**IN THE MATTER OF THE INQUESTS
INTO THE DEATHS FOLLOWING
THE TERRORIST ATTACK
AT FISHMONGER'S HALL**

**SUBMISSIONS ON BEHALF OF THE
METROPOLITAN POLICE SERVICE
REGARDING REGULATION 28**

I. INTRODUCTION

1. The Metropolitan Police Service ("MPS") has had the opportunity to review the submissions on Regulation 28 which have been served on behalf of the family of Saskia Jones (dated 29 June 2021), the family of Jack Merritt (dated 30 June 2021), and the IOPC (dated 28 June 2021) ("the submissions").

2. Having reviewed the submissions, there are two areas which touch upon the MPS and Counter-Terrorism Policing Headquarters ("CTPHQ"): i) recommendations related to the management of TACT offenders by police officers in the community; and ii) a recommendation related to guidance on communications between emergency responders.

3. In relation to these, the MPS makes the following submissions:

   i) It is not accepted that these matters of themselves present a risk of deaths occurring. In any event, the matters raised in the submissions have already been addressed by the implementation of Project Semper, as set out in detailed evidence provided to the Inquests. The system of nominal management has been overhauled since November 2019 at such a fundamental level that even if (as is not accepted) it posed a risk of other deaths occurring in future that risk has since passed;

ii) The evidence which was heard in the Inquests does not support the criticisms of the emergency response which are set out in the submissions of the representatives for the family of Saskia Jones, including in relation to communications between first responders. There was no evidence of delay in bringing trained medics into Fishmongers' Hall or of any adverse consequences from the timing of the communications between first responders, nor were there any criticisms of the formal guidance governing such matters, which was raised in evidence in the course of the hearings. In those circumstances, the test for imposing a recommendation to prevent future deaths is not met.

4. The MPS makes no representations in relation to the other recommendations set out in the submissions.

II. LAW AND PROCEDURE

5. The Coroner is required to make a report on the Prevention of Future Deaths ("a PFD report") only where the following criteria are met:

> "7. (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."[1]

6. Before making a PFD report, the Coroner must find, based on all of the available material, that there is a concern that "circumstances creating a risk of other deaths will occur, or will continue to exist, in the future" and must be satisfied that preventative action is required to address that risk.

[1] Paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 ("the 2009 Act").

7. It is open to a Coroner to decide not to make a PFD report on the basis that, although the evidence has revealed the existence of a concern falling within paragraph 7(1)(b), the Coroner is not satisfied that action should be taken in order to address that concern. This will often be because the Coroner is satisfied that action has already been taken to address the concern or that he considers that the information available to him is insufficient to enable him to reach an adequately informed judgment that further action is required.

8. The Chief Coroner's Guidance No.5, at paragraph 4, identifies the need for PFD reports to be "clear, brief, focused, meaningful and, wherever possible, designed to have practical effect."

9. The above is of obvious application in a case where substantial steps have already been taken to address areas of concern raised at the inquests. It is also of relevance in areas where concerns are raised which relate to matters of professional judgment which require specialist knowledge (for example matters relating to policy, tactics and specialist police operations). It should also be noted that the report is ancillary to the inquest and should not prescribe solutions, but only raise concerns.[2]

III. THE MANAGEMENT OF TACT OFFENDERS IN THE COMMUNITY

10. The submissions contain recommendations related to the management of TACT offenders by police officers in the community, including the need for specialist nominal managers and recommendations regarding liaison between CT officers and MAPPA.

11. We would urge the Coroner to avoid making recommendations of the prescriptive type suggested by the representatives of the family of Saskia Jones, which seek to dictate how agencies participating in MAPPA meetings must make certain decisions in relation to TACT offenders. For example, it would not be within the statutory bounds of a PFD report recommendation to impose a mandatory requirement for the police to obtain approval from MAPPA before varying visits with TACT offenders, nor would such a

[2] Chief Coroner's Guidance No. 5 at paragraph 27.

proposal be practicable. This is particularly the case where the circumstances in which that issue arose no longer exist because of fundamental and systemic changes to the management of TACT offenders in the community.

12. The steps which have been taken by CTPHQ following the attack on 29 November 2019 to improve the system for managing TACT offenders in the community were described in the evidence of ACC Ward as part of "Project Semper"[3] and have been set out in detail in the statement of ACC Jacques, dated 16 March 2021.[4] In addition, a number of relevant documents were served on the Inquest Team as exhibits to the statement of ACC Jacques.[5]

13. As the Coroner is aware, some recommendations for organisational learning were set out in the report of the IOPC regarding Operation Aragon.[6] Project Semper was implemented with the benefit of the final Operation Aragon report and, as set out at paragraph 35 of the statement of ACC Jacques, its recommendations were incorporated into Project Semper. An update on the implementation of each of the relevant recommendations was provided by AC Basu by letter dated 22 January 2021.[7]

14. Through the evidence of ACC Ward, the statement of ACC Jacques and the letter of AC Basu, detailed information has been provided to the Inquest about steps which have been taken to improve nominal management and address concerns arising from the evidence regarding the management of the individual responsible for the attack at Fishmongers' Hall on 29 November 2019.

15. Representatives for the family of Saskia Jones submitted Recommendation 19 (at paragraph 45), that "*police management of TACT offenders should only be undertaken by adequately trained and supported CT specialists and not Prevent officers*". The inclusion of this recommendation in a PFD Report would be unnecessary, as this issue has been fully addressed by the implementation of Project Semper.

[3] Transcript for 21/05/2021, Page 34/1.
[4] WS5074.
[5] See DC7594; DC7595; DC7596.
[6] DC7444.
[7] DC7592. It is noted that the contents of this document were referred to in evidence on 12/05/2021 (Transcript for 12/05/2021 at Page 41/13).

16. The reasons given for this recommendation (at paragraph 45) were that the authors lacked clarity on the current system and its arrangements:

> *"While it is understood that Prevent no longer manage TACT offenders in the wider West Midlands region, and there is now some training being rolled out in relation to Part 4 management, it is unclear what the new system is, and whether the management of TACT offenders in all areas of the country shall in future only be undertaken by adequately trained and supported CTU specialists."*

17. The MPS can confirm that, as set out in the witness statement of ACC Jacques[8] and the evidence of ACC Ward[9], following the implementation of Project Semper, TACT offenders in each region will be managed by trained Police Nominal Managers, or "PNMs", supported by Lead Responsible Officers and a governance framework created under Nominal Management as a new designated CT capability.

18. As the Chief Coroner's Guidance No. 5 states (at paragraph 4), a PFD report should be "designed to have practical effect". If the Coroner were to make a recommendation which has already been addressed by the implementation of Project Semper, it would have no practical effect.

19. The steps taken to address concerns regarding nominal management have not been partial or temporary. Instead, there has been a comprehensive overhaul of the system of nominal management of TACT offenders. This overhaul means that at present there is no risk of the circumstances described in the submissions creating a risk of other deaths in future, and as a result the threshold for making a PFD report has not been met.

IV. THE EMERGENCY RESPONSE

20. The representatives of the family of Saskia Jones stated at Section D of their submissions dated 29 June 2021 that there may be a need for "structured systems and guidance" relating to communications between emergency responders during "major incidents". In this case of course the major incident in question was a marauding

[8] WS5074, Paragraph 29.
[9] Transcript for 21/05/2021, Page 36/2.

terrorist attack. As the Coroner will be well aware the response to such an attack is structured and has joint operating at its core.

21. A comprehensive and fully functional system already exists; it has been referred to during the inquests as "Operation Plato". The relevant guidance is the Joint Operating Principles for the Emergency Service for Responding to a Marauding Terrorist Attack, which was disclosed to the Inquest and referred to in evidence ("the JESIP guidance").[10] The JESIP guidance addresses in detail the means of communication between emergency responders in the event of an MTA. The JOPS are under constant review and are currently in their sixth iteration (MTA JOP2) (the previous four JOPS were the MT**F**A JOPS 1-4).

22. Care should be taken to avoid the making of recommendations which could have far-reaching implications for the execution of an emergency response by the police, the LAS and the LFB in the absence of affected parties, without evidence of identifiable failings in this particular incident and without broader evidence as to the application of the guidance in other MTA scenarios. Operation Plato and the associated guidance has already been the subject of extensive expert analysis and review, including in previous inquests and inquiries. In particular the coroner noted during the London Bridge prevention of future deaths report dated 01.11.19:

> *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.*

23. At no stage during these inquests was any criticism made of Operation Plato or the JESIP guidance by any party. It was not the subject of any adverse questioning and the witness with expertise in emergency response and the application of Operation Plato, Superintendent Philip Ryan, was dispensed with by the agreement of all parties. The evidence of Inspector Settle that there has been an effective PLATO response was not challenged. No suggestion has been made that the Operation Plato framework was anything other than suitable and effective on the day of the attack.

[10] DC6162; referred to in the Transcript for 15/04/2021 at Page 127/5.

24. There was no delay in bringing the medical responders forward. In accordance with the JESIP guidance (as revised following the Regulation 28 recommendations in the Inquests arising from the deaths in the London Bridge and Borough Market attacks of 3 June 2017) the commanding officers on scene and in the control room did not wait until the scene was cold, but called medical responders forward into the warm zone as soon as the explosives dog had screened the IED and given no indication. The police commander did not wait for a LAS commander to arrive at the forward command post but (as envisaged under JOPS) took the lead in deploying LAS into the warm zone.

25. It was not suggested to any witness during the inquest proceedings that there was any delay, or that medical personnel could have been brought forward at an earlier stage. The overwhelming evidence was that medical personnel were brought forward at the first opportunity and at an earlier stage than in any previous MTA. According to the evidence of Dr Milne, this was the first occasion when HEMS personnel were deployed into a warm zone.[11]

26. The explosives dog gave "no indication" that explosives had been detected at approximately 14:18:50.[12] As stated in the evidence of Inspector Settle, this did not mean that no explosives were in fact present. His evidence was that, "balancing the need to save life with the need to protect responders, [Inspector Settle] and Inspector Atkins concluded, once the dog had given no indication, then you could justify sending paramedics forward in order to save life in Fishmongers'".[13]

27. Inspector Atkins made the warm zone declaration at 14:19:08 and it was confirmed by the GATFC Inspector Settle at 14:19:25. The first request was made by officers to the paramedics to come forward at 14:19:09, before the warm zone declaration was confirmed.[14] By 14:19:38 officers were in conversation with the paramedics, briefing them, formulating a plan to extricate the casualties and assisting in carrying their first aid equipment.[15] The first police medic entered the Hall at 14:19:39, just 14 seconds

[11] Transcript for 15/04/2021 at Page 67/2.
[12] DC6495.
[13] Transcript for 15/04/2021 at Page 130/18.
[14] DC6498.
[15] Ibid.

after the warm zone declaration was confirmed.[16] The paramedics and accompanying officers were visible on camera running towards the Hall from the RVP by 14:20:40.[17] By virtue of the plan and presence of armed officers no unarmed responders were put at risk. It should also be noted that excellent first aid was provided by police officers inside the hall whilst it was still a hot zone.

28. It was not suggested at any stage during the inquests that the medical responders could or should have been brought forward to the entrance of Fishmongers Hall before the I.E.D. had been screened by explosives dogs. As stated by Inspector Settle in his evidence, the entrance of the Hall was within approximately 50m of the I.E.D. and well within the cordon distance of 100m, such that after the attacker was neutralised the area remained a hot zone. It would not have been appropriate to deploy medical responders into a hot zone either when shots were being fired or when the IED still posed a real and immediate threat to life. This principle was not questioned or challenged in the inquests.[18]

29. Professor Deakin reviewed the relevant documentation and footage and concluded that the care provided by first responders did not contribute to the deaths of Saskia Jones and Jack Merritt, which were, tragically, unsurvivable. He did not make a finding that there was any delay in the attendance of medical personnel. In his evidence to the Inquest he went further, praising the actions of all involved in the provision of medical care:

> *"I would just like to take this opportunity to say that having watched the medical care from both the bystanders, so those people at the conference, and also the police who responded, it was absolutely outstanding. I was very impressed by the standard of care that was given in terms of the first aid. It's difficult to do it anyway, but in those difficult and harrowing circumstances, it's even more of a challenge, and I thought without exception, every single individual who delivered first aid care did an absolutely superb job and everything they possibly could have done under the circumstances."*[19]

[16] DC6495.
[17] DC7421 at 28.0.
[18] Transcript for 15/04/2021 at Page 129/12.
[19] Transcript for 28/04/2021, Page 87/24.

30. Similarly, in his closing remarks, the Coroner commented on the quality of the first aid provided and the speed of the emergency response:

> *"As we heard, the standard of first aid provided could not be faulted. The police responded to the emergency with speed, and the firearms officers who have given evidence in the most recent inquest hearings dealt with Khan at close quarters when most or all thought they may be dealing with a viable IED. They each acted with commendable bravery. Lives were saved as well as lost in this terrible attack."*[20]

31. In light of the above, it is submitted that the evidence does not support the proposed recommendation, nor does the conduct of the emergency response disclose "circumstances creating a risk of other deaths". The existing Operation Plato framework in relation to communications between first responders is clear and effective and has not been subject to criticism in these inquests. To make recommendations for change based upon the evidence that has been heard would be unjustified and could risk interfering with a system that as set out above saved lies in this terrible attack.

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[20] Transcript for 10/06/2021, Page 119/9.