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

WRITTEN SUBMISSIONS OF COUNSEL TO THE INQUESTS ON DETERMINATIONS TO BE MADE BY THE CORONER

Introduction

1. In these Submissions, we shall (a) set out the relevant legal principles governing determinations in inquests under the Coroners and Justice Act 2009 ("CJA"); (b) address the issue of Article 2 engagement; and (c) make provisional submissions on determinations which the Coroner may consider. We shall also make proposals for a process whereby representations may be made on the content of any Prevention of Future Deaths Report ("PFD Report").

2. Our submissions at this stage are provisional on those which are yet to be made by Interested Persons. It should also be noted that this document is being prepared and circulated before the conclusion of the evidence, and our comments are therefore necessarily subject to any important features of the remaining witness testimony. We shall address the submissions of others and additional evidence in our oral submissions.

3. In outline, our submissions are as follows:

   (a) As regards the four people who died as a result of being struck by Khalid Masood's car, the Article 2 procedural obligation is not engaged in their inquests. However, informative conclusions can and should be returned. We propose in each case a short-form verdict of unlawful killing (to recognise formally the fact that each person was murdered), coupled with a short narrative setting out the means by which the person met his/her death.

(b) As regards PC Palmer, we consider that the Article 2 procedural obligation is engaged in his inquest, on the basis that it is arguable that there was a breach of the state's general duty to safeguard life (by establishing and maintaining adequate security arrangements at the Palace of Westminster). We propose a short-form verdict of unlawful killing, coupled with a narrative addressing the means and circumstances of PC Palmer's death.

(c) As regards the content of any PFD Report, Interested Persons have been directed to file submissions setting out what (if any) matters they suggest the Coroner might include in such a report. Because of the particular facts of this case, we propose that the Coroner direct responses to those suggestions and then consider the responses before deciding whether to produce a report and on what matters.

The Law

Statutory Provisions and Legal Principles concerning Determinations

4. The statutory provisions governing determinations in inquests are contained in sections 5 and 10 of the CJA, which provide as follows:

> "**5 Matters to be ascertained**
>
> (1) The purpose of an investigation under this Part into a person's death is to ascertain –
>
> (a) who the deceased was;
>
> (b) how, when and where the deceased came by his or her death;
>
> (c) the particulars (if any) required by the 1953 Act to be registered concerning the death.
>
> (2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.
>
> (3) Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than –
>
> (a) the questions mentioned in subsection (1)(a) and (b) (read with subsection (2) where applicable);

(b) the particulars mentioned in subsection (1)(c).

This is subject to paragraph 7 of Schedule 5 [which addresses PFD Reports].

…

10 Determinations and findings to be made

(1) After hearing the evidence at an inquest into a death, the senior coroner (if there is no jury) or the jury (if there is one) must –

(a) make a determination as to the questions mentioned in section 5(1)(a) and (b) (read with subsection (2) where applicable);

(b) if particulars are required by the 1953 Act to be registered concerning the death, make a finding as to those particulars.

(2) A determination under subsection (1)(a) may not be framed in such a way as to appear to determine any question of –

(a) criminal liability on the part of a named person, or

(b) civil liability."

5. Rule 34 of the Coroners (Inquests) Rules 2013 ("the Rules") provides:

> "A coroner or in the case of an inquest heard with a jury, the jury, must make a determination and any findings required under section 10 using Form 2."

Form 2 is headed "Record of an inquest" and it contains the following headings:

> "1. Name of the deceased (if known):
>
> 2. Medical cause of death:
>
> 3. How, when and where, and for investigations where section 5(2) of the [CJA] applies, in what circumstances the deceased came by his or her death (see note(ii);
>
> 4. Conclusion of the coroner / jury as to the death (see notes (i) and (ii));
>
> 5. Further particulars required by the Births and Deaths Registration Act 1953 to be registered concerning the death…"

The Notes to that Form identify a number of long-established short-form conclusions, including that of unlawful killing. The Notes also state that the standard of proof for determinations generally is the civil standard (i.e. balance of probabilities), but that the standard of proof for an unlawful killing conclusion is the criminal standard (i.e. beyond

reasonable doubt). There is Court of Appeal authority supporting the application of the criminal standard of proof to unlawful killing conclusions: see *R v Wolverhampton Coroner, Ex Parte McCurbin* [1990] 1 WLR 719.

6. The following legal principles have been developed by the higher Courts to guide coroners and juries in conducting inquiries and returning determinations:

(a) The primary objective of an inquest is to produce determinations answering the four prescribed factual questions: who the deceased person was; and when, where and how he/she came by his/her death. The coroner (or jury) may not express conclusions on any other matters, save for supplying the formal particulars required for death registration (and subject to the coroner's power to make a PFD Report). See the statutory provisions cited above and *R v North Humberside Coroner, Ex Parte Jamieson* [1995] QB 1 at 23 (general conclusion (1)).

(b) The scope of inquiry in an inquest is primarily a matter of judgment for the coroner conducting it. In particular, it is a question of judgment (and often a difficult one) how far back to trace chains of events and causes. By extension, the question of which witnesses to call is a matter for the coroner. Although he/she should conduct a sufficient inquiry to answer the statutory questions, the evidence will often cover a wider scope than is strictly necessary for that purpose. See *R v Inner West London Coroner, Ex Parte Dallaglio* [1994] 4 All ER 139 at 155b and 164j. These principles apply across the board: see *McDonnell v HM Asst Coroner for West London* [2016] EWHC 3078 at [28]; *Coroner for the Birmingham Inquests (1974) v Hambleton* [2018] EWCA Civ 2081.

(c) Before the Human Rights Act 1998 came into force, incorporating the ECHR into domestic law, the "how" question was always to be read as meaning "by what means the deceased came by his/her death". That interpretation focuses attention on the physical means of death. The question was usually answered by the coroner or jury choosing between the recognised short-form conclusions and completing a short entry for the immediate circumstances of death. However, there was no objection to a short-form conclusion being supplemented or replaced with a brief narrative. See *Ex Parte Jamieson*; *R (Longfield Care Homes) v Blackburn Coroner* [2004] EWHC 2467 (Admin).

(d) Article 2 of the ECHR (the right to life) encompasses a positive procedural obligation on member states which includes a requirement to establish effective and independent investigations into deaths in certain circumstances. See *R (Amin) v SSHD* [2004] 1 AC 653 at [20]. Setting aside specific categories of case where the obligation is automatically engaged (e.g. suicides in prison and deliberate killings by state agents), the obligation to establish such an investigation is engaged where on the evidence it is arguable that the state or its agents committed a breach of a substantive Article 2 duty in relation to the death. See: *R (Humberstone) v Legal Services Commission* [2011] 1 WLR 1460 at [52]-[68]; *R (Letts) v Lord Chancellor* [2015] 1 WLR 4497 at [71]-[91]; *R (Parkinson) v Kent Senior Coroner* [2018] 4 WLR 106. The threshold of an "arguable" breach is low; "anything more than fanciful" (see *R (AP) v HM Coroner for Worcestershire* [2011] EWHC 1453 (Admin) at [60]).

(e) In *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182, the House of Lords held that, where the Article 2 obligation to establish an independent investigation into a death is engaged in connection with an inquest, the ordinary approach to inquest conclusions must be modified in one respect to satisfy Convention standards. The expression "how the deceased came by his/her death" in the statutory provisions is to be interpreted as meaning "by what means and in what circumstances the deceased came by his/her death": see [35]-[38]. In practice, this may require the coroner to return, or elicit from the jury, expanded narrative conclusions (see below). The decision in *Middleton* has now been given statutory force by section 5(2) of the CJA.

(f) The decision as to whether the Article 2 procedural obligation is engaged will have little, if any, effect on the scope of inquiry at an inquest or the conduct of the hearing. See: *R (Smith) v Oxfordshire Asst Deputy Coroner* [2011] AC 1 at [152]-[154]; *R (Sreedharan) v Manchester City Coroner* [2013] EWCA Civ 181 at [18(vii)].

(g) Section 10(2)(a) of the CJA precludes the coroner or jury from making findings which appear to determine any question of criminal liability of a named person. This form of words legitimises a coroner or jury returning in suitable cases the well-established conclusion that a death was due to unlawful killing. That conclusion may be given if it is found that death was due to an offence of murder,

manslaughter or infanticide: *R (Wilkinson) v HM Coroner for Greater Manchester South District* [2012] EWHC 2755 (Admin). It will commonly be necessary to consider specifically whether a particular person committed the relevant offence. That person will not be named in the conclusions, although it may be obvious from the circumstances, evidence and/or summing-up who has been identified as responsible. See: *R (Anderson) v HM Coroner for Inner North London* [2004] EWHC 2729 (Admin) at [21]; *R (Evans) v HM Coroner for Cardiff and Glamorgan* [2010] EWHC 3478 (Admin) (upheld on appeal: [2011] EWCA Civ 719).

Principles concerning Article 2 Duties

7. The legal principles governing substantive duties of the state under Article 2, ECHR, may be summarised as follows:

(a) Article 2 imposes a negative obligation on the state not to take life save in certain specified situations. It also imposes positive obligations to protect life, which fall into two categories: (i) a general duty on the state; and (ii) operational duties which are owed by state agents and agencies in certain types of case.

(b) The general duty has been described as requiring the state to "establish a framework of laws, precautions, procedures and means of enforcement" to protect the lives of citizens. See: *Middleton* at [2]; *Savage v South Essex NHS Foundation Trust* [2009] 1 AC 681 at [18]-[19]; *Oneryildiz v Turkey* (2005) 41 EHRR 20 at [89]-[90]. The general duty is addressed in detail in the healthcare context in *Parkinson* (cited above) at [49]-[50] and [82]-[92]. There, the Court identified the distinguishing feature of any breach of the general duty as being a "systemic failure"; a dysfunction in systems and practices rather than "ordinary negligence" of individuals.

(c) The general duty may extend beyond written procedures, to encompass the planning and control of operations (including police operations): see *Kakoulli v Turkey* (2007) 45 EHRR 12 at [106]. It may extend to instructions to armed police officers: see *Makaratzis v Greece* (2005) 41 EHRR 49 at [57]-[59].

(d) A determination of whether that general duty has been satisfied involves assessing the adequacy of legislation, policies, procedures and systems at a relatively high level of generality, taking into account their overall effect and the resources available to support them. See the discussion in *R (AP) v HM Coroner for Worcestershire* (cited above) at [52] and [65]-[74].

(e) In certain types of case, it has been held that state agents / agencies may owe an operational duty to protect an individual citizen or group of citizens against specific kinds of danger. This type of duty was first recognised by the ECtHR in *Osman v UK* (2000) 29 EHRR 245, a case concerning the duty of the police to protect individuals against reported threats. The Court formulated the critical test as follows (at [116]):

> "It must be established to [the] satisfaction [of the Court] 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 the 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."

The test of "real and immediate risk" of death has repeatedly been described as setting a high threshold: see *In re Officer L* [2007] 1 WLR 2135, at [20].

(f) The *Osman* operational duty to take reasonable steps to prevent an appreciable "real and immediate risk to life" has been incrementally extended by the ECtHR to certain other classes of case. In *Keenan v UK* (2001) 33 EHRR 38 from [88], the Court found that the duty was owed to those in state custody. It has also been held to apply where police operations have given rise to a risk of people being killed or killing themselves (e.g. *Makaratzis* [49]-[72]; *Mammadov v Azerbaijan* (2014) 58 EHRR 18 at [113]-[116]).

(g) In *Rabone v Pennine Care NHS Trust* [2012] 2 AC 72, the Supreme Court extended the *Osman* duty to the situation of a mental patient admitted voluntarily to hospital. It held that a distinction between voluntary and detained mental patients was illogical, where a voluntary patient was in practice subject to a similar degree of control. Lord Dyson (from [22]) identified certain indicia which might assist in considering whether the *Osman* duty would exist in a given situation. These included: (a) assumption of responsibility for welfare of the

deceased; (b) vulnerability of the victim; and (c) whether the risk involved is an ordinary one for individuals in a particular category. However, Lord Dyson stressed that these were merely factors which might be relevant, and that they did not provide "a sure guide" to whether the duty should be found to exist.

(h) Breach of Article 2 duties in relation to a death may be established without proof that a relevant failure probably caused the death. It is only necessary to prove that the deceased lost a substantial chance of surviving as a result of the breach: see *Van Colle v Chief Constable of Hertfordshire* [2009] 1 AC 225 at [138].

Principles concerning Narrative Conclusions in Article 2 Cases

8. Over the years since the *Middleton* case, the Courts have provided the following relevant guidance on the approach of coroners to eliciting and returning narrative conclusions in inquests in which the Article 2 procedural obligation is engaged:

(a) The objective of the narrative conclusion is for the coroner or jury to express conclusions on the key factual issues in the case, which might go beyond the immediate physical means of death. In particular, they may deal with underlying and contributory factors. Lord Bingham gave this further guidance in *Middleton* (at [36], in the context of a jury case):

> "If the coroner invites either a narrative verdict or answers to questions, he may find it helpful to direct the jury with reference to some of the matters to which a sheriff will have regard in making his determination under section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976: where and when the death took place; the cause or causes of such death; the defects in the system which contributed to the death; and any other factors which are relevant to the circumstances of the death."

He went on to say that interested persons could make submissions on the appropriate means by which a Coroner could return, or elicit from a jury, conclusions on the key issues. However, he stressed that "the choice must be that of the coroner and his decision should not be disturbed by the courts unless strong grounds are shown." In other words, a coroner has a considerable margin of judgment in deciding how to formulate or elicit a narrative verdict.

(b) On the facts of the *Middleton* case (a prison suicide case), the House (at [45]) suggested an appropriate wording for a narrative in that case: "The deceased took

his own life, in part because the risk of his doing so was not recognised and appropriate precautions were not taken to prevent him doing so". Lord Bingham explained (at [37]) that this embodied "a judgmental conclusion of a factual nature, directly relating to the circumstances of death".

(c) A narrative conclusion must not contravene the provisions of section 10(2) which prohibit any conclusion that appears to determine any question of criminal liability of a named person or any question of civil liability. See: *Middleton* at [37]. Since contravention of substantive obligations under Article 2 gives rise to civil liability under the HRA, an express finding of breach of those obligations is prohibited. See: *R (Smith) v Asst Deputy Coroner for Oxfordshire* [2008] 3 WLR 1284 at [24].

(d) The means of eliciting or stating appropriate conclusions on the key factual issues concerning means and circumstances of death will vary from case to case. In *R (P) v HM Coroner for Avon* [2009] EWCA Civ 1367 at [25]-[26], Maurice Kay LJ explained that the first task of a coroner is to identify the central issues, and the next is to devise a means for those issues to be resolved, which may be by a combination of (i) a choice of short-form conclusions and (ii) a supplementary narrative. See also *R (Bodycote HIP Ltd) v HM Coroner for Herefordshire* [2008] EWHC 164 Admin (at [23]), where Blake J found that, in the circumstances of the case before him, it might be appropriate to return a narrative either as well as, or as an alternative to, a short-form conclusion.

(e) Any narrative conclusion must be limited to matters relevant to the death(s) under investigation. Where an event or circumstance may have caused or contributed to the death(s) but cannot be proved probably to have done, the coroner has a power to return or elicit conclusions about that event or circumstance.

(i) In *R (Allen) v HM Coroner for Inner North London* [2009] EWCA Civ 623, at [40], the Court said that a coroner conducting an inquest in which Article 2 was engaged "was only obliged to investigate those issues which were, or at least appeared arguably to be, central to the cause of death."

(ii) In *R (Lewis) v Mid and North Shropshire Coroner* [2010] 1 WLR 1836, the majority of the Court (Sedley and Rimer LJJ) concluded that a coroner has the power to seek the conclusions of a jury on matters which did not

probably cause the death of the deceased. However, there was no duty to seek such conclusions: see [28]-[29]. Those principles were applied in *R (Le Page) v HM Asst. Deputy Coroner for Inner South London* [2012] EWHC 1485 Admin (Divisional Court).

(iii) In *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] 4 WLR 157, the Divisional Court held that serious failings (there admitted) 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. There is arguably a tension between this decision and those in *Lewis* and *LePage*, which has not been explored in any cases since *Tainton*.

(f) A narrative conclusion should not deal with abstract matters, such as matters of high policy.

(i) In *R (Scholes) v SSHD* [2006] EWCA Civ 1343 at [70], Pill LJ expressed concern that a coroner had sought to elicit a narrative conclusion by a jury questionnaire which addressed issues of broad policy, rather than concrete issues arising in the particular case.

(ii) In *R (Smith) v Oxfordshire Assistant Deputy Coroner* [2011] 1 AC 1 at 100G-H, Lord Philips said that inquests were fact-finding inquiries and would not be the right forum for resolving questions of policy (e.g. the overall competence with which military manoeuvres had been executed).

(g) There is no objection to a narrative conclusion in a *Middleton* inquest identifying relevant failures (see *Tainton*, cited above), or describing such failures as "serious": see *R (Smith) v Asst Deputy Coroner for Oxfordshire* [2008] 3 WLR 1284, Collins J.

(h) A narrative conclusion ought not to be too long or complicated.

(i) In *Coroner for the Birmingham Inquests (1974) v Hambleton* (cited above) the Court of Appeal stressed (at [18]) that a finding of a failure by the authorities to act appropriately would be made by means of a "brief factual conclusion" similar to the short conclusion suggested in Middleton itself.

(ii) In *Clayton v South Yorkshire Coroner* [2005] EWHC 1196 Admin at [31], the Court doubted the appropriateness of a three-page questionnaire put before it, apparently on the basis that it was disproportionate or overly complex.

(ii) *R (de Menezes) v Assistant Deputy Coroner for Inner South London* [2008] EWHC 3356 (Admin) involved a challenge to decisions of the coroner hearing the Stockwell shooting inquest regarding the drafting of a verdict questionnaire. In rejecting the challenge, Silber J said (at [26]-[27]) that the coroner had been justified in taking an approach designed to minimise the risk of confusion or undue complexity in the conclusion.

Article 2 in these Inquests

The Victims on Westminster Bridge

9. In our submission, the Article 2 obligation is not engaged in the inquests of Kurt Cochran, Leslie Rhodes, Aysha Frade and Andreea Cristea. All four were killed as a result of Khalid Masood driving the Hyundai vehicle into them on Westminster Bridge. We do not consider that any of their deaths arguably gives rise to a breach of duty by the state or its agents under Article 2. We expressed that view in the Pre-Inquest Review ("PIR") hearings, but the Coroner has kept the issue under review and it is right to address the topic finally now.

10. Since that view was accepted by all others at the PIR hearings and there has been no indication of a different view during the inquests, we can address the topic briefly, as follows.

(a) The evidence has not suggested any breach of the operational duty. There has been no evidence that at any point in time any agent of the state knew or ought to have known that any of those who died (either as individuals or as members of an identifiable group) was at a real and immediate risk of death and failed to act in response. The attack was planned in secret, without even the family and friends of Khalid Masood being aware of the preparations. It was executed without

warning and the victims on Westminster Bridge were all struck within seconds of the attack beginning.[1]

(b) Rigorous and proper questions have been asked by counsel for the bereaved families about policies and decisions governing the placing of barriers on streets and bridges in central London. However, the evidence does not establish an arguable breach of Article 2 substantive duties in this respect.

(i) Even if it may be suggested that policies of the police or highway authorities can be improved, the evidence does not indicate a systemic flaw existing in March 2017 which amounted to an actual or arguable breach of the general duty. The MPS and the police nationwide have a network of CTSAs[2] who provide guidance based on intelligence and understanding of relevant threats. There is no basis for saying that their advice on physical protective security is ignored,[3] and the works commenced on 4 June 2017 across London suggest otherwise.[4]

(ii) Based on the evidence of Ch Supt Aldworth[5] and Ms Hayward's statement,[6] there was no intelligence of threats specific to Westminster Bridge or even to bridges in general and the MPS gave no advice to erect barriers on the Bridge prior to the attack.[7] In those circumstances, there can be no question of any breach of the operational duty.

(iii) Given the scale of roadways in London (and even in central areas) it would not have been feasible to fortify all major streets with barriers.[8] Given the lack of specific intelligence or threat information singling out Westminster Bridge (or bridges generally), it is difficult to argue that barriers should have been erected there before 22 March 2017 (let alone that the failure to do so amounts to breach of an Article 2 duty).

[1] Khalid Masood mounted the kerb at 14:40:08 (Day 1, p62) and struck Kurt Cochran straight away (Day 1, p65). At 14:40:38 the Hyundai had collided with the wall, having struck each of the four victims on the bridge (Day 1, p59).
[2] Chief Superintendent Aldworth, Day 11, p41.
[3] Chief Superintendent Aldworth, Day 11, p44.
[4] Chief Superintendent Aldworth, Day 11, p49.
[5] Chief Superintendent Aldworth, Day 11, p47.
[6] WS5072/4, WS5104/4.
[7] Chief Superintendent Aldworth, Day 11, p45.
[8] Chief Superintendent Aldworth, Day 11, p65.

(c) Careful questions were also asked about the investigations pursued by the Security Service concerning Khalid Masood in the years running up to the attack.[9] Nevertheless, in our submission the evidence does not demonstrate an arguable breach of the operational or general duty:

(i) Witness L gave cogent answers as to why Khalid Masood was not investigated prior to 2009;[10] why he was justifiably closed as a subject of interest in December 2010;[11] and why an investigation was not opened into him thereafter.[12]

(ii) Even if any of those decisions could be criticised, it is impossible to say that the Security Service knew or ought to have known that the attack was imminent, let alone where it was directed. In those circumstances, there can be no arguable breach of the operational duty.

(iii) The procedures developed by the Security Service for review and investigation of subjects of interest were explained with clarity by the witness.[13] The evidence was that proper application of those procedures would not have led to Khalid Masood being under investigation in March 2017. Furthermore, Witness L explained convincingly that his limited and unsophisticated attack planning[14] could only have been detected by the most intensive surveillance,[15] which could not possibly have been justified by reference to facts known or reasonably discoverable about him.[16]

PC Palmer

11. By contrast, our submission is that Article 2 is engaged in relation to the inquest of PC Palmer. The evidence which has emerged during the hearing has significantly informed that view. The basis for this submission is that it is arguable that the state breached the

[9] Witness L, Day 12, pp10-186.
[10] eg Day 12, p136.
[11] Day 12, p58-59, p67.
[12] Day 12, pp68-74.
[13] Day 12, pp23-26.
[14] Day 12, p74.
[15] Day 12, p148.
[16] Day 12, pp184-185.

Article 2 general duty by not having adequate security arrangements at the Palace of Westminster. Specifically, criticisms may be made of briefing, supervision and assurance systems for failing to ensure that authorised firearms officers remained in close proximity to the Carriage Gates entrance (a known and identified point of vulnerability). Our reasons are as follows:

(a) The Carriage Gates entrance had been identified in multiple security reviews, and in firearms tactical assessments, as one of the most vulnerable points of entry to the Estate and an attractive entry point for an attacker.[17] Since early 2015, unarmed officers stationed at those Gates had been considered to be at particular risk.

(b) Given that the Gates remained open for much of the day and that the external crowd control barriers (introduced in 2016) were left open at times (including predictable times),[18] physical protective security at this highly visible access point was minimal.

(c) Against that background, repeated tactical assessments had stressed the need for armed officers to be present close to the Gates in the ordinary course of events, both as a visible deterrent[19] to any assault on the Palace and as a critical line of defence.[20] Commander Usher summarised the assessment as being that armed officers ought to be "tethered" to the Gates.[21]

(d) Post Instructions in force at the time of the attack[22] gave generally appropriate instructions, and there is no dispute that they were readily accessible to officers through use of the ADAM system. However, in our submission those facts alone do not preclude the possibility of a systemic failing. The system could be inadequate on the basis that inadequate procedures were adopted to ensure that the written instructions were known to armed officers and observed by them.

[17] Commander Usher, Day 10, p95. Eric Hepburn, Day 13, p152.
[18] Commander Usher, Day 10, p34, p36.
[19] Commander Usher, Day 10, p50, p88, p100.
[20] Commander Usher, Day 10, p96.
[21] Day 10, p91.
[22] DC8032, Commander Usher, Day 10, p59.

(e) There is evidence that armed officers were not complying with the strictures of Post Instructions, and that this was happening on a regular basis. In particular:

(i) Both armed officers on duty in New Palace Yard at the time of the attack (PCs Ashby and Sanders) gave evidence that they understood from briefings, from supervision and from standard practice, that they were to make a "roving patrol"[23] around the whole of New Palace Yard. It is likely that they did honestly understand that to be their role, as it was not easier[24] or more convenient to carry out such a patrol than to stand near the Gates. Furthermore, they recognised that this made their unarmed colleagues on the gates more vulnerable.[25]

(ii) It is also likely that PC Gerrard, the other officer on duty on the afternoon of the attack, understood his duty to involve a roving patrol, as the CCTV evidence suggests that he performed such a patrol.[26]

(iii) Both PCs Ashby[27] and Sanders[28] insisted that other officers with whom they had patrolled took the same approach. It must be at least arguable that they were right, and at least to the extent of some officers doing so. It would, for example, be a strange co-incidence if the attack happened on the afternoon when the only three officers with this view of the deployment were on duty.

(iv) PCs Ross[29] and Glaze,[30] the unarmed officers at the Gates at the time of the attack, also had the understanding that armed officers on duty in New Palace Yard would often not be in close proximity to Carriage Gates (as the applicable Post Instructions generally required them to be).

(iv) The MM1 document produced by the DPS following its review commissioned by Commander Usher indicated that PCs Ashby and

[23] PC Ashby, Day 6, p118. PC Sanders, Day 8, p15.
[24] PC Sanders, Day 8, p15.
[25] PC Ashby, Day 5, p181. PC Sanders, Day 8, p49.
[26] Witness statement of DC Overall, WS1484B.
[27] Day 6, p155.
[28] Day 8, p7.
[29] Day 5, p124.
[30] Day 5, p160.

Sanders were following a "practice… not unique to these officers" and that "wider command practice was reflective of the same misunderstanding".[31] Commander Usher's evidence was that this was a thorough process of review, and there is no basis for disbelieving its conclusions.[32]

(v) The only supervisory record of sergeants checking compliance with Post Instructions (that kept by Inspector Munns[33]) suggests that a sergeant on one occasion instructed firearms officers not simply to stand at Carriage Gates but to patrol further.[34] It contains no other entry to suggest that officers were being told (for example) to stay within sight of the Gates.

(f) There is evidence to suggest that systems for ensuring observance of changing Post Instructions were far from watertight. Officers were supposed to access these instructions via the ADAM system,[35] which was auditable.[36] However, as at 1 August 2016, only 13% of officers on the PaDP Command had logged in since December 2015,[37] when the relevant set of Post Notes had been updated.[38] Despite a suggestion by DCI Aldworth in January 2015 that compliance with enhanced safety measures (including the presence of armed officers at the Gates) be checked and the checks recorded,[39] there was never any centrally held record of such checks and no record at all after February 2016.[40]

(g) There is evidence to suggest that officers adopted a range of interpretations of Post Instructions. The MM1 document recorded that armed officers considered the instructions to be advisory only[41] (which senior officers said emphatically they were not)[42]. The statement of Inspector Rose suggests that his view of the extent

[31] WS5099/44. Commander Usher, Day 10, p94.
[32] Day 10, pp121-122.
[33] WS5131/4-42. cf Witness statement of Inspector Rose, WS5132.
[34] WS5131/24.
[35] Commander Usher, Day 10, p71.
[36] Commander Usher, Day 13, p102.
[37] Note from Counsel to the Inquests on use of the ADAM system, 27 September 2018.
[38] DC8032.
[39] WS5130/7.
[40] Commander Usher, Day 13, p4-5.
[41] WS5099/44.
[42] Commander Usher, Day 10, pp166-167.

of patrol permitted under the Post Instructions was at variance from the view held by at least some of the more senior officers.[43]

(h) Importantly, the MM1 document also records improvements in procedures being implemented by the Senior Leadership Team after the review, including "intrusive first and second line supervision" and dip-sampling to ensure regular reference by officers to the ADAM system.[44] These steps show that systems could readily be tightened to ensure that all officers were apprised of Post Instructions and observed them.

(i) On the basis of the material summarised above, it is arguable on the evidence that there were real systemic failings. More difficult is the question whether it is arguable that PC Palmer's chance of survival may have been improved by better systems to ensure that armed officers complied with the instruction to remain in close proximity to the Gates. This is a challenging question which involves a good deal of speculation.

(i) If the armed officers had been at the Gates, it is uncertain whether they (or either of them) would have initially started moving towards the sound of the collision (which sounded to many like an explosion). Their evidence on balance suggests that they both would have done.[45]

(ii) If the armed officers had begun moving towards the sound of the collision, it is then uncertain whether they (or either of them) would have become aware of crowds rushing past the Gates and started moving back.[46] It is then also a matter of some speculation where each would have been when Khalid Masood entered.

(iii) It is very difficult to say whether the armed officers would have been able to, and would have chosen to, take a shot at Masood before he inflicted the fatal stabbing injury on PC Palmer. There were different answers at different points in their evidence.[47]

[43] WS5132.
[44] WS5099/44.
[45] PC Ashby, Day 6, p169. PC Sanders, Day 8, p41, p51.
[46] PC Sanders, Day 8, pp36-57.
[47] PC Ashby, Day 7, p165. PC Sanders, Day 8, p37.

Having considered this question anxiously, we consider that it is arguable that PC Palmer's chance of survival would have been improved. It is not "fanciful" to posit that one or both of the officers might have remained at the Gates or moved back towards them and would have had a chance of taking an effective shot.

12. The effect of our submission that Article 2 is engaged should not be over-stated. It means that the determination in PC Palmer's inquest should address the circumstances as well as the means of death. It may be more judgmental and may address underlying and contributory causes. However, it should still be concise and must still comply with the statutory requirements.

Proposed Determinations

13. We propose that, for each of those who died, a Record of Inquest should be produced with all sections completed (including medical cause of death, as given by the relevant pathologist) and the following entry in each of sections 3 and 4: "See attached Determinations sheet". That sheet should then contain the determination as to how the person died.

Unlawful Killing Conclusion

14. In our submission, a short-form conclusion of unlawful killing ought to be returned in each case, supplemented by a narrative (both in a document annexed to the Record of Inquest and referenced in it). It is clear beyond any doubt that each of those who died was murdered. As the eye-witnesses to the events on Westminster Bridge made clear, and as the expert evidence of PC Keen demonstrates, Khalid Masood drove deliberately at pedestrians. He evidently intended to kill and maim. When he entered the Palace of Westminster, he immediately began a savage assault with knives on PC Palmer who bravely confronted him. It is right that the records of these inquests should state that each of those who died was unlawfully killed.

Narrative Conclusions – the Victims on Westminster Bridge

15. As submitted above, it is legitimate for some narrative conclusions to be provided in relation to each of those who died (irrespective of the engagement of Article 2). We put forward the following suggested forms of words for those conclusions (beginning, in each case, with the short-form conclusion). However, no doubt the Court will wish carefully

to consider any amendments or alternative forms of words provided by the bereaved families in particular. We should stress that these are being suggested as the narratives for the Records of Inquest. We are aware that a much more detailed account will be given in relation to each one in the Coroner's summing-up.

(a) Kurt Cochran

Kurt Cochran was unlawfully killed.

On 22 March 2017 Kurt Cochran was on a visit to London. He had been walking with his wife, Melissa, across Westminster Bridge. They had reached a point near the South Bank side when a Hyundai vehicle was driven deliberately onto the pavement where they stood. This was part of a terrorist attack. Kurt instinctively pushed Melissa away from the path of the vehicle and as a result was struck with full force by the vehicle. He was thrown over the parapet of the Bridge to the embankment below, falling from a height of 5.12 metres. In the fall, he suffered a serious head injury which was not survivable. Despite early medical attention from a nurse and an ambulance crew, he died at the scene.

(b) Leslie Rhodes

Leslie Rhodes was unlawfully killed.

On 22 March 2017 Leslie Rhodes was walking from the South Bank side of Westminster Bridge towards the North Bank side. He was struck from behind by a Hyundai vehicle which had been deliberately driven onto the pavement where he was walking. This was part of a terrorist attack. Leslie was carried along into the carriageway a distance of 33 metres. As a result of the impact, he suffered a devastating brain injury, which was not survivable. Despite early medical attention from a hospital doctor and a paramedic at the scene, and despite proper treatment at King's College Hospital, Leslie died on 23 March 2017 in hospital.

(c) Aysha Frade

Aysha Frade was unlawfully killed.

On 22 March 2017 Aysha Frade was walking across Westminster Bridge towards Parliament Square on her way home from work. While walking on the pavement, she was struck from behind by a Hyundai vehicle which had been deliberately driven towards her. This was part of a terrorist attack. Aysha was thrown into the air and into the path of the nearside rear wheels of a bus. Those wheels passed

over her, inflicting injuries which were immediately fatal. Aysha would not have suffered. She was assessed as dead at the scene by a paramedic and by a doctor.

(d) Andreea Cristea

Andreea Cristea was unlawfully killed.

On 22 March 2017 Andreea Cristea was walking across Westminster Bridge with her boyfriend, Andrei Burnaz, from the Parliament Square side. She was stopping at times to take photographs with her mobile phone. While on the pavement, she was struck by a Hyundai vehicle which was being deliberately driven towards pedestrians on the pavement. This was part of a terrorist attack. Andreea was thrown into the air and over the parapet of Westminster Bridge, landing in the river Thames below. She was carried by the current a distance of 100 metres and was in the water for around five minutes before she was recovered by a London Fire Brigade boat. She was treated by fire officers and then by paramedics, before being taken by ambulance to hospital. While in hospital, she received extensive and complex medical care over the following days. Despite the best efforts of clinicians, she died on 6 April 2017.

Narrative Conclusions – PC Keith Palmer

16. Based on the legal submissions above, we submit that the narrative conclusion concerning the death of PC Palmer should be in two parts: first, a passage describing the means of his death; and secondly, a passage addressing the broader circumstances and the adequacy of the security arrangements at the Palace of Westminster.

17. We suggest the following forms of words for others to consider and address in their submissions. In the second passage, we put forward (in italics) two alternatives dependent on whether the Court is persuaded that there were shortcomings in the system of supervision.

(a) PC Keith Palmer was unlawfully killed.

On 22 March 2017 PC Keith Palmer was on duty as an unarmed police officer stationed at the Carriage Gates entrance from Parliament Square into the Palace of Westminster estate. An attacker who had driven his vehicle into multiple pedestrians on Westminster Bridge entered the Gates and immediately began attacking PC Palmer with knives, driving him back into the New Palace Yard

area. PC Palmer stumbled against a low wall and the attacker continued his assault. In the attack, PC Palmer suffered a number of injuries, one of which was a serious stab wound to the chest. Although he was able to move away from the attacker, PC Palmer collapsed shortly afterwards. Despite prompt and capable medical attention at the scene, he suffered a cardiac arrest and could not be saved.

(b) Before the start of the attack, the armed officers stationed in New Palace Yard had not been in close proximity to the Carriage Gates entrance. They had been some distance away and out of view of the entrance because they had understood their duty to involve a roving patrol around the Yard. In fact, tactical advice and written instructions stated that armed officers should be stationed close to the Carriage Gates entrance so as to protect those in the Estate and their unarmed colleagues.

[Due to shortcomings in the system of supervision, the armed officers were not aware of a requirement to remain close to the Gates. Had they been stationed there, it is not certain whether they would have been able to prevent PC Palmer suffering fatal injuries.]

OR: *[The armed officers did not appreciate that there was a requirement to remain close to the Gates. Had they been stationed there, it is not certain whether they would have been able to prevent PC Palmer suffering fatal injuries.]*

PFD Report

Legal Background

18. Schedule 5 to the Coroners and Justice Act 2009 ("CJA"), which is given effect by section 32, provides as follows at paragraph 7(1):

"Where –

(a) a senior coroner has been conducting an investigation under this Part into a person's death,

(b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and

(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,

the coroner must report the matter to a person who the coroner believes may have power to take such action."

Further provision is made at paragraph 7(2)-(3), for (i) the recipient of a report to reply in writing and (ii) both the report and reply to go to the Chief Coroner.

19. Part 7 of the Coroners (Investigations) Regulations 2013 contains provisions for the making of PFD Reports. Regulation 28 provides as follows:

"(1) This regulation applies where a coroner is under a duty under paragraph 7(1) of Schedule 5 to make a report to prevent other deaths.

(2) In this regulation, a reference to 'a report' means a report to prevent other deaths made by the coroner.

(3) A report may not be made until the coroner has considered all the documents, evidence and information that in the opinion of the coroner are relevant to the investigation."

20. Before July 2013, the power to make such reports was contained in rule 43(1) of the Coroners Rules 1984. That provision was in terms similar to those of paragraph 7(1) of Schedule 5 to the CJA, but it provided that if the coroner considered that preventive action should be taken, then he/she "may" make a report.

21. The following principles govern the making of PFD Reports:

(a) As the Court of Appeal observed in the *Lewis* case (cited above), the regime makes it mandatory for a coroner to make a report if he/she forms the view that the relevant action needs to be taken. A coroner may no longer conclude that action ought to be taken but decide for some extraneous reason not to make a report. That is the effect of the words "must report" in paragraph 7(1).

(b) However, the power and duty to make a report only arise where the coroner forms the opinion, based on evidence relevant to his/her inquiry, that particular risks of death exist for which preventive action is required. In *R (Cairns) v HM Deputy Coroner for Inner West London* [2011] EWHC 2890 (Admin) at [74], Silber J

explained that the statutory expression "in the coroner's opinion, action should be taken…" reflects a discretionary judgment by the coroner.

(c) The jurisdiction to make PFD Reports is not limited to the reporting of circumstances and risks which were causally relevant to the particular deaths under investigation: see *Lewis* at [14]-[19]; Rule 43 Report of Hallett LJ following the London Bombings Inquests, [161]; Chief Coroner's Guidance No. 5, [17]. However, it does require that the material in the particular investigation has highlighted systemic risks or failures which may recur or continue, with potentially fatal consequences: see *R (Francis) v HM Coroner for Inner South London* [2013] EWCA Civ 313 at [7]-[8], Davis LJ.[48]

(d) A coroner may properly decide not to make a PFD report on an issue on the basis that he/she is not satisfied that further action is necessary. If, for example, it appears that a risk or issue has likely been addressed by action of some kind, or if circumstances have changed substantially since the death in question, the coroner may reasonably say he/she is not satisfied further action is required. Equally, a coroner may decide that he/she simply has insufficient material to form a view that there are particular risks of future deaths and/or that further action is required. See, for example, the approach taken by Hallett LJ to various issues in her Rule 43 Report after the London Bombings Inquests (e.g. [70] and [217]). See also *Jervis on Coroners (13th ed.)* at [13-125].

(e) The purpose of death investigation in both domestic and Convention law includes a concern to identify systemic failures and risks. See, for example *R (Amin) v SSHD* [2004] 1 AC 653 at [31]; *R (Sacker) v West Yorkshire Coroner* [2004] 1 WLR 796 at [11]. The domestic law scheme deliberately confers on a professional adjudicator (the coroner) the judgment whether such risks exist and whether they need to be addressed by action: see *Lewis* at [40]; *Middleton* at [38].

22. Chief Coroner's Guidance No. 5 also addresses PFD Reports. That document makes the following relevant points, with which we respectfully agree:

[48] Note also that a PFD Report should be made by reference to the material gathered and evidence given during the coronial inquiry. The jurisdiction to make a report is thus ancillary to the inquiry, and a coroner should not radically expand the scope of his/her inquiry in order to provide the foundation for a possible PFD Report. See: *R (Butler) v HM Coroner for the Black Country* [2010] EWHC 43 (Admin) at [74], Beatson J; Chief Coroner's Guidance at [14].

(a) PFD Reports are important, and their importance has been emphasised by Parliament modifying the rules in the way described above. See Guidance at [2]-[3].

(b) "Broadly speaking reports should be intended to improve public health, welfare and safety. They should not be unduly general in their content; sweeping generalisations should be avoided. They should be clear, brief, focused, meaningful and, wherever possible, designed to have practical effect." See Guidance at [5].

(c) If a report is made, it need not (and generally should not) prescribe particular action to be taken. It need not (and generally should not) apportion blame or be prejudicial (see, to the same effect, *Jervis* at [13-123]). The content of the report should be focussed and limited to the statutory remit. See Guidance at [24]-[27].

23. In summary:

(a) A coroner should make a PFD report if (but only if) satisfied of two propositions: (i) that there is a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and (ii) that in his/her opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances. In making a judgment on these issues (especially the second), the coroner is exercising a judicial discretion.

(b) The coroner must form his/her judgment based on the information revealed by the coronial investigation.

(c) It is not necessary for the coroner to conclude that the particular death under investigation was caused by the circumstances or risks which may be the subject of the report. However, it is necessary for the coroner to find that systemic risks or failures have been highlighted by the material in the particular investigation.

(d) It is perfectly proper for a coroner to say that a risk or issue has apparently been addressed, or that on the available material he/she cannot be satisfied that

preventive action need be taken. In making a decision, the coroner is entitled to take account of the passage of time and changes of circumstances since the deaths.

(e) Before deciding whether to make a report, the Coroner should consider whether it would be directed to improving public health, welfare or safety and whether it would be focussed, practical and within the statutory remit.

24. We would finally stress the point that PFD Reports will often draw attention to matters of concern or to risks, rather than prescribing particular solutions. A coroner is often not qualified to propose specific action and may not be aware of all the consequences of taking such action. A coroner may be unaware of exactly what remedial action is practicable and/or unaware of competing demands for resources. These considerations should not, of course, lead to paralysis. A coroner may raise a concern and be properly told that the problem cannot be perfectly solved.

Proposed Approach in this Case

25. In our submission, it would be appropriate in this case to adopt the following approach:

(a) Interested Persons have been given the opportunity to make submissions before the end of the inquests hearing on points they consider might usefully be made in a PFD Report. If any Interested Person has difficulty in formulating submissions before the end of the hearing, serious consideration should be given to allowing more time for written submissions.

(b) Other Interested Persons should then be given the opportunity to respond to those submissions in writing within a period of (say) 28 days, making observations on the proposed points. Those submissions should so far as possible be provided in open form (which can and will be circulated to all Interested Persons), but may if absolutely necessary include a closed annex.

(c) The Coroner should then consider the original submissions and any responses, before preparing and issuing any PFD Report. The issuing of any Report would then trigger the process of responses in the way laid out in the statutory provisions.

26. We propose this sequence of submissions, responses and Report for the following reasons. Given the subject-matter of these Inquests, it may be that representations are made for a PFD Report to address very complex subject-matter (e.g. questions of Parliamentary security, protective security of public places and/or Security Service procedures). In some cases, the points raised may address subjects which have already been covered by reviews undertaken before or since the attacks. In order that the Coroner can ensure that any PFD Report serves its proper purposes (as identified above), it would be best to allow public authorities to make observations on suggested points before the content of any Report is decided.

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