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

SUBMISSIONS ON BEHALF OF THE HOME SECRETARY
ON PREVENTION OF FURTHER DEATHS

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1. At the conclusion of the Inquest, the Coroner noted that he had received submissions from interested persons regarding matters he should address in a Prevention of Further Deaths ('PFD') report, and invited any further submissions to this effect by 4pm on 12 October 2018 (Day 16, page 191). Any interested person who wished to respond to those submissions was directed to do so by 4pm on 9 November 2018.

2. Further submissions, directed to the particular issues arising from the death of PC Palmer – including security arrangements in New Palace Yard, Post Instructions and AFO training – were served on behalf of PC Palmer's Widow and Family respectively. The Secretary of State understands that no further submissions have been served by the interested persons in relation to the involvement of the Security Service (MI5) in this case, and that the matters the Coroner is being invited to include in a PFD report in that regard remain those set out in the written submissions served by the interested persons on 2 October 2018.

3. Set out below is the Secretary of State's response to those submissions which are directly concerned with the work of MI5. In particular, they address the 6 proposed 'recommendations' set out at §§13-32 of the submissions served on behalf of the families of Kurt Cochran, Leslie Rhodes, Aysha Frade and Andreea Cristea ('the Families'). For ease of reference, the recommendations proposed by the Families are listed in an appendix to these submissions.

The Coroner's duty to make a PFD report

4. Pursuant to §7 of Schedule 5 to the Coroners and Justice Act 2009 the Coroner is required to make a PFD report if certain conditions are met:

"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."

5. As noted by Counsel to the Inquest, at §20 of their submissions, the principal effect of these provisions is to convert what was formerly a discretion (under Rule 43 of the Coroner Rules 1984) into a duty. As observed in *R (Lewis) v Mid and North Shropshire Coroner* [201] 1 WLR 1836, the Coroner is required to make a PFD report if s/he is satisfied that the §7 criteria are met.

6. The two criteria identified in §7 of Schedule 5 require careful, and separate consideration. First, the Coroner must be satisfied, having reviewed the totality of the relevant material (all 'documents, evidence and information' per Reg.28 of the 2013 Regulations) that there is a concern that 'circumstances creating a risk of other deaths will occur, or will continue to exist.' Further explanation as to the nature of the concern that must be identified in order to satisfy the first criteria is to be found at §10 of the Chief Coroner's Guidance No.5, as follows:

"Something revealed by the investigation (including evidence at the inquest) gives rise to a concern….The concern is that circumstances creating a risk of further deaths will occur, or will continue to exist, in the future. It is concern of a risk to life caused by present or future circumstances."

7. Second, the Coroner must be satisfied preventative action is required to address that risk. The second criteria involves the exercise of a discretion on the part of the Coroner, to the extent that it is necessary for him to form an opinion as to whether preventative action is required: *R (Cairns) v HM Deputy Coroner for Inner West London* [2011] EWHC 2890 (Admin).

8. The Secretary of State notes, and endorses, the submission of Counsel to Inquest (at §21) that it is not necessary for the matters of concern to be causally relevant to the

particular death(s) under investigation. However, it is important to note that, as observed by Counsel to the Inquest that it is necessary:

"..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."

9. The effect of the second criterion is that it is open to a Coroner to decide not to make a PFD report on the basis that, although the evidence has revealed the existence of a concern falling within §7(1)(b), the Coroner is not satisfied that action should be taken in order to address that concern. It may be that the Coroner is satisfied that the requisite action has already been taken and/or that he considers that the information available to him is insufficient to enable him to reach an adequately informed judgment that further action is required.

10. The need for the Coroner to consider carefully whether he is satisfied that further action is required in respect of any concerns he has identified is emphasised by the Chief Coroner's Guidance No.5, at §5, which identifies the need for PFD reports to be 'clear, focused, meaningful and, wherever possible, designed to have practical effect.' For a PFD report to be meaningful and practical it is clearly necessary for it to take careful account of any action that has already been taken, and to provide specific direction as to the action that, in the opinion, of the Coroner, needs to be taken.

11. In accordance with these principles it is submitted that the correct approach for the Coroner to adopt in respect of each individual 'recommendation' suggested by the Families in their submissions for inclusion in a PFD report is to ask the following questions:

    (i) Does the information before me establish that circumstances exist which create a risk that further deaths will occur?

    (ii) If so, am I satisfied that specific action needs to be taken in order to address that risk?

12. Before turning to the 6 individual 'recommendations' identified by the Families, each of which is addressed in turn, the Secretary of State advances the following submissions of general application, addressed to these two questions.

Risk of Further Deaths

13. There is no question of any deficiency in the systems or procedures operated by MI5 having played any causative role in the attack. On the contrary, the evidence clearly demonstrates that there was no realistic opportunity to have discovered Masood's attack planning, or to have taken steps which would have prevented him from carrying out the attack. The position is accurately summarised by Counsel to the Inquest, at §10(c)(iii) of their submissions:

> *"The procedures developed by the Security Service for review and investigation of subjects of interest were explained with clarity by the witness. 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 could only have been detected by the most intensive surveillance, which could not possibly have been justified by reference to facts known or reasonably discoverable about him."*

14. That is plainly correct. Even with the benefit of hindsight, and the exhaustive investigation of Masood conducted after the attack, there was nothing which would have justified the institution, and subsequent maintenance, of intensive monitoring of his activities during the years leading up to the attack. Indeed, as Counsel to the Inquest correctly identified in his questioning of Witness L (Day 12, page 184), it is highly unlikely that intrusive monitoring of the type required would have been lawful, either under the regime as it existed at the time or the current regime of judicial oversight.

15. The conclusions expressed by Counsel to the Inquest having considered the evidence given during the course of the Inquest are, of course, entirely consistent with the conclusion of the Post-Attack Review conducted by MI5. Lord Anderson noted, at §3.12 of his Report that: 'The review team concluded that actions taken in relation to the threat posed by Khalid Masood, including the decision to close him as an SOI, were sound on the basis of the information available at the time.' Lord Anderson

characterised the review as 'careful and trustworthy' and endorsed its conclusions as far as he was qualified to do so (§5.29).

16. No attempt has been made by any interested person to challenge this analysis. It would appear to be common ground that there was no arguable breach of the *Osman* operational duty as far as MI5 is concerned (Day 15, page 133); and the submissions advanced on behalf of the Families do not seek to suggest that there was anything MI5 should have done in this case that would have altered the outcome.

17. Instead, it is submitted that particular recommendations should be directed to MI5 in a PFD report on the basis that 'there is always room for improvement' (Day 15, page 135), which was subject to further elaboration as follows (Day 15, page 136):

"However, in relation to MI5, we do think that there is room for improvement in terms of decision-making, and a key feature, sir, of the evidence of Witness L was that all-important decision: when do they investigate, when do they not? When do they stop investigating? When do they revisit somebody who they have stopped investigating? Greater structure can only assist, sir. Good record-keeping or documentation that focuses the mind of the decision-maker so that everything of relevance is identified and appropriate weight is given to everything of relevance, and…..is it really the case that not so much weight should be given to serious records of violence? Is it really the case that not so much weight should be given to again and again and again associating with terrorists? Those sorts of points…are of real concern and we would invite you to consider whether improvements can be made in connection with such decision making."

18. In essence, therefore, the Coroner is being invited to make recommendations in a PFD report addressed to decision making procedures which have been carefully scrutinised and found to have worked entirely appropriately in the particular circumstances of this case. Khalid Masood was correctly closed as an SOI, on the basis of the information available at that time, and at no stage thereafter did the intelligence picture justify the institution of monitoring of a type which would have had even the remotest chance of discovering his attack planning.

19. That being so, it is submitted that it is necessary for the Coroner carefully to distinguish between circumstances which would trigger his statutory duty to make a PFD report, and circumstances which might indicate that there is some degree of 'room for

improvement' in the manner in which MI5 goes about the business of addressing the terrorist threat.

20. There is insufficient information before the Coroner to establish that circumstances exist which would create a risk that further deaths will occur. There is, of course, a risk that further terrorist atrocities will be committed and, as Lord Anderson correctly observed at §5.24 of his Report, 'not everything can be stopped', given that we do not live in a surveillance state and there are those who are willing to strike opportunistically without regard for their own lives. But the question, for present purposes, is not whether there is a risk of a further attack, but whether the information before the Coroner demonstrates that the circumstances in which MI5 assesses risk, prioritises resources, and identifies when (and when not) to investigate particular individuals, gives rise to a concern that those judgments are being exercised in such a way as to create a risk of further deaths.

21. The effect of the information before the Coroner is clear. There is no proper basis for such a concern. On the information available at the time the judgments were sound. There is nothing to indicate any defect in practice or procedure which might render such judgments unsound in a different case. In particular, there is nothing to indicate that the current procedures for determining which SOIs to investigate, and to what extent they should be investigated, give rise to risks of further deaths that would be reduced were those procedures to be amended; or that a different prioritisation of resources would be more effective in countering the threat from Islamist extremism.

22. For example, if one were to consider the recommendation advanced at §22 of the Families' submission – that 'the Service reviews its procedures for managing closed SOIs' – it is quite clear that there is no information before the Coroner to indicate that the manner in which closed SOIs are currently managed by MI5 gives rise to a risk of further deaths from Islamist extremism that would be reduced were particular action to be taken to change the way in which closed SOIs were managed. There is no information from which the Coroner could reliably conclude that if changes were made to the management of closed SOIs the risk of further deaths from Islamist extremism would be reduced, or that corresponding risks would not be increased by the re-deployment of resources. There is no information to support the conclusion that

the risk of further deaths would be reduced if more time was spent managing closed SOIs and less on managing open investigations.

23. Similarly, there is no information before the Coroner to demonstrate that, by way of further example, the devotion of additional resources to the recording of decisions to close SOIs, in circumstances where there was no evidence of involvement in extremist activity or attack planning, would reduce the risk of further deaths from Islamist terrorist attack. There is certainly no evidence that more detailed record-keeping of the decisions taken in Khalid Masood's case would have materially reduced the risk he posed, particularly given the soundness of those decisions. A finding that the current system of record-keeping was such as to cause a concern that it gave rise to a risk of further deaths would require some evidence that additional time spent on record-keeping would reduce the risk of SOIs being closed inappropriately, and thereby lead to additional plots being disrupted (or opportunistic attacks being prevented); and that the devotion of resources to this particular issue would not give rise to a risk arising from the reduction of resources elsewhere. It is submitted that there is simply no evidence before the Coroner that would permit such conclusions to be drawn.

24. The same analysis can be applied to each of the proposed recommendations suggested by the Families. The essential flaw in the approach that is being urged upon the Coroner is that it invites him to consider whether there might be 'room for improvement' in the way MI5 conducts (and/or records) its investigations. That is not the question posed by §7(1)(b) of Schedule 5, which requires a careful analysis of the available information to determine whether there are current circumstances which give rise to a risk that further deaths will occur. It is submitted that, on a proper application of the correct test, none of the matters identified by the Families establishes that circumstances exist which give rise to a risk that further deaths will occur.

The Need for Action

25. As explained above, the correct approach to the consideration of whether to make a PFD report requires the Coroner, if he considers that the §7(1)(b) criterion is met, to go on to decide whether, in his opinion, it is necessary to take action in order to address the risk identified. It is submitted that, in none of the respects identified by the

Families, is there sufficient information upon which the Coroner could conclude that further action is necessary.

26. The limitations on the ability of a Coroner, having heard evidence about the particular circumstances of an individual case, to make general recommendations as to operational decision-making by a specialist organisation such as MI5 were recognised by Hallett LJ in the course of her Rule 43 Report following the 7/7 Inquests, at §106:

"My conclusions, therefore, are that as far as the categorisation of targets and the structure of decision making are concerned, I feel these are very much areas best left to the experts. I have not heard enough evidence to justify making any criticism of the present system of prioritising targets. The ISC has now been alerted to problems in the past and will be in a position, in closed session, to exercise careful supervision of the process. Accordingly, I make no recommendation that procedures be examined to establish if there is room for further improvement in relation to assessing the risk posed by an individual or in relation to more formalised structured decision making as such."

27. That conclusion was reached in light of an acknowledgement of the 'huge task' that confronts MI5 on a daily basis (§11), and the conspicuous successes of MI5 in preventing acts of terrorism in the UK. Hallett LJ was aware that there were also many 'inconspicuous successes', the details of which could never be made public (§12). She described the work undertaken by MI5 to identify and assess risk, and prioritise resources, in the following terms:

"Members of the Service work unsung and tirelessly on behalf of the British public. They gather, sift and analyse vast quantities of intelligence material each year and try desperately to focus their precious resources and efforts on preventing the kind of murderous attack that took place on 7/7….One must never lose sight of the fact that the material confronting the Security Service at the time would have comprised literally thousands of strands of possible contacts and hundreds of possible targets. The desk officers must usually work at speed and in very difficult conditions. We do not know the precise details, but we know enough properly to infer that the sheer scale and number of the threats facing the UK was immense. If one plot is discovered to involve an imminent threat to life resources must be diverted to meet it at the expense of other investigations."

28. The same analysis applies in the present case. At §1.10 of his Report, Lord Anderson refers to the 20 Islamist-inspired terrorist plots that have been disrupted since October 2013. At §1.4 he notes that the threat level in the UK from 'international terrorism' has been SEVERE since August 2014, indicating that Islamist terrorist attacks in the UK

are 'highly likely'; and, at §1.5, that the growing scale of the threat from Islamist terrorism is 'striking'. He quoted the Director General of MI5, who has observed that the attack threat was at the 'highest tempo' he has seen in his 34-year career.

29. The same considerations which led Hallett LJ to conclude that matters of operational decision making, including the prioritisation of targets, were best left to 'the experts', apply equally to this investigation. It is for MI5, with its unique experience and expertise in this area, to determine how best to deal with the enormous volume of material that requires analysis, assessment and prioritisation. Indeed, the evidence demonstrates not only that the scale of threat has continued to increase since Hallett LJ's consideration of these issues in 2011, but also that MI5 has continued to be extremely successful in disrupting plots and preventing attacks.

30. That is not to say, of course, that the particular circumstances of this case should not be examined carefully for the purposes of 'squeezing every last drop of learning' from the investigation. That was precisely the purpose of the Post-Attack Review and the Operational Improvement Review described by Witness L in his evidence. Those reviews were conducted by a panel of appropriately qualified experts, none of whom had any prior involvement in the case.

31. Further, the quality and rigour of those reviews were assessed by Lord Anderson and his conclusions were clear. The Post-Attack Review narratives, when scrutinised against the underlying documents, 'stand up as impressively thorough and fair' (§5.10). The Operational Improvement Review is 'an impressive piece of prescriptive analysis, well reflecting the varied viewpoints and discussions that accompanied its formulation.' However, when it came to assessing the conclusions of the Operational Improvement Review, even Lord Anderson, with his extensive experience in this area and close familiarity with the entirety of the review process, recognised that these were matters of operational expertise in respect of which he would defer to the 'senior leadership of MI5', at §5.18:

"[T]here are recommendations in the OIR whose detailed evaluation requires knowledge and experience rather different from mine. To take one example, a number of the recommendations…are likely to have as their effect an increase in the volume of leads. While this may be desirable in principle, the processing of more leads will logically require the transfer of resources from other activities, perhaps including priority investigations. Whether the

quality of the extra leads will be such as to justify removing those resources from other areas of MI5's work is something of an imponderable, at least for me. While I have no reason to distrust the judgments made by the senior leadership of MI5 and CT Policing on this issue, it is ultimately a question of operational feel on which my independent verdict would have little value."

32. At §5.22 of his Report, Lord Anderson endorsed the following description by the Director General of MI5 of the work of those MI5 officers engaged in the assessment of intelligence, who make difficult judgments based upon the limited information available to them:

"They are constantly making tough professional judgments based on fragments of intelligence: pin pricks of light against a dark and shifting canvas."

In deferring to those with extensive operational experience of this task, and declining to pass judgment on whether the correct conclusions had been drawn following the Operational Improvement Review, Lord Anderson was not, in any sense, abdicating responsibility for making such judgments, he was simply recognising that these are matters of difficult judgment best addressed by those with specialist expertise; and that the risk of making recommendations based on an incomplete understanding of the operational realities, is that valuable resources are focussed in the wrong place. It was precisely the same analysis that led Hallett LJ to decline to address 'the system for prioritising targets', or to make a recommendation that procedures be examined to see if there was room for improvement 'in relation to assessing risk' or the development of a 'more formalised structured decision making [process].'

33. It is submitted that the Coroner should adopt the same approach in this case. Even if the areas identified by the Families as giving rise to 'room for improvement' could properly be characterised as 'concerns….creating a risk of other deaths' such as to satisfy the first of the Schedule 5 criteria – and it is submitted that they clearly do not, for the reasons set out above – the Coroner is not in a position to reach a properly-informed and reliable conclusion that 'action should be taken', beyond that which has already been taken in response to the Operational Improvement Review, such as to satisfy the second criterion.

The Individual Recommendations

34. In light of the general submissions of principle set out above, the Secretary of State addresses each of the individual recommendations proposed by the Families in turn.

Record-Keeping

35. The first recommendation, as set out at §20 of the Families' submissions is expressed in the following terms:

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

36. As to the rationale in support of the recommendation, it is asserted, at §19, that 'poor record-keeping' reduces the efficacy of later reviews of the 'suspect'. In support of that proposition the Families cite the observations of Hallett LJ in the course of her explanation as to why she had decided to make a recommendation in her Rule 43 report in the following terms: "*I recommend that procedures be examined by the Security Service to establish if there is room for further improvement in the recording of decisions relating to the assessment of targets*." Three points arise in response to the Families' analysis.

37. First, the recommendation made by Hallett LJ was followed and consideration was given to whether there was room for further improvement with regard to record-keeping in this area. The outcome of that consideration was reported in the Government's response to the Rule 43 Report, at §§21-30. It was reported that there had been significant development of MI5's prioritisation and records management systems. In particular, greater structure had been introduced into the decision making process, and more detail was captured in respect of individual prioritisation decisions (§30).

38. As to the issue of record-keeping in respect of decisions not to take specific actions, it was noted, at §31, that there were limits on what it was feasible for MI5 to record about decision making processes, 'as resources deployed on record keeping decisions below a certain threshold of importance would be better deployed elsewhere….particularly

in respect of decisions not to take specific actions.' It was confirmed that this was an issue which would be kept under review. It is clear, therefore, that the issue of record-keeping, and the extent to which resources that might be deployed elsewhere should be devoted to this activity, has been the subject of careful, and ongoing, consideration over the course of the last several years.

39. Second, the balance that has been struck in this regard reflects operational judgments as to the best, and most effective, use of finite resources. This was explained by Witness L in his evidence. He explained that operational judgments had been made both as to the extent of record-keeping (particularly in respect of negative decisions) and the form in which such records were made so as to provide a meaningful summary of the intelligence case in respect of an individual at a given point in time, rather than adopting a 'pro-forma' or 'tick-box' approach, (Day 12, page 167):

"In terms of the things in which we need to concentrate our time, we need to concentrate them on those things where we are actively pursuing an investigation and the things we're doing to justify, for instance, the necessity and proportionality, rather than the circumstances where we are not doing things, simply because the number of times we decide not to do something is potentially almost infinite…So we have better closure procedures now than we had in 2010. They are largely, however, a narrative of the intelligence case and where we have got to rather than a specific rationale. So in circumstances where a witness was giving evidence in a future case, they would likely to be drawing on the intelligence picture as was understood at the time rather than a pro forma approach explaining why a case had been closed."

40. Third, it is apparent from Lord Anderson's report that the Operational Improvement Review considered, in detail, the issue of information management (including record-keeping) and that a series of specific recommendations were made based upon that analysis, see §3.47(b). As he notes, at §3.48, those recommendations form part of a detailed report expending to 165 pages (not including annexes), and were the product of analysis by senior member of MI5, CT Policing, the Home Office and GCHQ. The process was overseen by the Operational Improvement Review Steering Board, the composition of which is described at §3.33. The quality and rigour of the process giving rise to the recommendations is described in §4.19 and §5.13. The Operational Improvement Review was assessed by Lord Anderson to be 'an impressive piece of prescriptive analysis.'

41. In summary, therefore, the position is that the Coroner is being invited to make a recommendation in materially similar terms to the one made by Hallett LJ in 2011, in circumstances where there is clear evidence that there was compliance with the original recommendation, the relevant issues were given detailed and careful consideration by appropriately qualified experts and a rigorous further analysis has been undertaken reflecting the particular issues raised by this case.

42. There is no evidence before the Coroner that the operational judgments reached as to the level of resources to devote to recording the reasoning for particular types of decisions, or the form in which such recording should be undertaken, are wrong. There is clear evidence that an intensive and rigorous analysis of the issues concerning information management has been undertaken by a multi-disciplinary team of experts and that detailed recommendations have been made. There is, therefore, no proper basis upon which the Coroner could conclude either that there is a cause for concern to the effect that MI5's record-keeping procedures are such as to give rise to a risk of further deaths, or that it is necessary to take action in this regard.

43. Moreover, there is nothing in the Families' submissions which would explain why, or how, the introduction of additional pro forma recording of decision-making would reduce the risk of further deaths from terrorist attacks. There is no attempt to identify from where the necessary resources should be transferred. And there is no analysis as to why the operational judgments that were reached in response to Hallett LJ's recommendation were wrong. Finally, there is no suggestion that an additional layer of pro forma record-keeping would have made any difference whatsoever to the decision making in respect of Khalid Masood.

Management and Review of Closed SOIs

44. Much the same analysis applies to the Families' second and third proposed recommendations, which can conveniently be analysed together and are expressed as follows:

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

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

45. As with the issue of record keeping, there is no information before the Coroner to indicate that MI5's procedures for the management of Closed SOIs is such as to give rise to a risk of further deaths from terrorist attacks, and there is certainly nothing to suggest that resources should be transferred to the management of Closed SOIs from some other aspect of MI5's activities.

46. The essential proposition underpinning these suggested recommendations is that there was intelligence regarding Masood, potentially available during the period 2010 – 2017, which should have led to a re-assessment of his status as a closed SOI. The flaw in that proposition, as explained by Witness L, is that it fails to distinguish between the concepts of risk and threat. In evidence correctly described by Counsel to the Inquest as 'cogent' (Submissions, at §10(c)(i)), Witness L explained why none of the intelligence relating to Masood, obtained after the decision to close him as an SOI in 2010 was sufficient to justify re-opening him as an SOI (Day 12, pages 68-74). In brief, Witness L explained that there was no intelligence to indicate that Masood was a member of ALM, and no evidence that he was engaged in extremist activity. Neither the fact of his association with members of ALM (of whom there would be several hundred at any one time), nor his expression of support for terrorist attacks, would be sufficient to identify him as a threat, or to justify making him subject to an investigation.

47. Witness L returned to the distinction between risk and threat later in his evidence, in the section from which the quotation in the Families' submissions (at §23) has been drawn. Witness L expressed the clear opinion that there was nothing in the available intelligence, even including that which had been identified after the attack, which would have justified re-opening Masood as an SOI (Day 12, pages 152-153):

Q. Right. Well, I suggest that, given the cumulative weight of all of this material by this stage of the chronology, something has gone wrong: do you agree?
A. No, I do not.
Q. And that there has been a missed opportunity and that he should have been reopened?

A. I do not agree with that.
Q. Then on top of all of that we have the intel from 2013 about expressing support for 9/11: yes?
A. yes, indeed.
Q. DCI Brown's evidence about that was that that would indicate that the person posed a risk: do you agree?
A. So risk and threat are two different things. I would not agree that that of itself suggested the person posed a threat, and the security services around investigating threats.

48. As set out above, the further point of relevance in this context is that even if Masood had been re-opened as an SOI at some point after 2012 there was nothing which, even with the benefit of hindsight, would have justified the type of 'extraordinarily intensive' (Day 12, page 184) and prolonged surveillance which would have been required in order to detect Masood's attack planning in the days leading up to 22 March 2017.

49. Accordingly, there is nothing in the information before the Coroner that indicates there was any aspect of MI5's procedures in this case which materially increased the risk of lives being lost in Masood's attack. The premise upon which the Families invite the Coroner to make a recommendation in this area is unsound. In any event, and regardless of the circumstances of Masood's individual case, there is nothing whatsoever to indicate that MI5's current procedures for managing closed SOIs are such as to give rise to a risk of further deaths from terrorist attack, which would be reduced were those arrangements to be changed in some way. It follows that the §7(1)(b) criterion is not met in this regard.

50. Even if, contrary to the submissions set out above, the Coroner were to identify a concern of this nature, there is clearly no need for action to be taken. The decisions to close Masood as an SOI and not to re-open him at any stage thereafter were considered in detail by the Post Attack Review, and issues regarding prioritisation and the re-assessment of Closed SOIs was considered, in detail, by the Operational Improvement Review. As Lord Anderson notes at §3.29 of his report, one of the seven specific matters included in the terms of reference was:

"the process by which individuals are categorised as closed subjects of interest, and how cases are then reviewed and escalated where indicators of potential re-engagement in terrorist activity."

51. The submissions set out above (at §§30-31 and 40) regarding the rigour of the Operational Improvement Review and the detail of the analysis leading to its specific recommendations are adopted, but not repeated. The critical point is that the task of reviewing the management of Closed SOIs has already been undertaken by a panel of senior experts, and recommendations made which focus on the identification of those involved in terrorist activity.

52. Identifying those individuals who pose a threat, out of the many thousands who view extremist material, or who express support for terrorist attacks, or who associate (to some degree) with members of extremist groups, is amongst the most complex and sophisticated tasks performed by MI5. There is simply nothing before the Coroner to indicate that the manner in which this task is performed, insofar as it concerns the review of Closed SOIs, requires action to be taken (per §7(1)(c)) and/or that the correct lessons have not been learned from the Operational Improvement Review.

53. Finally, in this regard, the management of Closed SOIs and the extent of the resources to be deployed to the very large number of individuals who fall into this category is a paradigm example of an issue of operational judgment involving decisions as to the most effective allocation of resources. This is precisely the type of issue which, as Hallett LJ observed, is best left to the experts. The potential effects of the allocation of a greater share of finite resources to Closed SOIs are obvious. It is a matter for MI5 as to how best to differentiate between risk and threat, and to allocate its resources accordingly.

<u>Extremist Material</u>

54. The fourth proposed recommendation advanced by the Families arises from the evidence discovered on Masood's laptop after the attack to the effect that he had viewed extremist material including terrorism-related images and speeches advocating violent jihad, and is expressed in the following terms:

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

55. As explained above it is necessary, when assessing this proposed recommendation, to distinguish between the concepts of risk and threat, and to acknowledge that it is a matter for the expert assessment of MI5 how most effectively to distinguish between the two. As Witness L explained in his evidence (Day 12, pages 72-73) it is 'depressingly common' for individuals to view this type of material. The task for MI5 is to identify those particular individuals, from the very many that view this type of material, who pose a threat and merit investigation.

56. It is also necessary to consider the extent to which it would be appropriate and proportionate for MI5 to undertake intrusive investigation and monitoring of an individual on the basis that he or she had viewed material of this kind, and in the absence of any intelligence to indicate attack planning or an intention to use violence (Day 12, page 72). As Witness L explained (Day 12, page 73), the number of people viewing material of this nature is 'very large'. The implications of placing them all under active investigation would be significant, and would require a very considerable extension of the activities of MI5, and the resources with which it is provided.

57. There is no information before the Coroner that the manner in which MI5 prioritises its resources in this area, and the significance it attaches to the viewing of extremist material in the absence of evidence of extremist activity, is in any way defective such as to give rise to a cause for concern. On the contrary, the explanation given by Witness L to the effect that it is neither proportionate nor desirable for MI5 to investigate people on the basis simply of the material they choose to view was cogent and compelling. There is, therefore, no material upon which the Coroner could conclude that the §7(1)(b) criterion is met in respect of this issue.

58. Furthermore, the Families' analysis, as set out at §§26-27 of their submissions, proceeds on a false premise. If there is intelligence that an individual is engaged in extremist activity or attack planning then, as a general proposition, it will be necessary to place him/her under investigation. But if there is no such intelligence it would clearly be impossible to justify the extremely intrusive surveillance that would be necessary in

order to monitor (or attempt to monitor) the material viewed by that individual online. Accordingly, the question of the 'weight' to be attached to 'a radical belief in the obligation to use violence, in the absence of information suggesting attack planning' simply does not arise. The precondition for authorising intrusive surveillance would not exist.

59. The Coroner has no evidence as to the current system for authorising intrusive surveillance of an individual's online activity, or as to the level of intelligence that would be required to justify such surveillance under the Investigatory Powers Act 2016. Nor does the Coroner have any information as to the resource implications of adjusting the 'weight' to be attached by MI5 to the viewing of extremist material, or the consequential effects of diverting resources to investigating those who view such material from some other part of MI5's activity. In those circumstances it is submitted that the Coroner could not properly be satisfied that action is required, even if he were to be persuaded, contrary to the submissions set out above, that there is a concern in relation to this issue.

Obtaining Information from Third Parties

60. The fifth and sixth proposed recommendations suggested by the Families are concerned with the same issue, and may conveniently be addressed together. In both cases it is proposed that procedures be put in place to 'ensure' that information is obtained from third parties, as follows:

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

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

61. The question of whether it is necessary to chase up particular enquiries of third parties in respect of particular SOIs is, self-evidently, one that falls to be addressed on the facts of each individual case. In some cases it may be that the missing information is of central importance in conducting the assessment that is being undertaken at that stage

of the investigation, in which case it will be necessary to ensure that it is obtained. In other cases, the information will not be of central importance, and devoting time and effort to chasing up the provision of further information of peripheral relevance will waste resources that could be better spent elsewhere.

62. There is no suggestion that the additional information which might have been obtainable from the police and/or prison service would have made any difference to the material decisions taken in respect of Khalid Masood. There is, therefore, no basis for concluding that, in the particular circumstances of his case, there was a pressing need to devote resources to the obtaining of such information.

63. Judgments as to whether to commence, and/or pursue certain lines of enquiry with third parties are taken on a daily basis by MI5 Officers, in circumstances described by Hallett LJ in the following terms:

They gather, sift and analyse vast quantities of intelligence material each year and try desperately to focus their precious resources and efforts on preventing the kind of murderous attack that took place on 7/7….One must never lose sight of the fact that the material confronting the Security Service at the time would have comprised literally thousands of strands of possible contacts and hundreds of possible targets. The desk officers must usually work at speed and in very difficult conditions.

64. The imposition of a requirement that every line of enquiry, or request for third party information be chased down to its ultimate conclusion would be to obstruct the proper exercise of judgments taken, on a daily basis, as to how best to prioritise resources and ensure that the most important information is obtained. As with the other recommendations advanced by the Families, there is simply no information before the Coroner to indicate that these judgments are being incorrectly exercised at present such as to give rise to a risk of further deaths (§7(1)(b)), or that action is necessary to address this issue (§7(1)(c)).

65. In reality, these recommendations are clear examples of the mistaken premise advanced by the Families to the effect that the PFD process should be concerned with whether it *might* be possible to identify any 'room for improvement.' The two issues identified are of a minor and administrative nature which did not materially affect the conduct of the case before the Coroner. The proposition that the identification of

administrative issues of this sort should trigger the statutory *duty* on the part of a Coroner to make a PFD report is clearly incorrect. In virtually any case of any significant complexity there will be instances in which one or more interested persons evidenced some degree of administrative inefficiency, or in which there will be some scope for procedural improvement. That is clearly insufficient, of itself, to trigger the obligation to make a report.

Conclusion

66. For the reasons set out above, it is submitted that the statutory criteria are not met in respect of any of the proposed recommendations advanced by the Families. There are no grounds for concern that the activities of MI5, in any of the respects identified, give rise to a risk of further deaths, or that action is required to address any such risk.

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5 November 2018

APPENDIX

RECOMMENDATIONS PROPOSED BY THE FAMILIES

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

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

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

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

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

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