes that there is no easy solution.

32. In addition, no system of security is, of course, perfect and it would have been, and remains, quite impossible to entirely remove the risk of a determined marauding suicide attack. Masood obviously intended that he would die trying to kill people in and around the Palace of Westminster. The evidence of Commander Usher that the number of attacks which might have been considered are bounded only by imagination (transcript day 10 p 32) is obvious and uncontroversial.

33. It is also clear that the fact that Masood was able to gain access to NPY was through no fault of the MPS. It was the evidence of Eric Hepburn that the will of Parliament was that the Carriage Gates were to be kept open, both as a practical measure and as a symbol of the openness of the United Kingdom's Parliament. This was also reflected by the evidence of Commander Usher (transcript day 10 p30).

34. In any event, the attack occurred at the time of a Division which meant the gates would have been open, as reflected in the agreement between the MPS and Parliament and in the Sessional Orders exhibited to Commander Ushers statement. This was not a matter upon which the MPS had any discretion (transcript day 10 p 35). Even if a decision had been made (as it was after the event, when informed by hindsight) that the gates be generally closed, save for access / egress, the gates would have to have been open to allow access to the estate during the division and, in any event, to allow Deputy Commissioner Mackey's vehicle to leave.

35. Not only are there multiple references to the consideration given by the MPS to the risk to unarmed officers, but the MPS had properly alerted Parliament to the risks faced by officers at Carriage Gates, and Chief Supt Aldworth had stated that the most obvious mitigation was to close the gates. Whilst this was not the subject of a formal recommendation following a tactical planning review, Parliament was aware of the risk but (for understandable reasons) wanted the gates to remain open (see evidence of Eric Hepburn transcript day 13 p 189).

36. For completeness, the MPS also submits that nothing turns on the issue of Westminster Bridge measures. The evidence of Chief Superintendent Aldworth was that the Home Office based Office for Security and Counter Terrorism maintains a list of crowded places, but that these are designated based upon specific definitions which might differ from a lay person's definition of a crowded place or space (transcript day 11 p 39). The MPS is not able to designate an area as a crowded place (transcript day 11 p 56). Although there has been no evidence from the Home Office, it is clear that Westminster Bridge had not been designated as a crowded place at the time of the attack (or, it is thought, afterwards).

37. The MPS has no power to mandate that (for example) bridge defences be put up (transcript day 11 p 42). Furthermore, there was no appreciation in March 2017 that bridges in central London might be the focus of a terrorist attack (transcript day 11 p 46). None of the barriers on the various London bridges pre-March 2017 were present to protect pedestrians from a vehicular attack (transcript day 11 p 47). Before the attacks there was simply no basis for the police to recommend that barriers be put up on Westminster Bridge (transcript day 11 p 147).

No systemic breach

38. Turning, specifically, to the issue of post instructions, the schedule of post instructions at **DC8040** is the clearest evidence of the MPS continually reviewing and improving security arrangements at Carriage Gates. The armed policing model was tactically assessed and modified on six different occasions between 2010 and 2016 in order to ensure the armed policing model was best suited to the threat as it was appreciated at the time. The fact that there was a recognised vulnerability at the gates when they were open means neither that those arrangements were deficient, nor that there was necessarily a breach of Article 2. No risk can be entirely eliminated.

39. After a tragic event of the type engaged in these inquests, it is of course possible to imagine actions which could have been taken which could have removed the possibility of the attack taking place at one particular location. New Palace Yard could have been flooded with armed officers or the gates could have been permanently closed. However, such measures would have been neither proportionate nor realistic. Armed officers are a finite resource. A disproportionate armed presence at Carriage Gates would have exposed other vulnerable locations. None of the reviews (whether with or without tactical firearms advice) recommended an increase in the number of armed officers in New Palace Yard or the closure of the gates.

40. It has been suggested that a better model might have been to have static posts "dressed back" from Carriage Gates. Whilst this would focus armed protection upon one area of vulnerability, the evidence is that the tactical assessments did not view static patrols as providing optimum protection to New Palace Yard. The tactical planning review generally favoured in fact the unpredictability of a patrol as providing a better model. This accorded with the evidence of PC Ross, who spoke of the risk of attackers targeting armed officers whose presence could be too predictable in a static post (transcript day 5 p 140 - 141) and of PC Glaze, who was also aware

of the danger of predictability and the need to protect not just Carriage Gates but also an attacker entering New Palace Yard over the railings from Bridge Street and other entrances (transcript day 5 p 193). The risk was also referred to in the historic reviews.

41. PC Ashby also gave evidence of patrols having the advantage of unpredictability (transcript day 7 p 155). Commander Usher fully explained the risk of a static post to hostile reconnaissance and/or an attack in which a police firearm is taken by a terrorist (transcript day 13 p 67 - 68). His conclusion was that a short patrol was the best tactic to strike a balance between armed support and unpredictability (transcript day 13 p126 - 127). Such a conclusion is beyond criticism, even with hindsight, given the axiomatic considerations identified in Osman (the difficulties involved in policing modern societies; the unpredictability of human conduct, and the operational choices which much be made in terms of priorities and resources).

42. It is of course common ground that PCs Ashby and Sanders were not patrolling as required by the post instructions at the time of the attack. However, that fact, of itself, cannot be evidence of a systemic failing.

43. The evidence of Commander Usher, Chief Superintendent Aldworth and Inspector Rose was that the officers should have been patrolling in accordance with their post instructions. No one seriously disputed that post instructions were generally clear and accessible (they were the 'very essence' of an AFO's functions). The evidence indeed establishes that MPS had put into place a proper system to ensure that officers were aware of post instructions. This included:

    (a) A computerised system, "ADAM", which allowed officers to access post instructions online. This system was in place from October 2012. There is significant evidence of inspectors and sergeants being informed by email of the introduction of the system, its purpose and the means by which AFO's can access post notes and briefings on demand. Emails have been disclosed which demonstrate that supervisors were sent links to updated post notes see **DC8048**.

    (b) Hard copy post instructions were available in the patrol room. PC Ashby accepted that it was possible that such a binder was present but that he had not looked at it (transcript day 7 p 143).

    (c) In terms of monitoring by supervisors, records have been produced which show regular inspections were carried out between September 2015 and February 2016, including supervision of PCs Ashby and Sanders on sector 3 (see statement of Inspector Scott). The evidence of Inspector Rose is that supervision continued even if this was not recorded in the manner of the document kept by Inspector Munns.

    (d) There is also the evidence of Chief Superintendent Aldworth to the effect that where he appreciated that officers were not adhering to post instructions, action was taken as a

result: see emails at **WS5103/15**. Chief Superintendent Aldworth also stated that he had taken action himself when he had seen officers not on posts (transcript day 11 p 24).

(e) Chief Superintendent Aldworth gave evidence that there would be a management meeting every day and that this would involve a review of the previous 24 hours and the plan for the day ahead which would include discussion of any failure to comply with post instructions (transcript day 11 p84).

44. In relation to the evidence to the contrary, the ability of the unarmed officers to gauge how long AFOs were in close proximity to the gates is limited. PC Ross accepted that his back would be to the AFOs, and that he focused on the gates, and so it would be hard to say when AFOs were present (transcript day 5 p 123 - 124). PC Glaze gave similar evidence that the AFOs would be behind them and the unarmed officers would be *busy doing our own job* (transcript day 5 p160 - 161) making observation of their presence impossible.

45. PC Ross said that ADAM was not in use when he was an AFO (which would date his AFO duties to before October 2012) but he was very familiar with post instructions of the kind at **WS5103/9** (see transcript day 5 p125 and p 119). His AFO experience substantially pre-dated the relevant post instructions, and so it is unsurprising that he was unaware of the more recent instructions.

46. PC Glaze transferred from an armed role on DPG to Lewisham in 2012 (see transcript day 5 p152) so he, too, would not have used ADAM and would not have had any knowledge of the relevant post instructions.

47. Commander Usher's evidence that it would be extraordinary for all sergeants and inspectors who received post note updates (such as those at **DC8048**) not to have briefed constables upon the content of them is compelling (transcript day 10 p121). Commander Usher had himself seen AFOs at Carriage Gates (transcript day 10 p 68) as had Chief Superintendent Aldworth who said that AFOs were at the gates *more often than not and greatly so* (transcript day 11 p 81).

48. There is also evidence of emails being sent to both the leadership and the entire command of the heightened threat to police officers (from substantial to severe) on 16.01.15. Chief Superintendent Aldworth told the court that he had slept on his office floor over this period to ensure that he briefed all officers on shift personally (see transcript day 12 p 98 - 99). This is relevant to the steps taken to address the heightened risk to police officers from 2015.

49. PC Ashby's evidence at transcript day 7 p 133 to the effect that nobody had ever informed him that ADAM was the primary means of accessing post instructions is, it is respectfully submitted, therefore unsustainable, not least because he accepted that he had himself accessed ADAM in June 2015 (transcript day 7 p 133) and had "presumably" found post notes as a consequence of this (transcript day 7 p134). Given their length of service as AFOs both officers must have been well aware of the presence and status of post instructions.

50. PC Ashby also accepted that he "may have" been aware of emails alerting him to updated post instructions and that it was his responsibility to open these emails and follow the relevant post instruction (transcript day 7 p 140). The "base room map", with alarm locations plainly marked upon it (**WS1633/5; WS1237B/7**), undoubtedly does not bear the hallmarks of a formal post instruction. The claim by PC Ashby that this was believed by everyone, over a matter of years, to be a post instruction cannot be accepted[3]. The laminated map, also, was plainly not a post instruction (like the map sent out by email by Supt Causer in February 2017 (**WS1237C/3**) providing a guide for incoming TSP pulse patrols, the laminated map said nothing whatsoever about the extent or nature of any patrol).

51. PC Sanders accepted that post instructions were clearly available on ADAM (transcript day 8 p62) and that everyone knew that there was a terminal with an ADAM system available for use (transcript day 8 p63). He further accepted that he "quite possibly" received emails concerning briefings (indeed he produced such an exhibit): transcript day 8 p65.

52. The court has heard close questioning of both the armed officers and the senior officers responsible for security at the Palace of Westminster. It is accepted that these have nevertheless revealed some shortcomings in the system by which the AFO's adherence to post instructions was supervised, specifically:

    a. There is some evidence that "short patrol" was interpreted differently by individual officers.

    b. PCs Ashby and Sanders' practice of not remaining in close proximity to Carriage Gates was 'reflective' of a wider practice (MM1).

    c. Compliance with post notes was not at all times recorded in the manner envisaged by the post instructions.

    d. There is evidence that only a comparatively small proportion of officers had accessed ADAM after December 2015 (probably because access was only required when post instructions were infrequently changed).

53. Such issues are not demonstrative of a systemic failing, but rather of a 'concatenation of unfortunate events[4]' in relation to the operation of the post instruction system. The evidence does not suggest that there was a general supervisory failure, or that the majority of officers went unsupervised or that they did not understand their post instructions. It suggests, rather, that a coterie of officers preferred to patrol as they saw fit. Those were operational failings.

[3] (1) The 'map' was self evidently not a post instruction; (2) It had red personal alarm locations on its face, and a legend detailing 'alarm locations'; (3) it said nothing about patrolling; (4) it underwent no alteration over 6 years; (5) the shaded area included a section towards St Stephen's Entrance, which no one suggested was part of the correct patrol area for Sector 3.

[4] This language is taken directly from *Long* above. It is not for a moment suggested that it is appropriate language to describe the tragic deaths of 22.03.17.

Any systemic breach too remote

54. In any event, even if these matters are viewed as systemic failings of such an order as to arguably give rise to a breach of Article 2, the court would need to be satisfied that they resulted in the loss of a real prospect of survival. This is not accepted for the following reasons.

55. **First**, the fact that the two AFOs were not at Carriage Gates is not necessarily a consequence of the compliance shortcomings set out above. Even if there had been a tighter supervision of the downloading or reading of post instructions, or their delivery by way of oral reminders, this would not necessarily have meant that PCs Ashby and Sanders would have complied. The 40 minute or so interval at the Colonnades between 13.54 and 14.40 is not particularly suggestive of good practice, even on PC Ashby and Sanders' own understanding of their patrolling obligations.

56. **Second**, in any event, even if PCs Ashby and Sanders had been following the post notes, whether they would have been present at Carriage Gates is a matter of complete speculation. It will never be known whether they might instead have been on the short patrol into New Palace Yard, and thus unable to deal immediately with a threat in immediate proximity to the gates. Such a patrol could have taken them in the region of 20 to 25 yards away from Carriage Gates towards the Cromwell Green search area (transcript day 10 p 60).

57. **Third**, the evidence clearly demonstrates that, even had they been at Carriage Gates, they would have moved towards the explosive noise on Bridge St, and would have had at least 20 seconds in which to do so before the crowd, and then Masood, appeared at Carriage Gates.

58. The obligation to advance to other threats in the sector, in other words, to self-deploy, is reflected in the first page of the post instructions, which required the AFOs to *immediately contain or confront a deadly threat.* This was explained by Commander Usher, who said that the post instruction required AFOs to respond to any emerging threat within their sector (transcript day 10 p52). It was Commander Usher's expectation that the officers would have advanced towards the noise from Bridge Street whether they had been at Carriage Gates or at the Colonnades (transcript day 10 p 88).

59. PC Ashby's evidence on this point was as follows (day 7 p 156 - 158)

> *Q. If you were standing by Carriage Gates, or the Cromwell Green exit, and a terrorist drove a vehicle into the gates, into the railings, I apologise, in Bridge Street.*
> *A. Yes.*
> *Q, with a bomb on board, or a bomb on him or her*
> *A. Yes.*
> *Q. Could you have ignored that threat?*
> *A. No, sir .*
> *Q. What would you have had to have done?*
> *A. I would have made my way to that location.*
> *Q. Would the same apply if you had been standing on*

Carriage Gates?
A. Yes, sir .
Q. Why would you have had to have gone to the emerging threat somewhere else in New Palace Yard?
A. Because of the nature of the threat, sir . As a police officer, an AFO, it's important that I get there and see if I can help.
Q. If you had been on Carriage Gates whether as part of a mobile patrol or a fixed post, that is to say a post from which you do not depart at all in the whole course of your patrolling duties
A. Yes, sir.
Q. What do you think you would have done on that day if you had heard the sound of that car exploding up against the railings in Bridge Street?
A. I would have gone there, sir, to assist.
Q. Would you have gone even though it left Carriage Gates unprotected in terms of an AFO?
A. Quite possibly, sir.
Q. Why would you have done that?
A. Because at that time I had no idea that it was what it's turned out to be so, you know, first and foremost I'm a police officer as well and I want to help.
Q. Because unless and until Masood comes in the gates, there is no obvious threat there, is there?
A. That's correct.
Q. Where is the only threat of which you would have been aware?
A. The vehicle, sir.

60. PC Sanders gave similar evidence (transcript day 8 p 77):

Q. Could you have ignored the explosive noise in Bridge Street?
A. No, sir.
Q. Could it have been a threat?
A. Yes, sir.
Q. Was it a threat?
A. I believed at the time it was, sir.
Q. Did the noise tell you anything about whether or not it was part of an armed attack on that part of Bridge Street?
A. It did when the radio communications came out and said that there had been an explosion at Portcullis House.
Q. Did you know whether the explosive noise was a bang from a car on the wall or an explosive attack on the wall designed to allow a breach, and an entrance into the yard?
A. That was my concern after the radio communication.
Q. And so did you have to go towards the noise?
A. Yes, sir.
Q. At the moment of the noise, had you been at the Carriage Gates, and in light of the factors which were relentlessly put to you, what would you have done?
A. Gone to the sound of the explosion, sir.

Q. There was a suggestion put to you that by leaving Carriage Gates, had you been there which, of course you were not you would in this hypothetical example have left unarmed officers vulnerable, and the point being made was that that was obviously an undesirable state of affairs, that you shouldn't, of course, be leaving unarmed officers vulnerable. As an AFO, had you been at Carriage Gates with the unarmed officers and the explosive noise had occurred on Bridge Street, would the presence of unarmed officers at the gates been something that would have prevented you from going to the noise at Bridge Street?
A. No, sir.

61. **Fourth**, such evidence as there is points towards it being highly unlikely that they would have been able to shoot Masood even had they remained at, or returned to, Carriage Gates. It is not clear that they would either have been in a physical position to deal with Masood when he came through Carriage Gates or able to neutralise the threat he posed by shooting him.

62. PC Ashby accepted that he could not say whether he would have had a clear shot due to the need to create a reactionary gap and the backdrop which included other officers, PC Palmer and members of the public running past the gates (transcript day 7 p 163 - 164).

63. PC Ross gave similar evidence to counsel to the inquests based upon his previous experience as an AFO (transcript day 5 p149). As did PC Glaze (transcript day 5 p 199 - 200).

64. PC Sanders did not feel able to comment upon whether he would have been able to shoot Masood or not and so the matter was not explored further (transcript day 8 p80). This simply reinforces the proposition that it is no more than speculation to say whether, had PCs Ashby and Sanders been by Carriage Gates (which they were not), they would have been able to shoot Masood when he entered.

<u>PFD report</u>

65. Commander Usher's evidence was that *as a result of the terrible events of 22nd March 2017 we instituted a series of changes in any event to ensure supervisors were absolutely certain that their constables were sure of their role on any post within the command, and I think that was a prudent thing to do irrespective of the finding of this court* (day 10 p 108).

66. The Chief Coroner has also had the benefit of the report by Sir Jon Murphy, and a document detailing work that has been completed in consequence of his report. Whilst this has not been disclosed to IPs for reasons of national security, it should be of substantial reassurance to the Chief Coroner that matters have been addressed and improvements made. Informed by these documents, counsel to the inquests asked Commander Usher to confirm that insofar as the report concerned New Palace Yard these matters had now been addressed which he did (transcript day 10 p 116).

67. The Chief Coroner is also aware that Carriage Gates are now permanently closed (save for vehicular entrance and exit) as a result of the events of 22 March 2017.

68. If other IPs advance (as part of the simultaneous exchange of written submissions) particular matters which they contend should be the subject of a PFD report, then the MPS would ask for a reasonable amount of time, perhaps 6 weeks, in which to respond.

Hugo Keith QC **3 Raymond Buildings**

Matthew Butt

2nd October 2018