UNDER THE **Inquiries Act 2013**

IN THE MATTER OF **a Government Inquiry into Operation Burnham and related matters**

MEMORANDUM OF COUNSEL IN REPLY FOR FORMER RESIDENTS OF KHAK KHUDAY DAD AND NAIK

Dated 30 November 2018

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1 This memorandum is filed further to the hearing of 21-22 November 2018 and the Inquiry's direction that submissions in reply were to be made by way of memoranda. A further memorandum is to be filed in response to the Crown memorandum of 23 November 2018. This memorandum should be read in conjunction with counsel's memorandum of 19 November 2018 and the submissions made at the hearing and will not traverse the ground covered therein. Rather, this memorandum is intended simply to address certain discrete matters arising at the hearing.

2 During the course of the hearing, it was indicated that the Inquiry was or would be conducting its own public source research, similar to that undertaken by Mr Hager. Counsel request further information regarding this work, including whether this work is being undertaken by the Inquiry, research staff, or by Mr Keith, as we are aware this is a significant and time-consuming task. It is for this reason also that counsel wish to be provided a list of documents held by the Inquiry, as this would enable us and other core participants to assist with this process.

3 Furthermore, in relation to the draft protocol relating to the classification review process, counsel are grateful for the opportunity to review the protocol. Without wishing to repeat matters discussed at length at the hearing, it is simply noted here that further to the matters raised in our memorandum of 8 November 2018, our primary concerns are:

3.1 The resourcing and timeframes available to Mr Keith to enable him to perform his role in a manner which is both efficient and timely on the one hand, but also effective and thorough on the other;

3.2 The lack of involvement of non-Crown core participants in the review process. It is submitted that for reasons of natural justice and given the central importance of Mr Keith's role, it is necessary that core participants be given the opportunity to make submissions as of right in the course of his review (facilitated by practical measures such as the provision of summaries or redacted versions of documents).

4 In the course of submissions, the Crown contended that the natural justice obligation on the Inquiry is to viewed narrowly and read down by the terms of s 14(3). Respectfully, this is not accepted. It is submitted that the overall content of the natural justice obligation is not diminished by s 14. Section 14 does not define natural justice; rather, the section provides guidance on a particular aspect of the obligation, and must be read alongside general principles of natural justice and the right to make submissions under s 17(3). In the absence of express words to the contrary, the Inquiry should be wary of drawing a narrow interpretation of natural justice under the Act. Thus, it follows that where the right to natural justice requires provision of summaries, redacted material, or material in full, provision of such information should not be subject to a further assessment of whether it is 'feasible or appropriate'. In this respect, counsel concur with Mr Ringwood's observation that the need to avoid *unnecessary* cost under s 14(2)(b) ought not to be seen to apply to costs that are necessary for the Inquiry to fulfil its function, including compliance with natural and open justice.

5 Counsel concur with Counsel Assisting's suggestion that the Inquiry could consider addressing the issues in the Terms of Reference in modules, with procedure being considered in relation to each module (such as disclosure). It is expected that this will assist counsel in creating a tailored, practical approach to issues of confidentiality and classification.

6 It is noted that Lady Hallett's concluding remarks at the West London Bombing Inquest were referred to in submissions, but a copy was not included in the bundle provided to the Inquiry. A copy has been annexed to this memorandum. The Inquiry's attention is drawn in particular to Lady Hallett's remarks regarding the impact of full cooperation by counsel on the inquest's ability to perform its role with full public scrutiny:

> Although it was necessary to hold some closed procedural hearings, during which intense time and effort was devoted by my team (in particular Mr Andrew O'Connor) the Security Service and the police to ensuring that as much relevant information as possible was put into the public domain, I am happy to report that they were very few. I should emphasise that these hearings were procedural only. I did not hear or consider evidence as such in the course of them. Instead, the Security Service and the police put before me material that was relevant to the issues, but which they reasonably believed could not be disclosed in an unredacted form without threatening national security. The system did in fact work well. I can confirm that a careful process was undertaken to ensure that open summaries of the relevant content of this material were prepared that were as full as possible,

> consistent with the interests of national security. This process was completed to my satisfaction. The resulting public gists were detailed and, together with the disclosed documentation and the lengthy oral evidence, this material allowed the most intense public scrutiny of the relevant issues.
>
> I know that the extremely tight timetable I set was meant that an enormous number of people from the various organisations represented before me, such as witnesses, support staff and inhouse lawyers have dedicated significant time and resources to assisting this process. I was promised the fullest cooperation by everyone and that is what I have received. I doubt that many lawyers will have been involved in such a consistently harrowing and difficult case. The legal teams before me instructed by the families and the organisations have read and considered huge quantities of documentation. Much of this was produced for us by the police and the Security Service, but also a considerable quantity was generated specifically for these proceedings. It was then disclosed by me following a lengthy exercise of collation and analysis by my legal team. Many of the lawyers have given up holidays and precious family time. I am very grateful to them for their industry, their representation, and for their care in ensuring that their questioning and submissions focused on the central and essential issues.

7 Reference was made during the course of the Inquiry to other inquiries which proceeded on a largely closed basis, including the Gaza Flotilla Inquiry. It is noted, however, that the terms of reference for the Gaza Inquiry were different in significant ways from the present Inquiry, in that the Gaza Inquiry proceeded largely on papers, based upon reports from national authorities.[1] This Inquiry, on the other hand, is tasked with conducting that initial fact-finding exercise.

8 Finally, one further point may be made with regards to timetabling. Counsel welcome the Inquiry's orders and directions with respect to timetabling in Minute 6. It is noted that for non-Crown core participants, funding is presently contingent on timetabling, as it must be requested in advance based upon estimates of the work required to proceed to the next event. For that reason, clear timetabling is essential to enable and support the involvement of non-Crown core participants in this Inquiry. For convenience, Counsel have attached to this memorandum an updated list of requested orders, rulings and directions.

Dated this 30th day of November 2018

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R E Harrison QC / D A Manning
Counsel for the Villagers

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[1] Report of the Secretary-General's Panel of Inquiry on the 31 May 2010 Flotilla Incident (July 2011) at 7.

ORDERS SOUGHTS

1 Further to the orders and directions made in Minute No 6 of the Inquiry, counsel seek from the Inquiry the following rulings, orders or directions:

1.1 That a primary purpose or function of this Inquiry is to satisfy the investigative obligation of the right to life in relation to the six individuals who lost their lives in Operation Burnham, and by analogy in relation to the further fifteen individuals who were injured,[2] and that the *Jordan* principles outlined above are therefore applicable;

1.2 That as of right, our clients are entitled to all information relating to the right to life, and that at a minimum this will require all information relevant to this issue including;

1.2.1 Lists of all material before the Inquiry.

1.2.2 Participation as of right in the classification review process, including the right to make submissions to Mr Keith;

1.2.3 Provision of redacted or bowdlerised[3] copies of material and summaries, pending the outcome of the classification review process.

1.3 That the Inquiry may not conduct a closed material procedure which has the effect of excluding core participants and their counsel from proceedings;

1.4 That the effect of s 15(1)(b) of the Inquiries Act is that restricting public access does not restrict the access of core participants.

1.5 That the effect of s 15(1)(c) of the Inquiries Act is not to exclude core participants from hearings held in private;

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2 *Shortland v Northland Health Ltd* [1998] 1 NZLR 433 at 444–5; *Seales v Attorney-General* [2015] 3 NZLR 556 at [164].

3 *Zaoui v Attorney-General (No 2)* [2005] 1 NZLR 690 at [74].

1.6 That a working List of Issues is to be adopted, to be subject to revision through the course of the Inquiry;

1.7 That discovery should be ordered and prioritised in certain respects, namely:

1.7.1 Lists of all open and classified and confidential material held by NZDF, MFAT, DPMC, GCSB and NZSIS and provided to the Inquiry as of 28 February 2019 are to be provided to all core participants, subject to such redactions as are necessary for the time being to maintain confidentiality or classification until such time as these issues have been resolved but including information such as title, category, format, date, author, and size, with appropriate listing protocol;

1.7.2 Prioritised discovery in relation to the right to life obligation in the course of the classification review process, encompassing all information relating to the six individuals identified above who are alleged to have lost their lives, and pertaining to the circumstances of their deaths, and by analogy in relation to the further fifteen individuals who were injured;

1.7.3 Core participants are to be able to nominate documents from the list of documents to have priority in the declassification process.

1.7.4 In relation to the above, we request as a top priority the rules of engagement and aide-memoires (including, for example, guidance cards issued to NZDF personnel), the International Security Assistance Force Investigation and the video footage of the Operations.

1.8 That the non-NZDF core participants be permitted to propose formal written questions of the NZDF and other Government agencies for the purposes of the Inquiry. Such questions are to be responded to promptly, subject to any contrary direction by the Inquiry.

1.9 That adequate discovery (including declassification of documents) and interrogatories will be completed and sufficient time allowed to analyse the results before beginning any hearings.

1.10 That the lists of witnesses provided to the Inquiry by the NZDF pursuant to para 12 of Minute 6 are to be provided on a confidential basis to other core participants.

1.11 That all material provided to the Inquiry by Crown Agencies pursuant to paras 10, 15, 17, 18, and 19 are to be filed with an accompanying unclassified memorandum, advising to the greatest degree possible what has been filed (including, for example, a list of documents with name, size, date and author for each, subject to such redactions as necessary).

1.12 That the Crown Agencies are to provide to the Inquiry and to core participants copies of correspondence with NATO, the United States and any other international partners regarding their efforts to obtain and secure the release of material relating to Operation Burnham.

1.13 That the Crown Agencies and/or NATO and the United States are to further clarify:

1.13.1 whether the information to be disclosed to the Inquiry may also be disclosed to non-Crown core participants;

1.13.2 whether such a request has been made;

1.13.3 if such a request has not been made, that this is to be requested by MFAT and also by the Inquiry. Counsel further request to be provided with a copy of any such correspondence or request.

Hearing transcripts

6 May 2011

1 Friday, 6 May 2011
2 (10.00 am)
3 Concluding remarks
4 LADY JUSTICE HALLETT: I should like to begin by thanking
5 those involved in these proceedings. The list is a long
6 one.
7 First, I should like to thank the bereaved families
8 who lost their loved ones on 7 July 2005 for their
9 understanding, for their support and their quiet
10 dignity. They have waited for nearly six years for
11 these proceedings to reach this stage. Despite their
12 obvious grief, they have maintained their sense of
13 fairness and moderation. They want to find out what
14 happened, how their loved ones died, and whether the 52
15 deaths could have been prevented, but they do not
16 necessarily seek to cast blame.
17 When we began this process, there were reservations
18 in a number of quarters about the need to resume the
19 inquests into the deaths of the 52 people murdered in
20 London on 7 July 2005. However, these proceedings have
21 gone much further than simply recording the sad fact
22 that 52 innocent members of the travelling public were
23 unlawfully killed in a dreadful act of terrorism. We
24 have explored in detail the circumstances of the deaths
25 of each of the 52 individuals and the adequacy of the

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1 emergency response. We have examined the background of
2 Mohammed Sidique Khan, Shehzad Tanweer, Hasib Hussain
3 and Jermaine Lindsay, the extent to which any of them
4 had previously come to the attention of the authorities
5 and how they were assessed by the Security Service. We
6 have unearthed material which has never previously seen
7 the light of day. We have caused organisations to
8 reassess their own systems and to acknowledge that,
9 despite improvements already made, more may be possible.
10 As a result, I have been able to reach certain
11 conclusions on the performance before 7/7 and on 7/7 of
12 the various organisations represented before me. I feel
13 able to make recommendations which the families hope
14 will result in improvements to the benefit of the public
15 generally, improvements which may save lives.
16 The bereaved families have had most of their
17 questions answered. Mr Neil Saunders, on behalf of the
18 represented bereaved families, was kind enough to
19 acknowledge that they feel the inquests have been as
20 thorough as they could legitimately have expected. Even
21 if a particular family member disagrees with any of my
22 conclusions, they have each had the opportunity to see
23 the material for themselves and to have the evidence
24 tested, wherever they lived. The material which formed
25 the basis of the questioning and a transcript of the

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1 days' proceedings was published on the website each day.
2 Families across the world affected by the London
3 bombings were, at the very least, entitled to that. The
4 same goes for the survivors, who are the next group of
5 people I wish to thank.
6 During the course of hearing evidence I ran out of
7 superlatives in describing the courage and heroism of
8 many of the surviving passengers on the Tubes and the
9 bus, and others who went to assist: from the desperately
10 injured who fought with death, to the passengers on the
11 bombed trains or passing trains, who, giving no thought
12 to their own safety, went to the aid of the dead and
13 injured. Members of the public played a huge part in
14 the rescue mission. Whilst I have had the opportunity
15 to express my gratitude to those from whom I have heard
16 evidence, I would also like to express my thanks to all
17 those from whom I have not heard for all their efforts
18 on that day.
19 There was a time when some of those who survived
20 wanted a public inquiry into what happened. These are
21 inquests governed by coronial law and, as such, they are
22 very different by their nature from a public inquiry.
23 However, throughout these proceedings, I made it plain
24 that I was happy to receive suggestions for possible
25 lines of enquiry from the survivors and from members of

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1 the public generally. I have considered carefully every
2 message received. I hope and believe the survivors have
3 not felt left out of the process.
4 I am not aware of our having left any reasonable
5 stone unturned. One would hope, therefore, that these

6 proceedings will be an end to the investigation of what
7 happened on 7/7. Many of the witnesses dreaded giving
8 evidence before me. A large number are still suffering
9 from post-traumatic stress and reliving the events of
10 7/7 was the last thing they needed. I wish to thank all
11 those who were prepared to put their own suffering to
12 one side to help me and the bereaved families.
13 In that category, I include those who went to the
14 scene as part of the rescue missions. These included
15 members of the public, doctors and staff from the
16 British Medical Association, members of
17 London Underground staff, officers from the British
18 Transport Police, the Metropolitan Police Service and
19 the City of London Police, members of the London Fire
20 Brigade, the London Ambulance Service and volunteers
21 from London's Air Ambulance, otherwise known as HEMS.
22 I have seen the unedited photographs of each scene, yet
23 I still cannot imagine the full extent of the horror
24 that greeted them on that day.
25 For those tasked with investigating the scene, the

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1 horror continued for many long, physically draining
2 days. I would like to thank the original investigators,
3 those who assisted me in my investigation and the
4 experts and the scientists who went out of their way to
5 provide the best possible analysis of the forensic
6 evidence. I am also indebted to the Ministry of Defence
7 who decided to devote considerable and hard pressed
8 resources to helping us. If the work of the experts
9 under Colonel Mahoney's "command" for us may in the
10 future contribute to the saving of lives in the
11 military, the families will feel something especially
12 positive has come out of this process.
13 I should mention again the Metropolitan Police
14 Service because it occupies a unique position in that it
15 performs a number of overlapping functions. Not only
16 were its officers among the first responders, the
17 Metropolitan Police was responsible for the
18 investigation into the bombings, known as
19 Operation Theseus, as a result of which it holds more
20 than 30,000 statements and 40,000 exhibits on its HOLMES
21 database. We have drawn considerably upon that
22 material, supplementing it where necessary. The
23 Metropolitan Police also acts as my Coroner's Officers
24 (in what they have called "Operation Ramus"). The
25 Operation Ramus team consisted of over 30

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1 Metropolitan Police officers and staff.
2 I am greatly indebted to that team and Chief
3 Superintendent McKenna in particular for their
4 dedication and industry in assisting in the collation
5 and preparation of this material for the inquests. They
6 have been inundated by our requests for further
7 information and documents, to which they have responded
8 with commendable efficiency.
9 Similarly, I have made huge demands upon the other
10 police forces involved and also upon the
11 Security Service. I am acutely conscious that I have
12 taken men and women who perform the vital function of
13 protecting the public from their normal duties. I truly
14 hope that the impact upon their respective services has
15 not been too great and that there is now a general
16 acceptance of the importance of the process to the
17 bereaved and to the families and to the public.
18 To my mind, the concerns that I would not be able to
19 conduct a thorough and fair investigation into the
20 security issues in wholly open evidential proceedings
21 have proved unfounded.
22 Although it was necessary to hold some closed
23 procedural hearings, during which intense time and
24 effort was devoted by my team (in particular
25 Mr Andrew O'Connor) the Security Service and the police

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1 to ensuring that as much relevant information as
2 possible was put into the public domain, I am happy to
3 report that they were very few. I should emphasise that
4 these hearings were procedural only. I did not hear or
5 consider evidence as such in the course of them.
6 Instead, the Security Service and the police put before
7 me material that was relevant to the issues, but which
8 they reasonably believed could not be disclosed in an
9 unredacted form without threatening national security.
10 The system did in fact work well. I can confirm
11 that a careful process was undertaken to ensure that
12 open summaries of the relevant content of this material
13 were prepared that were as full as possible, consistent
14 with the interests of national security. This process

was completed to my satisfaction. The resulting public gists were detailed and, together with the disclosed documentation and the lengthy oral evidence, this material allowed the most intense public scrutiny of the relevant issues.
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everyone and that is what I have received.
I doubt that many lawyers will have been involved in such a consistently harrowing and difficult case. The legal teams before me instructed by the families and the organisations have read and considered huge quantities of documentation. Much of this was produced for us by the police and the Security Service, but also a considerable quantity was generated specifically for these proceedings. It was then disclosed by me following a lengthy exercise of collation and analysis by my legal team. Many of the lawyers have given up holidays and precious family time. I am very grateful to them for their industry, their representation, and for their care in ensuring that their questioning and submissions focused on the central and essential issues.
Over 300 witnesses have been called; the statements of about 200 witnesses have been read. We have managed to adhere to our timetable, to the very day and very hour set. We have conducted the most thorough and complex review into the deaths of 52 people and we have completed the process significantly under budget without anyone claiming they have not had a proper opportunity to be heard. This is a huge tribute to the skills and industry of the inestimable Inquest team and I am extremely grateful to them. I mention just six, the six

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upon whom the greatest burdens fell for the greatest length of time: Hugo Keith QC, Andrew O'Connor, Benjamin Hay, Martin Smith, Tim Suter and Judy Anckorn.
At the beginning of the process, I decided upon a lengthy list of relevant issues to be explored during the inquests, contained in a document headed "Provisional Index of Factual Issues". Many of them no longer remain an issue because they have fallen away as the evidence has been heard. It should not be thought that because I make no mention of an issue, it was unimportant. It simply means that, having conducted a full, fair and effective enquiry, questions have been answered in such a way that the issue need play no part in my verdicts or in my rule 43 report.
It is important to record what my powers are before I deliver my verdicts. It would not be appropriate for me to write a full judgment or report of the kind I would produce if sitting as a judge in the Court of Appeal or chairing a public inquiry. I am limited to recording verdicts and submitting a rule 43 report where I consider it appropriate. If, therefore, anyone is expecting a summary of all the evidence, the issues and my conclusions upon them, they are mistaken. However, as I have made clear, I believe that although the format may not be the same as a judgment or a report, the

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cumulative effect of the hearings themselves, the verdicts and the rule 43 reports will be in essence what the bereaved and the survivors would have required of a public inquiry.
Section 11(5) of the Coroners Act 1988 requires that:
"An inquisition - shall be in writing under the hand of the coroner ... shall set out, so far as such particulars have been proved - who the deceased was; and how, when and where the deceased came by his death."
Rule 36 of the Coroners Rules 1984 echoes that provision in describing the functions of an inquest. However, it adds, rule 36(2):
"Neither the coroner, nor the jury, shall express any opinion on any other matters."
Rule 42 provides:
"No verdict shall be framed in such a way as to appear to determine any question of:
"(a) criminal liability on the part of a named person; or
"(b) civil liability."
Last year, I ruled that these would be "Jamieson" type inquests following the judgment of

24 Sir Thomas Bingham, Master of the Rolls, in R v North
25 Humberside Coroner, ex parte Jamieson [1995] QB 1.

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1 However, as Mr James Eadie QC observed during closing
2 submissions, there were times when the casual observer
3 would have been hard pressed to tell the difference
4 between these inquests and a wider ranging article 2
5 "Middleton" type inquest following (R (Middleton) v West
6 Somerset Coroner [2004] 2 Appeal Cases, 182). My
7 decision, however, does impact upon the content of the
8 verdicts.
9 It now appears to be common ground that there are
10 very real constraints upon me in completing the
11 inquisitions. These were explained by
12 Sir Thomas Bingham in Jamieson. He used the words
13 "a brief, neutral, factual statement" to describe the
14 permissible content of a verdict which does not offend
15 the Coroners Rules 1984 in non-article 2 inquests. He
16 gave three examples.
17 "The deceased was drowned when his sailing dinghy
18 capsized in heavy seas."
19 "The deceased was killed when his car was run down
20 by an express train on a level crossing."
21 "The deceased died from crush injuries sustained
22 when the gates were opened at Hillsborough Stadium."
23 Plainly he meant brief, neutral and factual and not,
24 as Mr Patrick O'Connor QC appeared at one time to argue,
25 lengthy and contentious. Such a verdict would plainly

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1 offend rules 36, 42 and the principles governing
2 non-article 2 inquests, unless, of course, the evidence
3 permitted a proper conclusion that failings of some
4 description played a causative part in the death.
5 However, it is also now common ground that the
6 evidence I have heard does not justify the conclusion
7 that any failings on the part of any organisation or
8 individual caused or contributed to any of the deaths.
9 In this regard, I will turn in a moment to address the
10 issue of survivability. All agree that concerns about
11 what happened before 7/7 or on the day cannot properly
12 and lawfully be reflected in the verdicts. That does
13 not mean, of course, that legitimate concerns which give
14 rise to possible risk to life in the future cannot be
15 reflected in a rule 43 report, to which I shall also
16 return.
17 With the considerable assistance of my legal team,
18 I have prepared, and I alone have reached verdicts of
19 unlawful killing on the 52 innocent people killed by the
20 four bombs. I shall now ask Mr Hugo Keith QC to read
21 out each of the names of the deceased.
22 MR KEITH: James Adams, Samantha Badham, Lee Baisden,
23 Philip Beer, Anna Brandt, Michael Brewster,
24 Ciaran Cassidy, Rachelle Chung For Yuen,
25 Benedetta Ciaccia, Elizabeth Daplyn, Jonathan Downey,

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1 Richard Ellery, Anthony Fatayi-Williams, David Foulkes,
2 Arthur Frederick, Karolina Gluck, Jamie Gordon,
3 Richard Gray, Gamze Gunoral, Lee Harris, Giles Hart,
4 Marie Hartley, Miriam Hyman, Ojara Ikeagwu,
5 Shahara Islam, Neetu Jain, Emily Jenkins,
6 Adrian Johnson, Helen Jones, Susan Levy, Sam Ly,
7 Shelley Mather, Michael Matsushita, James Mayes,
8 Anne Moffat, Colin Morley, Behnaz Mozakka,
9 Jennifer Nicholson, Mihaela Otto, Shyanu Parathasangary,
10 Anat Rosenberg, Philip Russell, Atique Sharifi,
11 Ihab Slimane, Christian Small, Fiona Stevenson,
12 Monika Suchocka, Carrie Taylor, Mala Trivedi,
13 Laura Webb, William Wise, Gladys Wundowa.
14 LADY JUSTICE HALLETT: Thank you. I have attached the
15 inquisition forms to this ruling and I hand them down
16 today. I do not intend to distress the families
17 unnecessarily by reading out each one individually.
18 Some, I know, will find I have been forced to include
19 detail that they had hoped could be avoided. Some will
20 find I have not included as much detail as they would
21 have wished. I hope they understand that much as my
22 Inquest team and I have borne the wishes of the families
23 in mind at every stage of the proceedings, when it comes
24 to formal matters such as the recording of the verdicts,
25 I am subject to the constraints imposed by the rules on

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1 a Jamieson verdict and I am obliged to provide some
2 degree of neutral specificity as to the circumstances of
3 death.
4 Rule 43. Rule 43(1) of the Coroners Rules 1984 as

5 amended by the Coroners (Amendment) Rules 2008 provides
6 as follows:
7 "Where:
8 "(a) a coroner is holding an inquest into a person's
9 death;
10 "(b) the evidence gives rise to a concern that
11 circumstances creating a risk of other deaths will occur
12 or will continue to exist in the future; and
13 "(c) in the coroner's opinion, action should be
14 taken to prevent the occurrence or continuation of such
15 circumstances, or to eliminate or reduce the risk of
16 death created by such circumstances.
17 "The coroner may report the circumstances to
18 a person who the coroner believes may have power to take
19 such action."
20 I heard submissions, both as to the scope of my
21 power under rule 43, and as to the approach that
22 I should adopt as to the exercise of that power in the
23 particular circumstances of these inquests. In the
24 light of those submissions, I make the following
25 preliminary observations, which are largely, if not

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1 entirely, the subject of consensus between the
2 interested persons.
3 The effect of the amendment to rule 43 in 2008 was
4 significantly to enlarge its scope. Whereas previously
5 the power could only be exercised with a view to
6 preventing similar deaths to those under investigation
7 at the inquest, a report can now be made relating to any
8 risk of further deaths, whether or not similar to the
9 deaths under investigation.
10 One consequence of this broadening of the scope of
11 the rule 43 power is that there is now a significant
12 distinction between the circumstances in which a coroner
13 is required to summon a jury under section 8(3)(d) of
14 the Coroners Act 1988 (which remain narrowly focused on
15 concerns relating to future similar deaths) and
16 circumstances justifying a report under rule 43. For
17 the record, whilst I have concluded, as set out below,
18 that there are a number of matters that justify the
19 making of a report under rule 43, I do not consider that
20 the conclusions I have reached on these matters are such
21 as to engage the mandatory requirement in
22 section 8(3)(d) to summon a jury.
23 I was addressed in some detail on the wording of
24 rule 43 and the criteria for exercising the power to
25 make a report. There are four features worthy of note.

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1 First, the condition for the exercise of the power
2 is that the coroner has a concern as to circumstances
3 creating a risk to life. This is a relatively low
4 threshold. The rule does not require, for example, that
5 I have concluded or am satisfied that such circumstances
6 exist. Second, the substance of the concern must be
7 circumstances creating a risk to life, but those
8 circumstances need not already exist at the time of the
9 decision to make a report. The concern must be of
10 a risk to life caused by present or future
11 circumstances. Third, the concern must be based on
12 evidence. Fourth, the coroner must be of the opinion
13 that action should be taken to respond to the concern as
14 to risk to life. However, it is neither necessary, for
15 appropriate, for a coroner making a report under rule 43
16 to identify the necessary remedial action. As is
17 apparent from the final words of rule 43(1), the
18 coroner's function is to identify points of concern, not
19 to prescribe solutions.
20 The focus of the evidence that I have heard during
21 this inquest has, of course, been on the events of
22 7 July 2005. A great deal of evidence has been given
23 about the systems in place and the equipment used by
24 Transport for London and the emergency services on that
25 day. With regard to the "preventability" issues, I have

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1 also heard evidence as to police and Security Service
2 capabilities and techniques in the years 2004 and 2005,
3 although the open nature of these proceedings has meant
4 that evidence could not be adduced regarding some
5 sensitive details. In addition, I have heard evidence
6 regarding changes and improvements that have taken
7 place, with the same proviso in relation to the
8 Security Service since that time.
9 In some instances, any concerns regarding systems
10 that were in place in 2005, and which would have
11 justified the making of a report, have been dispelled by
12 the evidence of improvements that have been made since.
13 There are other areas in which such evidence as I have

14 heard about developments since 2005 have not been
15 sufficient to allay my concerns: they are the subject of
16 my report.
17 The interested persons were in agreement that, in
18 order to explain the recommendations that I am making,
19 and to put them into context, it would be helpful for me
20 to summarise some of my factual findings on relevant
21 areas of the evidence. I agree that, in the
22 circumstances of these inquests, this is an appropriate
23 course to adopt, and I have done so. I have also made
24 reference to some (but not all) of the recommendations
25 that I was invited to make in submissions but which

17

1 I have decided not to pursue, and I have briefly given
2 my reasons for doing so. Again, the interested persons
3 were in agreement that I was entitled to do that.
4 I should also add that, given the exceptional nature of
5 the inquests, my rule 43 report is bound to be far more
6 detailed than would usually be the case.
7 I should now mention the question of "survivability"
8 which relates directly to my verdicts. When we began
9 the inquests, a number of the families questioned
10 whether or not their loved one might have survived if
11 help had reached them sooner. I am also acutely
12 conscious of how important it can be to some bereaved
13 families to know the exact circumstances of the death of
14 their loved ones. I have therefore reviewed the
15 evidence on this issue with the greatest of care, not
16 just in relation to Carrie Taylor and Shelley Mather
17 (whose families specifically maintained their requests
18 that I do so), but in relation to all the deceased. For
19 some, their injuries were so severe they would have died
20 instantly. For others, the position was less clear-cut.
21 Some survived for minutes, hours, even days after the
22 explosion before, sadly and finally, succumbing to their
23 injuries.
24 I was considerably assisted in my task by the work
25 of Colonel Mahoney and his team of experts. They were

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1 asked to explain the mechanics of death for someone
2 injured in an explosion generally and to consider the
3 cases of a number of the deceased who did not make it to
4 hospital where either the evidence indicated at first
5 blush they might not have died immediately or because
6 I had accepted a request from legal representatives to
7 look at the issue for a particular deceased.
8 We required Colonel Mahoney's assistance because the
9 decision was taken not to hold internal post-mortem
10 examinations of the 52 victims. Some of the families
11 approved of that decision and some did not. Those in
12 the latter group invited me to recommend that "coroners
13 should receive guidance" on the holding of internal
14 post-mortems even where the effective cause of death is
15 known, "if it is thought issues of survivability might
16 arise". They also asked me to consider recommending, in
17 effect, that bereaved families be given a greater say in
18 the decision-making process. I understand that this is
19 an issue that has troubled and continues to trouble
20 some. However, I ruled that this issue is outside the
21 scope of the inquests and I have heard no evidence at
22 all on how decisions of this kind are taken and what the
23 reasons for this particular and very difficult decision
24 were. I should say, for the avoidance of doubt, that
25 having heard nothing on the subject, I have no reason to

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1 doubt that the reasons were entirely sensible and the
2 decision justified, but ultimately the issue is not
3 a question for me.
4 I return to the evidence of Colonel Mahoney and his
5 team. Colonel Peter Mahoney is the Defence Professor of
6 anaesthetics at the Royal Centre for Defence Medicine.
7 He and his team have extensive experience of treating
8 military personnel injured by bombs and/or of reviewing
9 the deaths of those killed in explosions. They are
10 skilled at addressing the question of whether someone
11 injured in an explosion who suffers a particular
12 combination of injuries will be expected to survive.
13 Colonel Mahoney's evidence was that an explosion is
14 a rapid release of energy that sends out a high pressure
15 shock wave followed by a blast wind which is the heat
16 and explosive material radiating rapidly outwards. The
17 combined effect is called the blast wave. Those who are
18 unfortunate enough to be caught up in and injured by an
19 explosion suffer what the Colonel categorised as blast
20 injuries. Obviously the closer the victim is to the
21 seat of the explosion, the greater the risk of death,
22 and the further away, the greater the chances of

23 survival. Very small distances can make all the
24 difference to the chances of survival.
25 He divided blast injuries into different categories;

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1 the most significant being primary blast injuries which
2 usually involve serious trauma to internal organs
3 containing air such as the lungs and bowel. There may
4 be no or limited signs of external injury in those who
5 have predominantly suffered primary blast injuries.
6 I also heard that in an enclosed space, such as an
7 underground carriage or a bus, the incidence of primary
8 blast injuries is likely to be greater than in an open
9 environment. This is due to the concentration of the
10 shock wave. The blast wave, as it spreads out in an
11 enclosed space, can reflect off surfaces so that the
12 effects of the blast are concentrated in particular
13 areas.
14 A particular and, sadly, common example of primary
15 blast injury is blast lung. I heard evidence that the
16 lungs are particularly vulnerable to such injury. Blast
17 lung is categorised as bleeding into lung tissue. Blood
18 flowing through injured areas of the lung does not
19 contain sufficient oxygen; essentially the lungs become
20 stiffer and breathing more difficult. Blast lung can
21 evolve and worsen over the hours and days after an
22 explosion. It is a progressive illness and respiratory
23 function can deteriorate very rapidly. Although
24 Colonel Mahoney took care to emphasise that there were
25 always variables and exceptions, scientific research

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1 showed that a significant proportion of those who
2 suffered such injuries, but did not die immediately,
3 would subsequently succumb due to blast lung.
4 Bearing this evidence in mind, I have considered
5 whether any of the deceased could, on the balance of
6 probabilities, have survived the injuries they suffered
7 in case that had any impact on my verdicts in their
8 inquests. I do not intend to dwell upon the detail
9 because, in relation to the vast majority of the
10 victims, I am not now asked to do so. I have concluded,
11 bearing in mind Colonel Mahoney's caveats and the
12 severity of the injuries suffered by some of those who
13 survived, that the medical and scientific evidence in
14 relation to all 52 victims leads to only one sad
15 conclusion: I am satisfied on the balance of
16 probabilities that each of them would have died whatever
17 time the emergency services had reached and rescued
18 them. Consequently, there is nothing for me to add in
19 relation to this issue in box 3 of any of the
20 inquisition forms.
21 Turning to Carrie Taylor in a little more detail, as
22 I am asked to do, she survived, on the evidence, for
23 approximately 30 minutes or so after the explosion. She
24 was thought to speak to some of the witnesses. However,
25 one witness described her as unresponsive and

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1 Dr Quaghebeur, a fellow passenger who was on the scene
2 throughout, described her as making involuntary
3 movements and being uncommunicative.
4 Colonel Mahoney's carefully reasoned conclusion was
5 that the nature of her injuries, in particular the flash
6 burns and partial traumatic amputation of her leg,
7 indicated that Carrie was close to the source of the
8 explosion at Aldgate; closer than the initial assessment
9 which put her about 2.6 metres away. I fully understand
10 that Mr Taylor does not accept the analysis that she was
11 closer, particularly as Carrie was shielded from the
12 blast by at least three other passengers. However,
13 I can find no evidence to contradict the expert
14 assessment that the nature of her injuries indicates
15 a close proximity to the blast. I accordingly accept
16 that it was likely that she was exposed to several shock
17 waves, each with the potential of causing some degree of
18 primary blast injury. I am persuaded by
19 Colonel Mahoney's evidence that it was very likely that
20 Carrie suffered significant blast lung injury and that
21 she was thrown by the force of the blast from her
22 initial position with the likelihood of significant
23 other injuries including head and spinal injury. On the
24 balance of probabilities, in my judgment, it was
25 unlikely that Carrie Taylor would have survived.

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1 Consequently, there is nothing for me to add in relation
2 to this issue in box 3 of the inquisition form for
3 Carrie.

4 Thus, the only legitimate comfort I can give Mr and
5 Mrs Taylor is to agree with them that absent an internal
6 post-mortem, no one can now be absolutely certain that
7 Carrie would not have survived. Colonel Mahoney said
8 there are no certainties in this area. However, as
9 I have said, on the balance of probabilities, the expert
10 evidence points to only one conclusion: it is unlikely
11 she would have survived, whatever time she was
12 extricated from the carriage.
13 In relation to Shelley Mather, Colonel Mahoney
14 concluded that, given the nature of the fragmentary
15 injuries that she suffered, it was likely that the
16 device on the Russell Square train exploded close, but
17 not next to her. Her injuries indicated that the device
18 exploded to her left. She probably survived for
19 approximately 1 hour and 40 minutes after the explosion.
20 I heard evidence from Susan Harrison, who was badly
21 injured in the blast, that she was blown on to Shelley.
22 After the explosion, they were holding hands and
23 speaking to each other. When paramedics arrived at the
24 scene, Shelley was still conscious and presented as
25 gasping for breath with a distended abdomen. A number

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1 of unsuccessful attempts were made to decompress her
2 chest; a build-up of air from an air leak inside the
3 chest, known as a pneumothorax, was suspected as a cause
4 of the breathing difficulties. There is nothing to
5 suggest that those efforts at chest compression would
6 not have successfully drained a pneumothorax, if one
7 existed.
8 Shelley's breathing difficulties continued after the
9 decompression. Colonel Mahoney concluded, therefore,
10 that the most likely explanation was that Shelley had
11 a severe blast lung injury. She had been close to, but
12 not next to the bomb, when it was detonated. Her
13 distended abdomen also indicated the possibility of
14 other internal injury or that Shelley was swallowing
15 a lot of air. This could also indicate blast lung.
16 Taking the evidence as a whole, noting in particular the
17 valiant efforts made by the medics at the scene,
18 I conclude that on the balance of probabilities it was
19 unlikely that Shelley would have survived her injuries
20 even if she had been extricated from the scene earlier.
21 In a moment, I will ask Mr Smith to hand out the
22 inquest forms to the legal teams and any unrepresented
23 bereaved families who are present. Before I do, it is
24 my intention to publish the inquisition forms on the
25 inquest website as the formal record of each of the

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1 52 inquests; does anyone wish to make submissions on
2 that before I do so?
3 I announced on 11 March 2011 that I intended to make
4 a report under rule 43. I intend to publish it now, and
5 I have obtained the agreement of the Lord Chancellor (to
6 whom I am indebted), with whom a power lies to publish
7 such a report. It will be available, therefore, about
8 now on the inquests website for anyone who wishes to see
9 it. Mr Smith will be sending out the rule 43 report to
10 those to whom it is addressed later today and he will be
11 copying it formally to all interested persons.
12 Unless anyone has anything else to add, I therefore
13 propose formally to close the inquests into the
14 52 deceased.
15 There is one other matter to which I must now turn.
16 I also have jurisdiction over the inquests into the
17 deaths of Mohammed Sidique Khan, Shehzad Tanweer,
18 Hasib Hussain and Jermaine Lindsay and thus the
19 responsibility of deciding whether or not I should, in
20 my discretion, resume any or all of those inquests.
21 Under section 16(3) of the Coroners Act 1988, an inquest
22 may be resumed only if, in the opinion of the coroner,
23 they have sufficient cause to do so.
24 In my ruling in May of last year, I adjourned
25 consideration of this issue to give time to the families

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1 of these men to advance submissions if they wished to do
2 so. However, nothing was put before me at that time
3 that would have justified resumption of any of their
4 inquests and I made it clear that I would require good
5 and proper reasons before doing so.
6 On 11 March 2011 I ordered that any person wishing
7 to make representations should do so by 18 March. In
8 the event, none of the families have sought to argue
9 that any of these inquests should be resumed or, indeed,
10 submitted any representations at all. The only
11 submissions I have received have come from an
12 organisation calling itself the July 7th Truth Campaign.

I have considered those submissions, but in the light of all the evidence I have heard during the 52 inquests, I consider they have not provided any sufficient reason to resume the inquests into the four bombers. In any event, I consider that the organisation does not fall within the legal criteria for an interested person contained in rule 20(2) of the Coroners Rules 1984. In the light of the position adopted by their families, and given that the inquests into the deaths of the 52 victims have led to the most rigorous scrutiny of the events of 7 July 2005, I can find no cause whatsoever to resume the inquests into the deaths of the four men.

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Thank you all for your assistance.
MR KEITH: My Lady, before you rise, may I record, on behalf of all those of us who have engaged in these proceedings, our gratitude and appreciation of your dedication, your conscientiousness and your humanity in your conduct of these proceedings?
LADY JUSTICE HALLETT: Thank you, Mr Keith.
(10.47 am)
(The inquests adjourned)

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