CHIEF CORONER

INQUESTS ARISING FROM THE DEATHS
IN THE LONDON BRIDGE AND BOROUGH MARKET TERROR ATTACK

REGULATION 28 REPORT ON ACTION TO PREVENT FUTURE DEATHS

Addressees

This Report is being sent to the following:

(a) The Secretary of State for the Home Department;

(b) The National Counter Terrorism Security Office;

(c) The Director-General of the Security Service;

(d) The Chief of the Secret Intelligence Service;

(e) The Commissioner of Police of the Metropolis;

(f) The Commissioner of City of London Police;

(g) The London Ambulance Service;

(h) The Secretary of State for Transport; and

(i) The British Vehicle Rental and Leasing Association.

Coroner

1. I am the Chief Coroner of England and Wales. I am also a Senior Circuit Judge. I heard these Inquests in the capacity of a Judge nominated by the Lord Chief Justice pursuant to Schedule 10 to the Coroners and Justice Act 2009 ("CJA").

2. The address of my office is Room C09, Royal Courts of Justice, London, WC2A 2LL. The email address for my office is: chiefcoronersoffice@judiciary.uk.

Coroner's Legal Powers

3. I make this Report on Action to Prevent Future Deaths ("PFD Report") under paragraph 7 of Schedule 5 to the CJA and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 ("the Regulations").

Investigation and Inquests

4. The Inquests to which this Report relates include those of the eight victims of the terror attack which took place at London Bridge and Borough Market on 3 June 2017: Xavier Thomas; Christine Archibald; James McMullan; Alexandre Pigeard; Kirsty Boden; Sébastien Bélanger; Sara Zelenak; and Ignacio Echeverria Miralles de Imperial. They also include the inquests of the three attackers: Khuram Butt; Rachid Redouane; and Youssef Zaghba.

5. Dr Andrew Harris, Senior Coroner for Inner South London, formally opened the Inquests. After my nomination to hear them, I held Pre-Inquest Review hearings on 9 February 2018, 6 July 2018, 11 January 2019 and 12 April 2019. I held a hearing of the inquests of the victims of the attack (without a jury) from 7 May 2019, which ended on 28 June 2019. Immediately afterwards, I held a hearing of the inquests of the attackers (with a jury), from 1 to 16 July 2019.

6. In the inquests of the victims of the attack, I determined that each had been unlawfully killed and I gave further narrative conclusions for each. Attached to this Report are copies of the Determinations sheets for the eight victims.

7. In the inquests of the attackers, the jury returned a conclusion of lawful killing in each case and added a further narrative conclusion. Attached to this Report are copies of the Determinations sheets for the attackers.

8. Further details concerning the Inquests, including transcripts of the hearings and copies of relevant rulings, can be found on the Inquests website:
    - www.londonbridgeinquests.independent.gov.uk.

Circumstances of the Deaths

9. The Ruling on Article 2 and Determinations which I produced dated 2 August 2019, and which can be found on the Inquests website,[1] contains a detailed factual background section (at paragraphs 7-31). A very full factual summary can be found in the transcript of my summing-up on 27-28 June 2019, which can likewise be found on the website. The following paragraphs of this Report substantially reproduce the part of the Ruling which summarises the events of the attack itself.

10. On the evening of 3 June 2017, the three attackers drove a hired van from East London into the City of London. At 10.06pm, they drove south over London Bridge, mounting the east footway repeatedly. The van struck and injured many pedestrians. Xavier Thomas was thrown into the Thames and died quickly due to immersion. Christine Archibald was run over near the south end of the Bridge and suffered fatal injuries. At 10.07pm, the men crashed the van into railings outside the Barrowboy and Banker pub. In the van, they left a mobile phone which was running a directions application set with the destination of Oxford Street. Later investigations also showed that the attackers had made web searches about the Westminster area.

11. After the collision, the three men quickly left the van. They were armed with the ceramic knives (strapped to their wrists) and were wearing what appeared to be suicide vests (but which were in fact reasonably convincing fakes). They began stabbing people at street level, before descending to the courtyard of a restaurant, Boro Bistro. There, they attacked many more people. In this phase of the attack, they fatally wounded Sara Zelenak, James McMullan, Sébastien Bélanger, Alexandre Pigeard and Kirsty Boden.

12. At 10.09pm, the attackers returned to street level, moving south on Borough High Street and attacking further members of the public. Ignacio Echeverría Miralles de Imperial, who intervened to protect others, was fatally stabbed at this stage. Unarmed officers who confronted the attackers were themselves assaulted and injured.

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[1] See: https://londonbridgeinquests.independent.gov.uk/wp-content/uploads/2019/08/Ruling-on-A2-and-Determinations-2.8.19.pdf.

13. At 10.10pm, the attackers turned into Stoney Street, which borders Borough Market. They attacked people in the road there and entered various bars as they moved up the street. Between 10.13pm and 10.14pm they were in Black & Blue restaurant, where they stabbed three customers. After leaving, they moved back down Stoney Street. Noticing some unarmed officers and members of the public in the covered market area, they charged down Middle Road a short distance before returning. At 10.16pm, they were back in Stoney Street, where they set upon an unsuspecting bystander.

14. While the terrorists were engaged in that attack, an armed response vehicle of the City of London Police ("CoLP") arrived in Stoney Street. On seeing the officers arrive, the attackers immediately charged them, knives raised. They did not respond to verbal commands. The officers responded by firing on the attackers, each of whom fell to the ground. In the period that followed, armed officers of the CoLP and Metropolitan Police Service ("MPS") kept the three men covered with firearms, because they believed them to be wearing suicide vests. The officers fired on Redouane and Butt on further occasions when they made movements which appeared consistent with attempts to detonate explosive devices.

15. From the start of the attack, emergency calls were received in large numbers, first referring to the van striking people on the Bridge and shortly afterwards also to people having been stabbed. A large-scale operation was mounted by the police forces, by the London Ambulance Service ("LAS") and by the London Fire Brigade ("LFB"). It involved hundreds of emergency services personnel attending the scene. The conditions which faced the emergency services for some hours were very challenging. It was not known whether there were further attackers, further potential attack sites or explosive devices. Various well-intentioned but inaccurate reports were received over the night, all of which had to be addressed.

Coroner's Concerns

16. During the course of the Inquests, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths could occur unless action is taken. In the circumstances, it is my statutory duty to report to appropriate persons who may be able to take remedial action. In this Report, I address various topics and I identify matters of concern which are being reported to the addressees. Each matter of concern

is denoted by an "MC" reference and is highlighted in bold. In each instance, the public authorities (and, in one case, an industry body) to which the point is addressed are identified.

17. In preparing this Report, I have taken into account submissions from the bereaved families of what matters I should consider raising and the responsive submissions from other Interested Persons. The need to give time for those submissions and to consider them explains why this Report is being issued some months after the end of the Inquests.

18. In this Report, I shall explain what matters of concern I am raising and shall also address points raised by the bereaved families which do not in my view justify inclusion as matters of concern in a PFD Report. It is not normal practice for coroners to include in such reports explanations for not including certain matters. PFD Reports of coroners generally are, and should continue to be, short and succinct documents produced quickly after inquests. This report by contrast is an extensive document, as is appropriate to these exceptional Inquests (just as Hallett LJ produced a lengthy PFD Report following the London Bombings Inquests). It should not be seen as a model for inquests generally.

Legal Principles

19. Before addressing the particular topics relevant to this Report, I shall set out the applicable legal principles. In doing so, I shall largely adopt the submissions of Counsel to the Inquests, which have not been disputed by Interested Persons in their submissions. Again, I should acknowledge that it is not normal practice for coroners to set out the law in PFD Reports. The wide public interest in this Report warrants including an explanation of the law.

20. Schedule 5 to the CJA, which is given effect by section 32, provides as follows at paragraph 7:

> (1) Where –
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> > (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."

21. Part 7 of the Regulations 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."

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

(a) The regime provides for a coroner to make a report if he/she forms the view that a risk of future deaths can be seen and that preventive action ought to be taken. If he/she forms that view, it is necessary to make a report with the relevant content. That is the effect of the words "must report" in paragraph 7(1). See *R (Lewis) v Mid and North Shropshire Coroner* [2010] 1 WLR 1836 at [14]-[16] and [19].

(b) The power and duty to make a report only arise where the coroner forms the opinion, based on his/her inquiry, that particular risks of death exist for which preventive action is required. As Silber J said in *R (Cairns) v HM Deputy Coroner for Inner West London* [2011] EWHC 2890 (Admin) at [74], 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 reporting circumstances and risks which were causally relevant to the particular deaths under investigation: see *Lewis* (cited above) 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 general or 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.

(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 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 law and the law of the European Convention on Human Rights 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* (cited above) at [40]; *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182 at [38].

23. Chief Coroner's Guidance No. 5 also addresses PFD Reports. As that document explains:

(a) PFD Reports are important, and their importance has been emphasised by Parliament modifying the rules so that reports must be made in appropriate circumstances. 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].

24. In summary:

(a) A coroner should make a PFD Report 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. Each of these issues, especially the second, is a matter of judgment.

(b) The coroner must form his/her judgment based on information revealed by the particular 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 usually necessary for the coroner to find that general or 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.

25. Finally, it is important to note 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, 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 there is no perfect or practicable solution.

Protective Security

Background

26. The evidence at the Inquests addressed various topics concerning prevention of terrorist attacks and protective security. As to the latter, considerable evidence was heard to explain why the footways of London Bridge did not have physical protective security measures, such as barriers or bollards, at the time of the attack. The Inquests also heard evidence as to how the decision was taken to install temporary, but apparently robust, hostile vehicle mitigation ("HVM") barriers on London Bridges in the immediate aftermath of the attack. The evidence is summarised in my Ruling on Article 2 and Determinations.[2]

27. Other matters relevant to prevention of attacks and protective security were also considered during the hearings. Given the prevalence of "vehicle as weapon" attacks

[2] See Ruling, paragraphs 22-31.

in recent years, witnesses from the police, the Security Service (MI5) and Hertz UK Ltd were questioned about systems which might be introduced to enable the authorities to discover attempts by subjects of interest ("SOIs") to hire vehicles. Questions were also asked about the levels of armed policing in the capital and about police officers' weaponry more generally.

Definition of Priority Crowded Places

28. Advice on protective security is part of one strand of the Government's CONTEST counter-terrorism strategy. According to the evidence in the Inquests, the Office of Security and Counter-Terrorism ("OSCT") at the Home Office and the National Counter-Terrorism Security Office ("NaCTSO") use a set of criteria or definitional tests whereby a limited number of sites are designated as priority Crowded Places and placed in Tier 1 or Tier 2. Police Counter-Terrorism Security Advisers ("CTSAs") based in local forces engage proactively with those responsible for prioritised Crowded Places, advising on security measures (including but not limited to HVM measures). Sites which are not designated nationally as priority Crowded Places may be categorised locally as Tier 3 sites and may be subject to advice by CTSAs, but these will be matters of discretion at the local level. The Home Office also has a range of publications and online resources available which concern protective security. Some, for example, provide detailed technical guidance about engineering of security measures.

29. The public definition of "Crowded Place" which has been in place since 2012 is very broad, including a huge range of sites and public spaces. However, a site may only be treated as a prioritised Crowded Place (in Tier 1 or 2) if it satisfies certain criteria or tests. Those criteria or tests are highly sensitive for very good reasons, and they were not made public in the Inquests. However, the evidence was that a site could only satisfy the criteria if (a) it met a threshold of crowd density and (b) it had a degree of geographical specificity.

30. In 2017, London Bridge did not meet the requisite level of crowd density. Furthermore, it could not in any event have been treated as a priority site under the national criteria because it lacked the necessary geographical specificity. As a consequence, it was not the subject of pro-active advice by CTSAs prior to 2017. This was despite the fact that it was a particularly attractive target for terrorists, as identified in 2017 by a local CTSA

(PS Hone) and by a private consultancy company (Cerastes Ltd). The witness put forward by the OSCT to give evidence frankly accepted that it was a matter for concern that London Bridge was not within the definition of a priority Crowded Place, and that the definitional tests could be challenged as too rigid.[3]

31. In my Determinations concerning the deaths of Xavier Thomas and Christine Archibald, I concluded that there were weaknesses in systems for assessing the need for physical protective security measures on the Bridge and implementing them promptly. One weakness I identified in my Ruling was that the national criteria for identifying sites which would receive proactive advice were apparently too rigid in the two respects specified above. I remain of that view.

32. For the Home Office, it has been submitted that the concern I raised related to the system for prioritising sites rather than the definition of a Crowded Place, which (as noted above) is extremely broad. It is pointed out that prioritisation of sites is a matter for NaCTSO and CTSAs. It is also said that a new system for prioritising sites is under consideration, and that there is an ever-increasing range of guidance readily available (including through online resources). For the CoLP and City of London Corporation, it has been said that there is increasing local co-operation and that CTSAs locally are not limited by prescriptive criteria in selecting sites for proactive advice.

33. Notwithstanding those submissions, I consider that the evidence gave cause for concern that future fatal terrorist attacks may be planned and committed using vehicles as weapons. I also consider that more can be done to ensure that the system for prioritising sites is fit for purpose. The national criteria which identify sites that should be considered for pro-active advice are important. Their importance is not diminished by the fact that there is national written guidance or by the fact that CTSAs locally have a discretion to advise in relation to other sites. It is troubling if the criteria or tests have the effect that an area as busy as London Bridge cannot meet the crowd density requirement. It is also troubling if stretches of roadway or other open spaces cannot meet a strict requirement for geographic specificity.

[3] Day 31 transcript, p127, 129-131 and 157-158.

MC1 – Addressed to the Secretary of State for the Home Department and NaCTSO: I suggest that there be a review of the sensitive national criteria and tests for identifying sites as priority Crowded Places (or for otherwise designating sites at a national level as justifying proactive advice on protective security). In that review, one aim should be to ensure that the criteria are not excessively rigid so as to exclude sites which may be particularly attractive and vulnerable to terrorists. If and to the extent that the Secretary of State considers that any other Government agencies should play a part in addressing this concern, their assistance should be enlisted.

Review / Assurance of Protective Security Systems

34. In the course of the evidence, questions were asked about systems of assurance for ensuring that the tests for prioritising sites and the list of national priority sites remain appropriate. Against that background, the bereaved families have suggested that consideration might be given to appointing an independent reviewer of protective security (in a role analogous to that of the Independent Review of Terrorism Legislation). For the Home Office, it has been submitted that this would not be a necessary appointment, and that reviews of counter-terrorism policy, strategy and systems already take place to an appropriate extent.

35. I have already expressed concern about the criteria and systems for prioritising sites for protective security advice. It follows from the points I have made that there is a related concern that the limitations or rigidity in the criteria were not identified by national authorities before June 2017 (although there was evidence that some officers, notably Commander Gyford, harboured doubts about them at the time[4]). There is thus a case for considering some form of assurance process to check the continuing fitness for purpose of criteria and the list of priority sites in future. However, I am not persuaded that this requires an appointment of a figure comparable to the Independent Reviewer of Terrorism Legislation. It could, for example, be by periodic internal review; by the use of external consultants (such as Cerastes); or by sampling / test exercises.

[4] Day 29 transcript, p23.

MC2 – Addressed to the Secretary of State for the Home Department and NaCTSO: I suggest that consideration be given to putting in place systems of periodic review / assurance to ensure that the criteria for identifying priority sites for protective security advice remain fit for purpose and that the list of such sites remains appropriate.

Statutory Duty / Guidance concerning Protective Security

36. The City of London Corporation ("CoLC") was the local authority responsible for the structure of London Bridge, while Transport for London ("TfL") was the highway authority responsible for the roadway on the bridge. Although CoLC was undertaking work to improve protective security across the City in the period before the attack, there was a troubling lack of clarity about what legal responsibilities such authorities had to assess sites and areas of roadway and to implement physical protective security measures.

37. In the Inquests, reference was made in some questioning to section 17 of the Crime and Disorder Act 1998, which requires local authorities and TfL (among other public authorities) to exercise their functions with regard to the need to prevent crime and disorder, which includes terrorism. It was suggested that this duty, read with the powers of highway authorities to install security measures (under section 66 of the Highways Act 1980), provides the necessary statutory duty on highway authorities to identify sites vulnerable to terrorist attack and install physical protective security.[5] However, the responses of TfL's witness to those questions suggested to me that even a conscientious highway authority might not interpret the legislation in that way. I was left with the clear impression that local authorities in general, whether in their capacity as highway authorities or as otherwise responsible for major public sites, do not see it as their duty to identify locations as vulnerable to attack and assess protective security requirements. No doubt they will often respond to advice from CTSAs and other pro-active steps taken at a national level.[6] However, the evidence did not suggest that there is systematic assessment by local authorities to identify and protect vulnerable sites or stretches of

[5] See for instance day 31 transcript, p34-36.
[6] For example, guidance documents issued following attacks around the world.

roadway. One can readily contrast the clear duties and rigorous systems in place for identifying and responding to tripping hazards on the pavement.

38. It should also be noted that there was evidence from Deputy Assistant Commissioner D'Orsi of the MPS suggesting that police working in the front line of counter-terrorism protective security would appreciate the introduction of a clear legal duty on private owners of sites to take reasonable steps to ensure protection of visitors from a terrorist attack.[7] She contrasted the exhaustive legal duties to ensure health and safety of visitors against the lack of any comparable duty to protect from terrorism. The existence of such a duty could help the police in persuading private owners of sites to comply with recommendations to take protective action.

39. Submissions have been made by the bereaved families that the Government should be encouraged to introduce primary legislation imposing duties on public authorities and/or private owners regarding protection of sites and roadways from a terrorist attack. I see the force of those submissions, but I also appreciate that a lot of careful work would have to be done to ensure that any statutory duty was effective without being too onerous or prescriptive. It is not my role to dictate the right policy response. However, unless and until such statutory duty is to be introduced, I consider that there would be real value in the Government producing guidance on what existing legal duties require in practice of highway authorities and others regarding assessment of sites and roadways and installation of physical protective security. If it is considered that section 17 of the Crime and Disorder Act 1998 provides the necessary basis for legal duties, the guidance should say so and indicate what it requires in practical terms.

40. Submissions have also been made by the bereaved families that guidance could usefully be given to CTSAs on the duties owed by highway authorities and other public bodies regarding assessment of sites / roadways and installation of protective security measures. In addition, it has been suggested that consideration should be given to conferring on CTSAs the power to compel duty holders to implement counter-terrorism measures. I agree that there would be real value in providing further guidance to CTSAs, especially given the lack of clarity about what the law requires of highway

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[7] Day 28 transcript, p20-22.

authorities in practice. However, I do not consider that steps ought to be taken to empower CTSAs to compel installation of particular measures. To do so would extend their role from advisory to one of enforcement (analogous to that of the Health and Safety Executive). It would impose additional burdens on them and require a structure of enforcement powers and safeguards (such as appeal procedures).

MC3 – Addressed to the Secretary of State for the Home Department: I suggest that consideration be given either (a) to introducing legislation governing the duties of public authorities (including highway authorities) regarding protective security or (b) to producing guidance indicating what existing legal duties require in practice of public authorities regarding assessment of sites for protective security needs and implementing protective security measures.

MC4 – Addressed to the Secretary of State for the Home Department and NaCTSO: I suggest that consideration be given to producing guidance for CTSAs explaining what existing legal duties require in practice of public authorities regarding assessment of sites for protective security needs and implementing protective security measures.

Hostile Vehicle Mitigation Measures

41. The evidence in the Inquests demonstrated a lack of clear procedures for considering promptly the installation of temporary and permanent HVM measures, at a time when such procedures were needed. The police considered that the only means of installing HVM measures at short notice was to call upon the National Barrier Asset ("NBA") and that it could only be used in the event of a specific threat to a location. TfL had the means of procuring temporary barriers, but was not aware that London Bridge had been singled out as particularly vulnerable. As a result, PS Hone in early 2017 could only contemplate the installation of permanent HVM measures, which would take months or (more likely) years.[8]

42. According to submissions received from CoLC, CoLP and TfL, a number of structural improvements have taken place since June 2017. TfL has now become part of the

[8] Day 29 transcript, p175-176.

security governance arrangements operated between CoLP and CoLC. There is now a Public Realm Security Advisory Board ("PRSAB") on which all three of those bodies are represented and which includes in its remit the need to ensure that HVM measures can be installed in fast time to deal with emerging security concerns. TfL is now represented on the Security Review Committee, chaired by the Deputy Assistant Commissioner (Special Operations) of the MPS, and it has commissioned work through the Centre for Protection of the National Infrastructure on protective security measures. Furthermore, the NBA is now the responsibility of a special body, the National Vehicle Threat Mitigation Unit.

43. As indicated above, the evidence raised good reason for concern about the arrangements which existed in mid-2017 for procuring and installing temporary protective security measures swiftly in response to emerging or newly appreciated threats. It appears that steps have been taken to address the problem, but it is difficult for me to be satisfied that they are entirely sufficient. In particular, it is not clear to me to what extent good practice has been adopted across the country, including in major metropolitan areas other than London. I therefore consider that this remains a matter justifying inclusion in this Report.

MC5 – Addressed to the Secretary of State for the Home Department and NaCTSO: I suggest that consideration be given to taking measures to make CTSAs, police forces and local authorities aware of protective security equipment / infrastructure which can be installed in response to emerging threats (including the criteria and timescales for making particular forms of asset available). I also suggest that consideration be given to encouraging highway authorities and other public bodies, especially in metropolitan areas, to adopt security boards similar to the PRSAB adopted in London, with a view to ensuring that there is good understanding of what measures can be taken in the short and longer term to protect sites and areas assessed to be vulnerable.

Existing Barriers on London Bridges

44. The family of Xavier Thomas has understandably expressed concern that, despite the passage of over two years since the attack, some bridges in London (including London Bridge) still have temporary barriers in place. It has been said that progress towards

implementing permanent solutions is too slow. The Thomas family has also suggested that the ongoing work should include a review of options for adding netting to bridge structures. In response, CoLC and TfL have provided some information about ongoing work on planning of permanent HVM measures on the bridges. They have also explained that netting under bridges has been considered carefully in the past and ruled out for good reasons (e.g. difficulties of attaching the netting and challenges of removing people / objects from it).

45. While I have sympathy with the points made by the Thomas family, I do not consider that this point meets the criteria for inclusion in a PFD Report. First, the Inquests did not consider in any detail the progress of plans to install permanent HVM measures on the bridges. Secondly, there was no evidence to establish that the present arrangements put lives at risk. However, I should say that I expect the relevant public authorities to make every effort to progress the installation of permanent measures on the London bridges. Funding disputes between public bodies would not be a satisfactory reason for delay in the planning and installation work.

Level of Firearms Policing

46. A number of the bereaved families come from countries where a much higher proportion of police officers carry firearms than in the United Kingdom. They were concerned that the first police officers to encounter the attackers were armed only with batons and irritant sprays. It has been submitted on their behalf that the Government and police forces should assess whether current levels of firearms officers are appropriate to risks being faced, especially in London. The point is made that the facts of this case demonstrated the value of having armed officers in a position to respond to a marauding attack as quickly as possible.

47. In response, the Home Office and the two London police forces have made the point that levels of armed policing are determined by a combination of national policy and local consideration of resource needs. In recent years, the Government has provided substantial sums for an uplift in the numbers of armed officers. In London, the numbers of Armed Response Vehicles ("ARVs") have been increased over a long period.[9] On

[9] See in this respect the evidence of DAC D'Orsi at day 28 transcript, p49-50.

the night of the attack ARVs arrived swiftly and in numbers to confront the attackers. It is also pointed out by CoLP that that force is considering extending provision of Tasers to response officers.

48. A number of police witnesses in the Inquests were asked about levels of armed policing in the capital. Based on all the evidence, I am satisfied that careful consideration is given at national level and in London to the requirement for armed officers. Decisions have apparently been made that increasing the numbers and patrols of ARVs is the most effective means of implementing the armed policing uplift in London.[10] On the night of the attack, armed officers arrived on the scene swiftly and were able to identify and neutralise the threat at a very early stage. Overall, I am not satisfied that the level and type of armed policing is a matter which should be addressed in a PFD Report. No doubt the subject will be kept under review by the Home Office and the London forces in the future as it has been to date.

Counter-Terrorism Investigations

Introduction and Overview

49. The evidence of Witness L (MI5 officer) and Witness M (MPS counter-terrorism senior investigating officer) made clear that, in recent years, the UK has faced a serious threat from low sophistication attacks by Islamist terrorists. In particular, the rise of the so-called Islamic State (or ISIL) and its call to arms has motivated such attacks. Individuals in Western states can be radicalised by material available online, and plots can be developed through modern communications technology. These phenomena have posed an unprecedented challenge to MI5 and counter-terrorist police ("CTP"), who now have to monitor large numbers of individuals (current and closed Subjects of Interest ("SOIs").[11] Although attack methodologies of low sophistication may often result in lower tallies of dead and injured, they can be harder to detect in the planning and preparation phases.

[10] See the evidence of Supt McKibbin at day 23 transcript, p114.
[11] See the evidence of Witness L at day 24 transcript, p58-62.

50. Accordingly, there are circumstances creating a risk of future deaths occurring in the future. This assessment is confirmed by the national threat assessment level, which has been SEVERE for most of the time in recent years. The question for me in deciding on the content of this Report is whether the evidence in these Inquests has indicated that further action should be taken by MI5, CTP and others to counter this threat.

51. There was substantial evidence about the pre-attack investigation into Khuram Butt and pre-attack intelligence about the attackers generally. As I explained in my Ruling on Article 2 and Determinations,[12] I concluded that it would be wrong to criticise the pre-attack investigation, since the work of MI5 and SO15 (the Counter-Terrorism Command) was generally thorough and rigorous. I was not persuaded that investigative opportunities had been lost which could realistically have saved the lives of those who died.

52. It is also important to recognise that a great deal of work has been done by MI5 and CTP since the terrorist attacks of 2017 to learn from the investigations into those attacks and to develop their systems and practices in response to the learning. That work is substantial and continuing. The Post-Attack Reviews and Operational Improvement Review which have been disclosed to the Inquests Team and which were summarised in evidence[13] are extremely detailed and analytical. Much of the work on improving systems has necessarily been highly technical and focused on information management, but that reflects the nature of the terrorist threat in the modern world. The review work has itself been subject to external assurance in the form of Lord Anderson's work of review, continuing in his recent Stock-Take Report.

53. In deciding what (if anything) to say in this Report concerning MI5 and CTP, it is important for me to take account of what I know of the ongoing review work. I must also bear in mind that the evidence in the Inquests has provided only a limited snapshot of the work of the Security Service. That work involves sophisticated techniques of monitoring and investigation, and it requires officers constantly to make judgments about the prioritisation of resources. It would be wrong for me to dictate methods of

[12] See Ruling, paragraphs 93-104.
[13] See in particular the evidence of Witness L at day 24 transcript, p46-57.

investigation or to impose rigid rules that might interfere with good operational judgment of the professionals.

54. Nevertheless, it would also be wrong for me not to register in this Report features of the evidence in these Inquests which suggest possible areas for improvement. In my view, the appropriate way to do this is to raise matters with MI5 and CTP which could properly be considered in the course of their continuing work of review and improvement of investigative practice. In doing so, I shall be careful to avoid being over-prescriptive or unrealistic.

Suspension of Investigations and Flexible Response to Periods of High Workload

55. The MI5 investigation into Khuram Butt was suspended on two occasions: from 26 February 2016 to 24 March 2016; and from 21 March 2017 to 5 May 2017. The latter suspension was for six weeks and concluded just a month before the attack. It is possible that, but for that suspension, further useful intelligence about Butt would have been obtained, including more information about his links to the other attackers.

56. Witness L gave evidence that investigations are suspended when the demands on the Service are at their highest and experienced personnel need to be diverted to other work with an even higher priority.[14] He said that suspension of investigations is a necessary feature of the work of the Service, allowing it to concentrate its energies and staff on investigations into SOIs who pose a known threat of active attack planning.

57. The bereaved families have raised a concern that an investigation such as that into Khuram Butt, which was a P2H investigation into a Tier 1 SOI (i.e. a relatively high priority investigation), could be suspended twice and for significant periods. They accept that suspensions are not merely a function of limited financial resources, since suspensions primarily reflect the need to divert the efforts of experienced personnel. However, they argue that the evidence of suspensions suggests a need for MI5 to be increased in size, even though it is larger now than ever before.

[14] See day 24 transcript, p21-23.

58. The families have also pointed out that the effect of these suspensions was that work of gathering intelligence on Butt largely ceased. They suggest that consideration be given to introducing more flexible systems whereby investigative work on significant SOIs such as Butt may be scaled back at times of highest demand on MI5, without the work being stopped. In response, it has been pointed out for the Service that the systems include flexibility. It is possible to suspend investigation into some SOIs in an investigation but not others, as happened here. Furthermore, a suspension does not discontinue all intelligence gathering and it is usually followed by efforts by investigators to bring their knowledge up to date.

59. In my view, the appropriate response to these submissions is to raise the fact that suspensions of priority investigations are a matter of legitimate public concern. In its continuing review work, the Security Service should give careful consideration to the way in which such investigations are suspended, including the value of flexibility in the systems.

MC6 – Addressed to the Secretary of State for the Home Department and the Director-General of the Security Service: Although MI5 must be able to prioritise and divert resources at times of greatest demand, the suspension of priority investigations is a matter of legitimate public concern. Accordingly, the systems for suspending such investigations (including the criteria for suspension, recording of suspension decisions and systems for re-building intelligence after suspensions) should be specifically considered in the continuing work of review and improvement. That work should also give consideration to the potential value of flexible systems for scaling back, rather than necessarily suspending, investigative work at times of high demand.

The Potential Lone Actor Tool

60. In recent years, MI5 has developed the Potential Lone Actor ("PLA") process, which forms part of the overall work of assessing the level of threat posed by an SOI. It is at an early stage, and it is being developed and refined with the benefit of learning from other countries (including the USA and Australia). It involves a threat rating being

produced, based on considerations of intent and capability. It is, however, only one part of MI5's threat assessment work.[15]

61. In this case, Khuram Butt was subject to assessment twice using the PLA process. In September 2015, he was assessed to have a strong intent but weak capability, producing an overall assessment of "medium risk". In May 2017, he was assessed as having moderate capability and moderate intent, producing an overall assessment of "unresolved risk". Witness L acknowledged that such assessments were imprecise and had inherent limitations.[16] However, he pointed out that the PLA assessments of Butt did not result in any downgrading of investigative work.

62. The bereaved families have submitted that MI5 ought to review the PLA process. They focus particularly on the validity of "capability" as a factor in the assessment process, since a low sophistication attack does not require specialist equipment or techniques. In response, the point has been made that the factor of "capability" is concerned also with a person's ability and preparedness to carry out unsophisticated attacks (e.g. signs that a person is prepared to act violently and to break the law). It has also been stressed that there is no evidence that any weakness in the PLA process adversely affected the investigation in this case.

63. In my view, the evidence of Witness L gives cause for concern that the PLA process may be imprecise and highly variable in its assessments. If it is to be used at all, investigators must be able to have some confidence in it. This requires some form of assurance to take place in the years ahead, in order to check that it is a reliable and valuable tool.

MC7 – Addressed to the Secretary of State for the Home Department and the Director-General of the Security Service: I suggest that MI5, in its continuing work of review and improvement, give consideration to some form of assurance to test the reliability of the Potential Lone Actor process.

[15] See the evidence of Witness L at day 24 transcript, p28-36.
[16] Day 25 transcript, p48-49.

"Mindset" Material and its Significance

64. In the months and years preceding the attack, Khuram Butt accessed over the internet and viewed a large amount of material of an extremist nature.[17] Some was propaganda for Islamic State, and that included violent images. Other material included sermons from extremist preachers. MI5 and CTP gained access to this material after Butt was arrested on a fraud charge in October 2016 and his devices were seized. It is debatable what could be deduced from the material about his mindset and intentions. While Witness M accepted that it showed an interest in martyrdom operations, he and other witnesses (including Witness L) made clear that SOIs often view such material without ever planning or committing an attack.[18] The SO15 witnesses generally gave evidence that appropriate use is made of powers to arrest and charge SOIs where offences have been committed, including offences of disseminating material encouraging terrorism.

65. The bereaved families have submitted that MI5 and CTP ought to review and challenge their assumptions about the weight to be placed on an SOI's possession of material which shows an extremist mindset but is not indicative of a criminal offence or actual attack planning. In response, MI5 and the MPS have made the point that very many SOIs possess such material and it must be a matter for the judgment of experienced investigators what weight to place upon it in all the circumstances of each investigation. They have maintained that there is no evidence that investigators are not capable of making such judgments properly.

66. In my view, it would be wrong to raise this matter as a point of concern. Judgments about what can be deduced from an individual's possession of extremist material are inherently difficult, but I am not satisfied that there is any evidence of investigators lacking the skills and experience to make those judgments competently. Urging them to place more weight upon such material risks preventing them focusing their energies on SOIs who present the greatest or most immediate threat: to prioritise everybody is to prioritise nobody. Of course, I expect MI5 and CTP to keep under review the value and significance of different kinds of "mindset" material.

[17] Very detailed evidence was given on this subject by DS Ager: see day 18 transcript, p78-193.
[18] See day 20 transcript, p17-18 for Witness M's evidence on this topic.

67. The evidence about the prevalence of extremist material raises to my mind a different concern. While there are offences of possessing a document likely to be useful to a person in committing an act of terrorism (section 58, Terrorism Act 2000) and of disseminating terrorist publications (section 2, Terrorism Act 2006), there is no offence of possessing terrorist or extremist propaganda material. It may be impossible to take action even when the material is of the most offensive and shocking character. The evidence at the Inquests indicates to me that the lack of such an offence may sometimes prevent CTP taking disruptive action which could be valuable in their work of combatting terrorism.

68. I appreciate that careful judgments need to be made to ensure that new offences do not interfere with civil liberties and cannot be used to prevent legitimate dissent. However, I would observe that in the field of pornography, legislation of recent years has criminalised possession of carefully defined categories of the most offensive material (see for example section 62 of the Coroners and Justice Act 2009). Having reflected upon the evidence in these Inquests and in the Westminster Bridge Terror Attack Inquests, I have formed the view that consideration ought to be given to legislating for further offences of possession of the most serious material glorifying or encouraging terrorism. The ultimate decision must be for Government, taking account policy considerations and striking the proper balance between liberty and security, but that should not prevent me raising the issue in this Report.

MC8 – Addressed to the Secretary of State for the Home Department: I suggest that consideration should be given to legislating for further offences of possessing the most serious material which glorifies or encourages terrorism.

Locations Attended by Subjects of Interest

69. As set out in my Ruling on Article 2 and Determinations, in the pre-attack investigation into Khuram Butt further work could have been done to establish coverage at the UFC gym where he spent a lot of time and apparently met his fellow attackers.[19] Further work could also have been done to identify the local school where he was reported to

[19] See Ruling, paragraph 61(a).

be teaching a Quran class (later identified as the Ad Deen School).[20] In any minute examination of an investigation, it will almost always be possible to identify further steps which could have been taken. Moreover, as I was careful to explain in the Ruling, it was entirely speculative whether further work in establishing coverage at the gym and identifying the school would actually have advanced the investigation.[21]

70. The bereaved families have submitted that this Report should raise a concern that investigators ought to make further efforts to identify locations where targets spend time. They have also proposed that MI5 analyse how the significance of the UFC gym came to be missed or under-appreciated prior to the attack.

71. In my view, this would not be a suitable subject to include as a matter for concern in this Report. It is apparent to me that MI5 and CTP already make efforts as part of their priority investigations to identify and establish appropriate coverage of locations where SOIs spend most time.[22] What work to do and what techniques to use are matters of judgment, and there is a real danger that priorities may be distorted by overly prescriptive guidance. There is no need for a further analysis of the pre-attack investigation into Butt, given that it has already been the subject of the large institutional review exercise and has been publicly examined in these Inquests.

Co-working between MI5 and Counter-Terrorism Police

72. Priority investigations of SOIs are led by intelligence, and distinct roles are played by the MI5 and CTP teams.[23] MI5 officers generally take the lead in gathering intelligence and developing leads, using their particular skills, techniques and legal powers. The CTP team is kept informed of the investigation and it is called upon to carry out action requiring the use of police powers. On the evidence, MI5 and SO15 officers work more closely together than security service and police officers in almost any other jurisdiction. The officers from the two services working on a particular case have Joint Operational Team ("JOT") meetings, the regularity of which depends on operational

[20] See Ruling, paragraph 61(b).
[21] See Ruling, paragraphs 99-100.
[22] Witness L gave evidence that MI5 did seek to task greater coverage of the gym: day 24 transcript, p130 (although it was not a significant investigative priority: see p124).
[23] See the evidence of Witness M, especially at day 19 transcript, p41-44.

needs. There can also be daily contact as required. Nevertheless, not all information is immediately shared by MI5 officers with their police colleagues.

73. Although I was generally impressed with the level of co-operation between MI5 and CTP, it is evident that there is room for improvement in this regard. On a number of occasions during his evidence, Witness M accepted that he had been unaware of information which was in the hands of MI5.[24] The reviews which followed the attacks of 2017 highlighted the need for closer co-working in some respects, notably recommending that the police team be consulted on proposed suspension of a priority investigation. The Intelligence and Security Committee of Parliament also stressed that more work could be done in promoting communication and co-ordination between the MI5 and CTP teams working on an investigation.[25] According to the submissions on behalf of MI5 and the MPS, further work is being done to improve joint working arrangements, including a project leading to co-location of elements of CTP and MI5 by 2023.

74. In my view, it is appropriate that I should in this Report encourage continued efforts to develop and improve co-working arrangements. In particular, it is important that SO15 officers working on an intelligence-led case should be kept reasonably up to date with the intelligence. If JOT meetings are not very regular (and there may be good reason for that), structured briefings to the SO15 senior investigating officer should take place reasonably regularly to ensure that he/she is well-informed. I should add that police teams who carry out post-attack investigations also do valuable work to promote public safety, and it is desirable that MI5 should provide them with as much information as possible which is relevant to their investigations. Having said all that, I should add that I am not prepared to dictate particular working practices to MI5 or SO15.

MC9 – Addressed to the Secretary of State for the Home Department and the Director-General of the Security Service: The evidence in this case revealed a need to improve communications and co-working between MI5 and CTP officers working on the same investigation. The work which is going on to improve joint

[24] See for instance day 19 transcript, p104-5 and p135.
[25] See the ISC Report, "The 2017 Attacks: What needs to change?" at p53-58.

working is to be welcomed. There is in particular a need for the police senior investigating officer in an intelligence-led investigation to be briefed regularly and thoroughly by MI5, especially if JOT meetings are not being held regularly. For the sake of completeness, efforts to improve communications between MI5 and CTP should extend to communications between MI5 and post-attack investigation teams.

Making Use of Information from Members of the Public

75. In this case, two calls were made by members of the public to report concerns about Khuram Butt to the authorities. One was an anonymous call to MI5 at a very early stage which provided only limited information. That call could not be followed up because it was anonymous, and police were not informed about it. The second was a call from Butt's brother-in-law, Usman Darr, to the anti-terror hotline in September 2015. The fact of that call was not communicated to MI5, who thereby lost the opportunity to obtain any further information from Mr Darr. Having said that, it is debatable how much more intelligence could have been obtained from Mr Darr even if he had been willing to co-operate at a later stage.[26]

76. The bereaved families have submitted that a concern ought to be raised that MI5 and CTP should improve their systems to ensure that contact from members of the public is correctly routed and filed. For MI5 and the MPS, the response has been made that the facts summarised above do not reveal any weakness in information processing systems and that much valuable work is already being done to improve information management.

77. In my view, the facts of this case do give cause for some concern that communications from members of the public may not reach investigation teams (or all members of such teams). It is noteworthy that neither one of two calls in this case was passed on as it should have been. Whether or not more useful intelligence could in fact have been obtained from Usman Darr, it is troubling that a close family member of an SOI in a priority investigation could contact the authorities in the proper way without it coming to the notice of the MI5 officers working on the case.

[26] For the evidence of Witness L concerning the call from Usman Darr, see day 24 transcript, p83-86.

MC10: Addressed to the Secretary of State for the Home Department and the Director-General of the Security Service: The evidence in this case gave cause for concern that calls made by members of the public reporting on a significant SOI were not being communicated to MI5 and CTP officers working on the relevant investigation(s). In the continuing work to improve information management, efforts should be made to avoid recurrence of this problem.

Matters arising from the Schengen Information System Evidence

78. This topic does not concern the investigation into Khuram Butt, but dealings of the authorities concerning Youssef Zaghba.[27] In March 2016, Zaghba was stopped at Bologna airport after he gave a bizarre answer to a standard question by apparently confessing to an intention to travel for terrorist purposes. As a result, the Italian authorities entered his name on the Schengen Information System, but under an alert relating to serious crime rather than terrorism. The referencing error had the effect that he was not drawn to the attention of MI5 when he entered the UK on later occasions.

79. The bereaved families have suggested that I raise a concern that systems ought to exist so that an individual who has been entered on the Schengen System under the wrong alert can still be brought to the attention of the security services of other countries to which he/she travels. However, I agree with the response made on behalf of MI5 that the evidence I have summarised is indicative of a simple, one-off error by the Italian authorities rather than any remediable flaw in the Schengen System.

80. However, I consider that there is another aspect of this evidence which does justify a matter of concern being raised. On 15 April 2016, the Italian authorities put a series of questions about Zaghba to the UK Secret Intelligence Service (MI6). It took around seven weeks (until 9 June 2016) for the document to be translated and passed to MI5 and to MI6 headquarters. This was due to limited translation facilities. When the document was translated, it went to the wrong addressee in MI5 and there was a further mistake which led to it not being filed anywhere in MI5's records. It is fair to add that,

[27] For Witness L's evidence on this topic, see day 25 transcript, p3-11.

if the document had been properly considered by MI5 it would have produced a nil return (because the Service had no information about Zaghba).

81. I fully accept that the misdirection and filing failure at MI5 appear to be matters of individual human error to which there is no obvious structural solution. However, I am troubled that it should have taken seven weeks for a document of modest length from a foreign security service to be translated from a major European language by MI6 and passed on. Witness L added to that concern by acknowledging that such a delay for translation is not uncommon.[28] This suggests that more substantial and/or better-funded translation services are required.

MC11 – Addressed to the Chief of the Secret Intelligence Service and the Director-General of the Security Service: I suggest that consideration be given to improving facilities for translating communications received from foreign security and intelligence services, since the evidence in this case reveals a troubling delay in the translation of such a communication.

Statutory Duty to Report Terrorist Planning

82. In the Determinations I returned concerning the victims of this attack, I recorded that one of the attackers (Khuram Butt) exhibited to close family members multiple warning signs of his extremist views and conduct but that in the main these were not reported to the authorities.[29] The bereaved families have referred to that finding and have suggested that the Government should consider whether the legal framework requiring terrorist intent and planning to be reported is sufficiently robust.

83. As is pointed out by the Secretary of State for the Home Department, there is already a criminal offence of failing to report information that might be of assistance in preventing an act of terrorism: section 38B of the Terrorism Act 2000. Decisions on prosecution under this or any other offence are matters for the Crown Prosecution Service and are governed by its Code. I am not persuaded that the Government ought to be encouraged to add further offences to the statute book in this regard. The scope

[28] Day 25 transcript, p7.
[29] See Ruling on Article 2 and Determinations, paragraph 116.

of the existing offence represents a careful balance between security and liberty, and there would be real civil liberties concerns about making it a criminal offence not to report extreme views of friends and family members to the police.

Subjects of Interest Working on the Transport Network

84. In May 2016, Khuram Butt obtained employment as a customer service officer for London Underground, a role which gave him access to a number of stations including Westminster. MI5 and SO15 officers became aware of this at an early stage, but did not intervene. They had no intelligence that Butt intended to use his employment for terrorist purposes, and indeed there is still no information at all to suggest that he did. Furthermore, Witness M explained that police would have concerns about data protection law and about interfering with the employment relationship.[30] Witness L pointed to section 2(3) of the Security Service Act 1989 which general prohibits MI5 from disclosing information to an employer with a view to affecting a person's employment.[31]

85. The bereaved families have submitted that it is concerning that a person such as Butt, who was understood to have aspired to attack planning in mid-2015, should have obtained employment on the Underground system a year later. Since attacks have in the past been directed at the Underground, care should be taken to avoid giving persons of concern access to secure areas. The families have proposed that TfL should be informed where employees or potential employees are under investigation by MI5 / CTP, or alternatively that there should be some system for notifying MI5 of the names of applicants for jobs on the public transport system.

86. In my view, this is not a matter which should be raised by a PFD Report. There is a vast number of jobs which could present opportunities for terrorist action. These include jobs relating not only to the public transport network (itself a huge number), but also (for example) jobs relating to utilities companies and jobs involving provision of services at Government buildings. Particular forms of employment have their own vetting requirements which are no doubt justified and kept under review, as they should

[30] Day 19 transcript, p86-87.
[31] Day 24 transcript, p103-105.

be. However, giving MI5 or CTP the power and responsibility for barring SOIs from significant fields of the job market would not be desirable or satisfactory. It would add to their burdens and cause people to lose employment opportunities simply because (unknown to them) they were associated with MI5 investigations. Section 2(3) of the 1989 Act reflects concerns of that kind.

87. It may, of course, happen that the decision of an SOI to take employment in the public transport field will prompt MI5 officers to adjust their view of the risk presented by that SOI. Such an event might cause them to step up monitoring. That is very different from asking MI5 officers to intervene covertly in employment relationships.

Measures for Preventing "Vehicle as Weapon" Attacks with Rental Vehicles

88. The attacks on Westminster Bridge and London Bridge in 2017 show that a motor vehicle is a lethal weapon and that large vehicles have a greater capacity to kill and injure. On the evidence, terrorist attacks using vehicles as weapons have increased in frequency over recent years, and a significant proportion of them have involved the use of rented vehicles (including the 2017 attacks at Westminster, London Bridge and Finsbury Park). The hiring of a large vehicle by an SOI can therefore be a cause for concern and may prompt action by police. In this case Witness M, the senior investigating officer of the police pre-attack investigation, indicated in evidence that he would have had Khuram Butt's vehicle stopped if he had been informed by MI5 officers of the hiring.[32] However, the van was only hired a few hours before the attack and MI5 was not aware of the hiring in advance of the attack.

89. The question was raised both with the rental company (Hertz) and with Witness L (the senior MI5 officer who gave evidence) as to whether a system could be devised whereby all vehicle hires would be reported in real time and the names of hirers compared automatically against a list of SOIs, resulting in a notification to MI5 in the event of an SOI hiring a vehicle. Witness L accepted that such a system would be possible in principle, but that there might be very significant technical challenges and costs in operating it. Overall, he was doubtful of the merits of the idea.[33] Mr Fulbrook

[32] Day 19 transcript, p130-132.
[33] Day 25 transcript, p124-125.

of Hertz said that the company could and would comply with any requirement to report all hires in real time, although he too accepted that the system envisaged could be challenging to establish and operate.[34]

90. A related topic which was explored was the development of the Rental Vehicle Security Scheme ("RVSS"). That scheme was the result of discussions between the Department for Transport, police and rental industry representatives. It has resulted in the production of a code of good practice, which requires sensible measures to be taken such as (a) only accepting electronic forms of payment, (b) carrying out driver licence verification checks and (c) training staff to identify and report suspicious behavior. At present, the scheme is not mandatory. Although 80% of vehicle rentals in the UK are by companies which have signed up to the scheme, very many smaller rental companies are not signatories.

91. In my view, the Department for Transport and the Home Office should consider whether any further measures can practicably be taken to reduce the risk of rental vehicles being used in terrorist attacks. The measures to be considered should include a reporting scheme of the kind described in paragraph 89 above and the possibility of making the RVSS scheme mandatory. These measures should be considered in discussions with the industry body, the BVRLA. I should stress that I accept that careful judgments may have to be made balancing the cost and difficulties of such measures against their realistic benefits (recognising of course that renting is not the only means for terrorists to obtain large vehicles).

MC12 – Addressed to the Secretary of State for the Home Department, the Secretary of State for Transport and the BVRLA: I suggest that consideration is given to taking further measures to reduce the risk of rental vehicles being used in terrorist attacks. The measures to be considered should include (a) introducing a scheme for real-time reporting of rentals and automated checking of the results against lists of SOIs and (b) making the current RVSS scheme mandatory.

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[34] Day 33 transcript, p25-26.

Emergency Response to Terrorist Attacks

Introduction

92. As I wrote in the Ruling on Article 2 and Determinations, the night of the attack saw a massive operation by the emergency services to search for potential attackers and devices; to evacuate the public from the area of the attack; and to provide medical assistance to the injured.[35] It is right and proper that questions were asked of witnesses about every aspect of the emergency response and that every effort should be made to learn lessons from what happened. However, it is important to emphasise at the outset that the operation was generally well-managed. Many seriously injured people were provided with assistance and conveyed to hospital, receiving life-saving care. Those who tragically died had all suffered terrible injuries which could not have been treated at the scene. On the clear evidence in the Inquests, all eight died within 15 minutes of the attack beginning.

93. Many individual police officers, LAS staff and other emergency services personnel worked bravely and tirelessly in the emergency response. The Inquests heard from some of them, and there was further evidence from those who were injured about the people who assisted them. Nothing that I say in this section of this Report should be read as any kind of coded criticism of individuals. This Report is solely concerned with identifying any areas where improvements might be made in systems and practices. It is also fair to point out, that in important respects, the procedures of the emergency services performed well on the night of the attack. The Operation Plato strategy in particular resulted in a prompt and massive deployment of police and other services to the area which undoubtedly strengthened the emergency response.

94. One particular issue on which questions were asked at the Inquests was why there was a period of time while police officers were providing medical care to injured people in the Boro Bistro courtyard (which was below street level), during which LAS staff did not go into that area and the officers were not advised to take casualties to ambulances a short distance away. The answer in simple terms was that the area was not in easy

[35] Ruling, paragraph 5.

view and was regarded as unsafe, such that practically as soon as LAS staff came close to it they were warned away by armed police. This reflects a terrible fact of marauding terrorist attacks, namely that it may be unclear for a period where casualties are and how best to get help to them. Systems and practices can and should be examined to address this problem, but it is impossible to cater for every possible situation.

The Model of Hot, Warm and Cold Zones

95. The emergency services use a set of procedures in the event of marauding terrorist attacks which involve designating areas as hot, warm and cold zones.[36] A hot zone is an area of greatest threat, where attackers still are or may be. A warm zone, typically adjacent to a hot zone, is an area where attackers are not believed to be but where a threat remains (e.g. because attackers may return to the area). A cold zone is an area where no known threat exists. At the time of the attack, the procedure was that LAS staff would not be directed into a hot zone. LAS staff would only be directed into a warm zone if they were specially trained and equipped and were accompanied by armed police.

96. Concern was expressed during the Inquests that these procedures were too inflexible and that they had the capacity to prevent ambulance personnel being sent to casualties in need of help. In fact, on the night of the attack, these procedures did not result in any opportunity being lost which might have saved any of those who died. Furthermore, those who had been injured in the Boro Bistro area were moved out of that area to receive specialist medical help. It should also be recognised that LAS staff put themselves in harm's way to render medical assistance to the injured. For instance, Mr Beasley (LAS Incident Response Officer) remained close to the scene of the attack to direct LAS resources even after police had directed him to leave for his own safety. HART paramedics such as Ms Collison deployed to the area later in the evening unanimously volunteered to enter areas still classified as hot zones.

97. Despite those important features of the evidence, I accept that the procedures as they stood at the time of the attack could be criticised on the basis that whole areas would be classed as out of bounds to LAS staff, preventing more nuanced judgments being

[36] See for instance the evidence of Supt McKibbin at day 23 transcript, p20-26.

made about where staff could appropriately be sent. Such judgments must necessarily involve a difficult balance between getting medical care to those in need and limiting the danger to staff, but they should not be restricted by inflexible rules.

98. In their submissions, the bereaved families have raised a number of concerns about the procedures described above. They have suggested that the zoning model unrealistically assumed that fixed areas could be categorised reliably as hot and warm zones early in an incident. They have criticised the procedures for being based on the false premise that hot zones will be of limited size and will be quickly "declassified" once a threat has been neutralised. In fact, in this case, both warm and hot zones were relatively large areas and remained classified as such for hours after the terrorists had been shot. The families argued that the guidance ought to acknowledge that emergency services personnel will enter hot and warm zones and deal with the need for supporting them in such areas. In particular, it has been submitted that better procedures ought to exist for sending paramedic assistance to casualties in hot and warm zones and for extracting them from such areas.

99. In response to those submissions, the LAS and the police forces (the MPS and CoLP) have made the important point that the relevant procedures changed very substantially in early 2019. At that time, a new version of the Joint Operating Principles for emergency services response to a marauding terrorist attack ("JOPs") was introduced. At about the same time, revised Contingency Planning Guidance was produced for Operation Plato, the police strategy for responding to a marauding terrorist attack. These documents have made a number of important changes. They now permit emergency responders (including paramedics) to be sent into hot and warm zones even if they are not specially trained and equipped and/or do not have an armed police escort. The new guidance documents stress speed of deployment and contain new advice on decision-making in designation of hot and warm zones. They make clear that deployment of staff should not be delayed pending the arrival of Plato commanders from the three emergency services.

100. In my view, the revision of the JOPs and Plato Guidance addresses the principal concerns raised by the evidence. It is encouraging to see that the emergency services had revised their procedures even before the detailed evidence was heard in these

Inquests. Nevertheless, I still consider it appropriate to record concerns arising from the evidence in the Inquests. The evidence revealed weaknesses and limitations in emergency response procedures as summarised above. While they have been addressed in the main JOPs and Plato guidance document, I would like to stress to the emergency services that they should also be kept in mind when producing other procedural and guidance documents and when devising training exercises.

MC13 – Addressed to the LAS, MPS and CoLP: The evidence in these Inquests gave rise to concerns that procedures for emergency response to marauding terrorist attacks were inflexible. In particular, the evidence suggested that large areas could be designated hot and warm zones for long periods and formally placed out of bounds to most ambulance and paramedic staff. This feature of the procedures gave rise to a risk of delay in getting medical help to casualties. While this lack of flexibility has apparently been addressed in the revised Joint Operating Principles, I suggest that procedures generally be reviewed to ensure that they accord with the requirements of speed and flexibility of response which appear to be recognised in that document. I also suggest that training exercises be devised which address demanding situations with features such as (a) hot and warm zones of uncertain extent; (b) a need for re-assessment of hot and warm zones; and (c) a need to locate and assist casualties in dangerous areas.

Location and Extraction of Casualties

101. The bereaved families have suggested that this Report should raise a concern about procedures for locating casualties. Specifically, they have proposed that, in any marauding terrorist incident, there should be a designated person with the responsibility for analysing reports to ascertain the locations of casualties. In this case, information from emergency calls was received from an early stage which referred to injured people in the Boro Bistro area, but that information was not immediately passed to emergency responders on the front line.

102. In response to that proposal, LAS have stated that there is already work underway to review major incident action cards in order to incorporate learning from the London Bridge attack. The MPS have responded that the particular proposal put forward might

be too prescriptive, since such attacks are hugely variable and in some cases it would not be of value to have a person with the designated role which is suggested.

103. In my view, there is some substance in the concern raised by the families. In some cases there may be a real benefit in having a person in the LAS or MPS control room review the records of emergency calls to help identify the areas where injured people may be. However, the MPS is right to say that it would be too prescriptive to require that somebody must always perform that task at an early stage in a marauding terrorist attack. My suggestion will therefore be that procedural documents and training exercises produced by LAS should stress the importance of identifying the location of casualties at an early stage, in co-ordination with the police. This may be done by reviewing emergency call records, but there may also be other means available.

MC14 – Addressed to LAS: The evidence in these Inquests highlighted the importance of identifying the location of casualties at an early stage in a marauding terrorist attack. I suggest that LAS review its guidance documents and training exercises to ensure that they stress this point and indicate practical means of locating casualties (e.g. from information in emergency call records).

The "Run, Hide, Tell" Message

104. As is well known, the advice given to members of the public in the event of a terrorist attack is summed up in the slogan, "Run, Hide, Tell". The bereaved families have suggested that this message ought to be reconsidered. If there are likely to be delays in providing medical assistance, should people instead be advised to find their way to locations where they may receive help?

105. In my view, there is no basis for raising a concern about the "Run, Hide, Tell" message. It is part of a broader set of public safety guidance which has plainly been the result of careful thinking. The Inquests received no evidence to suggest that the existing message poses risks to life. In fact, the evidence suggested that this message and the broader public safety guidance of which it forms a part may have saved lives on the night of the attack. In particular, there was evidence of people getting quickly to safety and of premises being secured against the attackers.

Medical Equipment and Training

106. On the night of the attack, a number of those seriously injured received first aid for a period from police officers, before they could be brought to ambulances. The officers in question acted bravely and professionally in providing care to the injured, often without knowing whether attackers might be nearby. However, their medical skills and equipment were naturally more limited than those of ambulance staff and paramedics. At the Inquests, questions were asked about whether in future it might be possible for police officers (or some officers) to have additional equipment and training. The bereaved families have made the point that, if police officers are to be the first responders sent into areas of danger where there are casualties, they should be given a higher level of first aid training. It has also been pointed out that some equipment, such as tourniquets, could usefully be provided to officers.

107. In response to those points, the LAS has explained that it is continuing to work with police regarding provision of further medical equipment to front-line officers (including tourniquets). The CoLP has replied that steps have already been taken (a) to enhance the first aid capabilities of officers above national standards; (b) to provide emergency dressing packs at rail stations; (c) to provide emergency trauma packs for businesses; and (d) to provide “stop the bleed” kits. The MPS has replied that firearms officers (who will often be among the first sent into dangerous areas) already have relatively high levels of first aid training, and that there are regular reviews of training and equipment.

108. In my view, it is appropriate to raise a concern on this subject in this Report. It is likely that there will be situations in the future, whether involving terrorism or serious crime, where police officers have to provide urgent first aid to people with severe knife injuries. The evidence at the Inquests showed that officers could be assisted by further training and equipment, an impression reinforced by the fact that LAS and the CoLP have taken steps in that direction since the attack. A further point should be made that officers’ vehicles could usefully have more spare equipment (such as airways and dressings), to avoid shortages in major incidents.

MC15 – Addressed to the MPS and CoLP: I suggest that the emergency services give serious consideration to enhancing first aid capabilities and equipment of either police officers generally or groups of officers (e.g. firearms officers or officers designated for advanced medical aid training). This should include consideration of training some officers in advanced life-saving procedures analogous to battlefield medicine. It should also include considering (a) wider provision of equipment such as tourniquets and "stop the bleed" kits and (b) the inclusion of more spare equipment in officers' vehicles.

Communications Technology

109. Airwave radios used by police officers and other emergency services can be used to select between multiple channels (or talk groups). Channels can be set up quickly to deal with major incidents. As the Inquests heard, there were at the time of the attacks channels specific to the CoLP, the MPS and to firearms officers across London. The bereaved families have suggested that consideration should be given to whether these channels are being used in the most effective way, especially in communicating with ARVs. They point to the fact that one of the first ARV officers to arrive at London Bridge, PC Duggan, was not initially aware that the incident was a terrorist attack (as opposed to a serious road traffic accident on the Bridge).

110. In my view, there is no basis for raising a concern in this regard. The first radio messages after the attack began referred to a serious road collision on London Bridge. PC Duggan in his ARV heard a message to that effect (at 10.09pm), and he went quickly to the Bridge with his colleague, arriving there within two minutes (at 10.11pm). He then ran over the Bridge, checking on the injured until he reached a person in a critical condition requiring help (Christine Archibald). From 10.13pm to 10.20pm, he assisted in giving CPR to Christine until the arrival of an ambulance. He then went to his ARV, collected his primary weapon, and moved south of the Bridge. As he proceeded south, he heard shots from the direction of Borough Market at 10.23pm, and moved towards the direction of the shots.[37] It should be noted that PC Duggan could not have prevented the fatal injuries even if he had been made aware any earlier of the terrorist attack taking

[37] For a summary of PC Duggan's movements as tracked by reference to CCTV footage, see the evidence of Det Supt Riggs at day 33 transcript, p124-128.

place. It should also be noted that he was not the first ARV officer on the scene. He behaved with exemplary courage and professionalism, at first providing urgent help to a critically injured person and later moving towards the sound of gunfire.

111. This history of events does not demonstrate any systemic deficiency in communications technology. There were some radio messages not heard by PC Duggan, because he was focused on the task before him. However, that does not suggest a failing in the radio technology or the way it is operated by the London police forces. It is inevitable in a major incident that some officers will not hear every radio message, but the evidence indicated to me that the radio talk groups generally function well.

112. A separate point was made about radio technology, with specific reference to the emergency button on police radios. Officers are trained to press the button when urgent assistance is needed, and its effect is to override other radio traffic. Often, the most important piece of information for an officer to convey in an emergency is his or her location. However, in a major incident, multiple officers may press the button at the same time, in which case none of their communications will be heard. That is what happened during the critical period of the attack in this case. Against that background, the bereaved families have suggested that the police consider whether the emergency button is a sufficiently reliable method of summoning assistance in major incidents.

113. In response, the MPS have pointed out that the emergency button is a valuable tool for officers in general policing. It is also noted that, in a marauding terrorist attack, police do not rely simply on conventional radio messages to summon assistance. The Operation Plato strategy in particular involves the summoning of large numbers of officers to the scene. The CoLP makes the further points that communications difficulties are an inevitable feature of major incidents, and that improved communications technology is being explored.

114. In my view, the points made by the MPS and CoLP are very valid. However, I consider that one subject could usefully be considered in light of the communications difficulties which occur in major incidents. The ongoing work of reviewing communications technology should consider the following questions. Where multiple officers transmit urgent assistance messages simultaneously and they cannot all be heard immediately,

is it it possible for the messages to be isolated, recorded and listened to by control room staff so that the information is not lost? If this is not presently possible, could it be made possible?

MC16 – Addressed to the MPS and CoLP: The evidence in the Inquests raised a concern that there will often be communications difficulties in the early stages of a major incident, including difficulties resulting from multiple officers attempting to make urgent radio transmissions at the same time. In the ongoing work of reviewing and improving communications technology to address these difficulties, consideration should be given to whether it may be possible for control room staff to isolate and record messages so that they can be listened to separately.

Technology for Locating Emergency Services Personnel

115. One of the challenges which faced police officers, especially in the early period of the attack, was that some were attempting to assist casualties but unaware where or how close ambulances might be. With information about where ambulance staff and vehicles are, officers are able to make decisions about whether to move casualties or to provide first aid at the scene. Even those in the police control room were not always aware in real time precisely where ambulances were, particularly in the early stages of the incident.

116. At the Inquests, questions were asked as to whether technical measures could be introduced to enable the locations of LAS vehicles and personnel to be precisely identified and passed on to police officers at the scene of an incident. In his evidence, Paul Woodrow of LAS accepted that it might be possible to use GPS positioning through radios to assist in locating LAS resources.[38] The bereaved families have suggested that this is a proper matter for inclusion in this Report. In response to that suggestion, LAS has stated that it intends considering the issue with other emergency services, and that the technical measures under consideration include web-based mapping and use of drones. The CoLP and the MPS have similarly responded that the topic is being considered at national and local levels, with the CoLP in particular looking at geo-location using officers' devices.

[38] Day 27 transcript, p65.

117. In my view, it is appropriate to register in this Report the concern that more might be done to help identify the precise locations of emergency service personnel and communicate those locations to other first responders. This may save lives in future incidents, and a review of the technical options would be valuable.

MC17 – Addressed to the LAS, MPS and CoLP: I suggest that consideration be given to introducing / improving technical measures to assist in identifying the exact locations of emergency services personnel so that they can be communicated reliably to other first responders.

Co-Location of Control Rooms / Control Room Staff

118. The evidence at the Inquests demonstrated that the London emergency services generally collaborate very well, and that there are detailed procedures for communications between the services in major incidents. In a marauding terror attack, the Operation Plato strategy provides for a conference call to be set up quickly between the MPS, LAS and LFB control rooms and for staff from the latter two services to go to the MPS control room. The strategy also provides for Plato commanders at the scene to station themselves together at a Forward Control Point.

119. In his evidence, Mr Woodrow of LAS indicated that further steps might be taken to improve communications between the services. In particular, he said that it would be worth considering stationing a small number of LAS and LFB staff permanently in the MPS control room and that this might help ensure that information received by one service could be passed swiftly to the others.[39] Similarly, Supt McKibbin of the MPS said that this option could be explored.[40] In its submissions concerning this Report, the LAS has expressed an intention to look at the option with other services in the Blue Light Collaboration Programme. The MPS has responded that co-location of entire control rooms was impractical, but has not addressed specifically the option of having a small number of LAS and LFB staff stationed in the MPS control room.

[39] See day 27 transcript, p64-65.
[40] See day 23 transcript, p69-70.

120. In my view, it is appropriate to suggest in this Report that consideration be given to the option discussed by Mr Woodrow. There might ultimately be reasons for rejecting it, but it ought to be considered seriously.

MC18 – Addressed to the MPS and LAS: The evidence at the Inquests indicated that life-saving efforts of the emergency services, especially in major incidents, are improved by better communications between them. Given the challenges of communications in the early stages of incidents, I suggest that consideration be given (including through the Blue Light Collaboration Programme) to the possibility of having a small number of LAS and London Fire Brigade staff stationed in the MPS control room at all times.

The City of London Police

121. The London Bridge attack took place at the physical border between two police forces in London; the MPS and CoLP. The bereaved families have suggested that the Government, together with the MPS and CoLP, should consider whether the existence of two forces in the London area makes it more difficult to co-ordinate an effective response to a terrorist attack. They raise a concern that the existence of the border between the forces could impede communications in major incidents.

122. I am firmly of the view that it is not appropriate to suggest in this Report that the continued existence of the CoLP as a force ought to be reviewed. First, there was no evidence that the existence of the CoLP or the working relations between the MPS and CoLP created any real problem on the night of the attack. Neither was there any evidence that they have the capacity to create difficulties in future. To the contrary, all the evidence was of good collaboration between the two forces. Secondly, there are good reasons for the existence of a force with responsibility for the City of London area. For instance, evidence in the Inquests concerning protective security (including from PS Hone) showed that some valuable counter-terrorist tactics have been pioneered in the CoLP area and that the force has developed a particular understanding of the commercial centre it is responsible for policing. Thirdly, the independent existence of the CoLP as a force is a matter of policy which is not in any event a suitable topic for a Report of this kind. It would require a clear business case and a balancing of policy priorities and costs.

Marine Policing on the Thames and Searches for Casualties in the River

123. The final topic to be considered is that of marine policing on the Thames and in particular the procedures for carrying out searches for people believed to have fallen into the river. The family of Xavier Thomas has raised this topic. They acknowledge that, on the evidence, it is very likely that he died very soon after falling from London Bridge and that further or different methods of search would not have saved his life. However, they suggest that lessons can be learned for the future from the searches which did take place.

124. First, the Thomas family has suggested that the Marine Policing Unit ("MPU") should review its search technology to assess whether it is fit for purpose, including considering whether hand-held infrared ("IR") devices would be more effective than the infrared equipment presently fitted to vessels. They refer to evidence from PC Bultitude of the MPU that the IR equipment was not the most practical in some conditions and circumstances and that its controls could be "fiddly". In my view, it would not be appropriate to raise this topic in this Report. PC Bultitude told the Inquests that the IR equipment on his vessel was very useful in some situations, in particular for picking up heat sources in sterile situations.[41] However, in a search at night of the kind which occurred in this case, it was better for an officer in PC Bultitude's position to focus on driving the vessel while his colleagues scanned the water with the benefit of the searchlight. I am not satisfied that the evidence reveals a significant deficiency in search equipment which calls for inclusion in this Report. In any event, the MPS has indicated that a tender process is underway for new vessels, and that this will include new and improved IR devices.

125. Secondly, the Thomas family has suggested that there should be a review of procedures for sharing of information between HM Coastguard and the MPU during searches of the Thames. They point to the fact that MPU vessels diverted from the search in this case in order to provide urgent assistance to people on the banks of the river, and that the Coastguard was not immediately made aware of this happening. In my view, the evidence does not reveal any systemic deficiency in communications between the MPU

[41] See in particular his evidence at day 3 transcript, p51-52.

and Coastguard. It was a reasonable decision for the MPU vessels to leave the search in order to perform other urgent and important duties, and the procedures which exist allow for such decisions to be taken. When they did so, enough vessels remained engaged in the search.

126. Thirdly, the Thomas family has pointed to the fact that the search for Xavier was suspended on the night of the attack after 47 minutes. It has been proposed that consideration be given to setting minimum times for such searches. In my view, it would be wrong to take that step. The evidence of the search on the night of the attack was that it was extensive and that it was continued for a proper time. The time to be dedicated to a search for a casualty in the water must depend on a judgment of how long the search can usefully be continued. Such judgments will in turn depend on a wide range of considerations, including the information received about the location of the casualty; the general conditions (including lighting); the tidal conditions; what can be seen on and in the water; the number of vessels involved in the search; and the extent of search. Setting minimum search times would result in searches being carried on beyond any sensible assessment of their proper duration (unless the minimum times were so short as to be meaningless). It would risk keeping vessels committed to a search when they are needed for life-saving work elsewhere (including possibly for other searches).

Action Should be Taken

127. In my opinion, action should be taken to prevent future deaths. I believe that the various addressees of this Report have the power to take the action relevant to them (as set out above).

Your Response

128. Each addressee is under a duty to respond to this report within 56 days of the date of this report, namely by 26th December 2019. Allowing for the Christmas and New Year break, this date will be extended to 10th January 2020. I, as the coroner responsible for the Inquests, may extend the period upon application.

129. Each response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, it must explain why no action is proposed.

Copies and Publication

130. I have sent copies of my report to the following:

(a) all Interested Persons in the Inquests (identified in the attached list); and

(b) the office of the Chief Coroner of England and Wales.

131. I am also under a duty to send a copy of any responses to the office of the Chief Coroner.

132. In my capacity as the Chief Coroner of England and Wales, I may in due course publish this Report and/or any responses in complete or redacted or summary forms. I may send a copy of this Report to any further person who I believe may find it useful or of interest. Addressees and others may make representations to me, in my capacity as the nominated Judge responsible for the Inquests, about the wider release or publication of any responses.

HH Judge Lucraft QC

Chief Coroner of England and Wales
(Sitting as a Nominated Judge)
1st November 2019

Annexes

(1) Determinations sheets for the inquests of the victims of the attack.
(2) Determinations sheets for the inquests of the attackers.
(3) List of Interested Persons in the Inquests.

Determinations Sheet – Xavier Thomas

Xavier Thomas was unlawfully killed.

On 3 June 2017, Xavier Thomas was visiting London. He had been walking south across London Bridge with his partner, Christine Delcros. They had reached a point about midway across the Bridge when a Renault van was driven deliberately towards them and other pedestrians on the pavement. This was part of a terrorist attack. Xavier was struck by the front offside of the van with significant impact. Christine was struck by the van as well. He was thrown over the balustrade of the Bridge into the River Thames below, falling from a height of at least 13 metres. Xavier died immediately or almost immediately upon entering the water. A search was carried out by the Coastguard and Metropolitan Police Service, the first boat arriving approximately seven minutes after Xavier entered the water. Xavier was probably not on the surface of the water during the search. Xavier's body was recovered from the River Thames on 6 June 2017. He was assessed as dead by a police officer.

Multiple warning signs about the extremist views and conduct of one attacker were known to a number of his close family members in the months and years before the attack. In the main these were not reported to the authorities.

One of the attackers was a Subject of Interest under active investigation by the Security Service at the time of attack and for around two years before it. He was subject to surveillance in varying degrees but was not the subject of live monitoring in the days immediately before the attack. The other attackers had not been identified before they carried out the attack together.

At the time of the attack described above, there was no form of physical protective security on London Bridge, despite the fact that it was a location which was particularly vulnerable to a terrorist attack using a vehicle as a weapon. There were weaknesses in systems for assessing the need for such measures on the bridge and implementing them promptly. Absent such weaknesses, suitable hostile vehicle mitigation measures may have been present.

Determinations Sheet – Christine Archibald

Christine Archibald was unlawfully killed.

On 3 June 2017, Christine Archibald was visiting London. She had been walking south across London Bridge with her fiancé, Tyler Ferguson. They had passed the midpoint of the Bridge when a Renault van was driven deliberately towards them and other pedestrians on the pavement. This was part of a terrorist attack. Christine tried to avoid the van and Tyler tried to protect Christine with his arm. Christine was struck with full force by the vehicle. She was carried forward with the van until it crossed the central reservation, where Christine's body was released. She was run over by the van. Christine was immediately unconscious and died nearly instantly from these injuries, which were not survivable. Christine was treated by Tyler, members of the public, police officers, Emergency Ambulance Crew, a student paramedic and doctors. She was assessed as dead at the scene by a doctor.

Multiple warning signs about the extremist views and conduct of one attacker were known to a number of his close family members in the months and years before the attack. In the main these were not reported to the authorities.

One of the attackers was a Subject of Interest under active investigation by the Security Service at the time of attack and for around two years before it. He was subject to surveillance in varying degrees but was not the subject of live monitoring in the days immediately before the attack. The other attackers had not been identified before they carried out the attack together.

At the time of the attack described above, there was no form of physical protective security on London Bridge, despite the fact that it was a location which was particularly vulnerable to a terrorist attack using a vehicle as a weapon. There were weaknesses in systems for assessing the need for such measures on the bridge and implementing them promptly. Absent such weaknesses, suitable hostile vehicle mitigation measures may have been present.

Determinations Sheet – Sara Zelenak

Sara Zelenak was unlawfully killed.

On 3 June 2017, Sara Zelenak was with a friend in the Borough area. Three attackers had deliberately driven a Renault van into multiple pedestrians on London Bridge and into railings on Borough High Street, next to the Barrowboy and Banker public house. That was part of a terrorist attack. The attackers left the van and immediately began attacking further pedestrians, including Sara, with knives. During or immediately before the attack, Sara lost her footing. She suffered a number of injuries when stabbed by one or more of the attackers, dying at or very near to the place where she was attacked. One of Sara's injuries was a stab wound to her neck, of which she died extremely rapidly. That injury was not survivable. She was treated by police officers and was assessed as dead at the scene by a paramedic.

Multiple warning signs about the extremist views and conduct of one attacker were known to a number of his close family members in the months and years before the attack. In the main these were not reported to the authorities.

One of the attackers was a Subject of Interest under active investigation by the Security Service at the time of attack and for around two years before it. He was subject to surveillance in varying degrees but was not the subject of live monitoring in the days immediately before the attack. The other attackers had not been identified before they carried out the attack together.

Determinations Sheet - Alexandre Pigeard

Alexandre Pigeard was unlawfully killed

On 3 June 2017, Alexandre was working at Boro Bistro as a waiter. Three attackers had deliberately driven a Renault van into multiple pedestrians on London Bridge and into railings on Borough High Street, next to the Barrowboy and Banker public house. The attackers had left the van and had immediately started attacking further pedestrians with knives. The attackers then went down a stone stairway towards Boro Bistro. This was all part of a terrorist attack. Alexandre heard the noise of a collision at street level and immediately moved towards the base of the stairway to help. In that area, Alexandre was stabbed with the knives of one or more attackers and suffered serious injuries, including to his neck. Alexandre was able to return to Boro Bistro, following the wall to his left hand side. At some time, an off-duty nurse saw Alexandre and came to help him. Alexandre told her to run away. At the other end of the courtyard he was stabbed again, during which time he fell to the floor. He was stabbed whilst he was on the ground. As a result of his multiple injuries, he suffered rapid and fatal blood loss, particularly from the wounds to his neck and chest. He died quickly. His injuries were not survivable. Alexandre received treatment from a police officer, who went to treat the injured regardless of any risk to himself but who saw no sign of life and went to help other victims. Approximately three hours after Alexandre received his injuries, he was confirmed as dead at the scene by a paramedic.

Multiple warning signs about the extremist views and conduct of one attacker were known to a number of his close family members in the months and years before the attack. In the main these were not reported to the authorities.

One of the attackers was a Subject of Interest under active investigation by the Security Service at the time of attack and for around two years before it. He was subject to surveillance in varying degrees but was not the subject of live monitoring in the days immediately before the attack. The other attackers had not been identified before they carried out the attack together.

Determinations Sheet – Sébastien Bélanger

Sébastien Bélanger was unlawfully killed.

On 3 June 2017, Sébastien Bélanger was with a group of friends around Borough Market. Three attackers had deliberately driven a Renault van into multiple pedestrians on London Bridge and into railings on Borough High Street, next to the Barrowboy and Banker public house. The attackers had left the van and had immediately started attacking further pedestrians with knives. The attackers went down a stone stairway towards Boro Bistro. This was all part of a terrorist attack. At or around the base of the stairway, Sébastien was attacked. Despite efforts to defend himself, he suffered a number of injuries when stabbed with the knives of one or more attackers. His most significant injuries were to his chest. Sébastien received prompt treatment, including CPR, from members of the public and police officers who stayed to treat him regardless of any risk to themselves. At the time at which treatment commenced, Sébastien had not died. However, his injuries were very serious and he could not be saved, despite the best efforts of the police officers and members of the public. Sébastien was carried to an ambulance where he was assessed as dead by a paramedic.

Multiple warning signs about the extremist views and conduct of one attacker were known to a number of his close family members in the months and years before the attack. In the main these were not reported to the authorities.

One of the attackers was a Subject of Interest under active investigation by the Security Service at the time of attack and for around two years before it. He was subject to surveillance in varying degrees but was not the subject of live monitoring in the days immediately before the attack. The other attackers had not been identified before they carried out the attack together.

Determinations Sheet – Kirsty Boden

Kirsty Boden was unlawfully killed.

On 3 June 2017, Kirsty was with a group of friends at Boro Bistro. Three attackers had deliberately driven a Renault van into multiple pedestrians on London Bridge and into railings on Borough High Street, next to the Barrowboy and Banker public house. The attackers had left the van and had immediately started attacking further pedestrians with knives. The attackers then went down a stone stairway towards and into Boro Bistro. This was all part of a terrorist attack. Kirsty was aware that there had been a collision at street level and she moved towards the entrance to Boro Bistro. She was a nurse and told her friends that she needed to go and help anybody who might be injured in the collision. Kirsty was attempting to provide assistance to a man who had received serious knife injuries from the attackers, Alexandre Pigeard, when she was herself assaulted by one or more of the attackers and was stabbed with their knives. She received a stab wound to the left side of the chest, which was the fatal injury. Kirsty was able to move along an alleyway a short distance towards the Mudlark public house where she collapsed. She died within minutes. Her injury was not survivable. Kirsty received treatment from friends, members of the public, police officers and an off-duty doctor. She was assessed as dead at the scene by the doctor. Approximately three hours after Kirsty received her injuries, she was confirmed as dead by a paramedic.

Multiple warning signs about the extremist views and conduct of one attacker were known to a number of his close family members in the months and years before the attack. In the main these were not reported to the authorities.

One of the attackers was a Subject of Interest under active investigation by the Security Service at the time of attack and for around two years before it. He was subject to surveillance in varying degrees but was not the subject of live monitoring in the days immediately before the attack. The other attackers had not been identified before they carried out the attack together.

Determinations Sheet – James McMullan

James McMullan was unlawfully killed.

On 3 June 2017, James McMullan was with a group of friends in the Borough Market area. James left the Barrowboy and Banker public house and went towards Boro Bistro. Three attackers had deliberately driven a Renault van into multiple pedestrians on London Bridge, before crashing it into railings on Borough High Street, next to the Barrowboy and Banker public house. The attackers left the van and immediately began attacking further pedestrians with knives. The attackers then went down a stone stairway towards Boro Bistro. This was all part of a terrorist attack. Around the area at the top of the stone stairway, James was attacked and suffered stab wounds, resulting in rapid blood loss. It is likely that he was attempting to assist a young woman, Sara Zelenak, who had been attacked when he himself was stabbed. He moved from where he was attacked, entering an alleyway at one side of Boro Bistro. This location was out of sight from most of the Boro Bistro courtyard. He collapsed in that alleyway. James later received treatment from police officers. They stayed to treat him regardless of any risk to themselves but they saw no sign of life. He had died very quickly after receiving his injuries, which were not survivable. Police officers carried James to a paramedic, who assessed him as dead.

Multiple warning signs about the extremist views and conduct of one attacker were known to a number of his close family members in the months and years before the attack. In the main these were not reported to the authorities.

One of the attackers was a Subject of Interest under active investigation by the Security Service at the time of attack and for around two years before it. He was subject to surveillance in varying degrees but was not the subject of live monitoring in the days immediately before the attack. The other attackers had not been identified before they carried out the attack together.

Determinations Sheet - Ignacio Echeverría Miralles de Imperial

Ignacio Echeverría Miralles de Imperial was unlawfully killed.

On 3 June 2017, Ignacio had been skateboarding in London with friends. He and his friends had been cycling north up Borough High Street towards the river. Meanwhile, three attackers had deliberately driven a Renault van into multiple pedestrians on London Bridge and into railings on Borough High Street, next to the Barrowboy and Banker public house. The attackers had left the van and had started attacking further pedestrians with knives. This was all part of a terrorist attack. They had entered the courtyard of a restaurant and had assaulted people there, before continuing south on Borough High Street. The attackers set upon a number of members of the public and a uniformed police officer. Ignacio saw this and got off his bicycle, moving forward on foot to confront the attackers. Ignacio used his skateboard as a weapon and endeavoured to protect the victims of the attack, including the police officer who had been stabbed. Ignacio suffered a number of injuries when stabbed with the knives of one or more attackers. During the attack he fell to the ground where the attack continued. He received a stab wound to the upper back, which was the fatal injury. Ignacio rapidly lost consciousness and died within minutes. His injury was not survivable. Ignacio received treatment from his friends, members of the public, and police officers. He was moved to the north side of the Bridge because the area in which he was attacked was unsafe. He was assessed as dead by a doctor at that location.

Multiple warning signs about the extremist views and conduct of one attacker were known to a number of his close family members in the months and years before the attack. In the main these were not reported to the authorities.

One of the attackers was a Subject of Interest under active investigation by the Security Service at the time of attack and for around two years before it. He was subject to surveillance in varying degrees but was not the subject of live monitoring in the days immediately before the attack. The other attackers had not been identified before they carried out the attack together.

Determination Sheet

This is to set out the conclusions of the Jury as to by what means and in what circumstances Khuram Butt came by his death.

Short-form Conclusion: Lawful Killing

Khuram Butt was in the process of attacking Mr Filis in Stoney Street when City of London armed police arrived on the scene. He ran at them armed with a knife, ignoring clear warning shouts. The officers backed off to create a reactionary gap but he continued and was shot by the police officers who feared for their lives.

After falling to the ground, he was covered by City of London and Metropolitan Police officers who saw what they thought was an explosive device on him. While being observed he made significant movement.

Further warnings to remain still were given. He continued moving and the police officers shot him again. This was due to fears that he would detonate the device leading to loss of life.

Determination Sheet

This is to set out the conclusions of the Jury as to by what means and in what circumstances Rachid Redouane came by his death.

Short-form Conclusion: Lawful Killing

Rachid Redouane was in the process of attacking Mr Filis in Stoney Street, when City of London armed police arrived on the scene. He ran at them armed with a knife, ignoring clear warning shouts. The officers backed off to create a reactionary gap but he continued and was shot by the police officers who feared for their lives.

After falling to the ground, he was covered by City of London and Metropolitan Police officers who saw what they believed was an explosive device on him. While being observed he made significant movements.

Further warnings to remain still were given. He continued moving and officers shot him again. This was due to fears that he would detonate the device leading to loss of life.

Determination Sheet

This is to set out the conclusions of the Jury as to by what means and in what circumstances Youssef Zaghba came by his death.

Short-form Conclusion: Lawful Killing

Youssef Zaghba was in the process of attacking Mr Filis in Stoney Street when City of London armed police officers arrived on the scene. He ran at one of the officers armed with a knife, ignoring clear warning shouts.

Youssef Zaghba got within very close range of the officer, causing him to shoot in defence of himself and others. After falling to the ground he was covered by City of London and Metropolitan Police officers who saw what they thought was an explosive device on him. No further significant movement was seen.

INQUESTS ARISING FROM THE DEATHS IN THE LONDON BRIDGE AND BOROUGH MARKET TERROR ATTACK OF 3 JUNE 2017

LIST OF INTERESTED PERSONS

- Family of Christine Archibald
- Family of James McMullan
- Family of Alexandre Pigeard
- Family of Kirsty Boden
- Family of Sébastien Bélanger
- Family of Sara Zelenak
- Family of Xavier Thomas
- Family of Ignacio Echeverría Miralles de Imperial
- Former partner of Rachid Redouane
- Widow of Khuram Butt
- Family of Youssef Zaghba
- Secretary of State for the Home Department
- Commissioner of Police of the Metropolis
- Commissioner for the City of London Police
- British Transport Police
- London Ambulance Service
- London Fire Commissioner
- Independent Office for Police Conduct
- Hertz UK Limited and Probus Insurance Company Europe DAC
- Transport for London
- City of London Corporation
- Barts Health NHS Trust