

**TRANSPORT FOR LONDON**

**BOARD**

**SUBJECT: CORONER'S RECOMMENDATIONS FROM THE INQUESTS INTO THE LONDON BOMBINGS OF 7 JULY 2005**

**DATE: 29 JUNE 2011**

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**1 PURPOSE AND DECISION REQUIRED**

- 1.1 The purpose of this paper is to report on the outcome of the London Bombings Inquests and the implications for Transport for London (TfL) of the Coroner's verdict and recommendations.
- 1.2 The Board is asked to note the paper.

**2 BACKGROUND**

- 2.1 On 11 October 2010, the Inquests into the death of the 52 people killed in the London Bombings were resumed by the Coroner, Dame Heather Hallett.

**3 INQUEST HEARING**

- 3.1 The Coroner heard evidence from survivors, first responders and emergency services for each of the four locations. Some 300 witnesses were called and over 200 statements read. A total of 35 employees of TfL, past and present, gave evidence and 19 of their statements were read. TfL employees giving evidence were provided with witness support.
- 3.2 Evidence on command and control for London Underground (LU) was given by Howard Collins, Chief Operating Officer, Andy Barr (Gold Control) Network Co-ordination Manager and Geoff Dunmore, Operational Security Manager (who was also in attendance for the evidence given for the three Underground locations). For Surface Transport, evidence was given by Alan Dell, Network Liaison Manager who was initially Gold Control. Witness Statement evidence was also provided from Mike Weston, Operations Director.
- 3.3 Evidence on command and control was also given by the Metropolitan, British Transport and City of London police forces, London Fire Brigade and London Ambulance Service. Evidence was also given about the background of the bombers and from the Security Services on the issue of preventability.
- 3.4 From the outset, TfL offered its assistance to the Coroner in providing evidence and documents. The Coroner acknowledged that she had received the fullest cooperation from everyone as promised. She was also able to acknowledge that, as a result of keeping to the very stringent timetable she had set, the Inquests had concluded on time and under budget.

- 3.5 TfL witnesses attended as required and gave their evidence in a professional manner. In many cases, as recognised by the Coroner, they had to relive the harrowing events which faced them on the day. Those who were amongst the first to respond to the bombings on the Underground were praised by the Coroner for demonstrating great courage in assisting passengers. She said that their efforts were invaluable and showed that the rigorous training undertaken by LU employees paid dividends. The Coroner also praised staff within the station control rooms, line controllers and Network Control Centre (NCC) who ensured that swift steps were taken to call the emergency services.
- 3.6 The Commissioner has written to the TfL employees, past and present, who assisted the Inquests by giving evidence and providing statements. The Inquests were a long awaited and crucial step for all those involved, particularly for the relatives of all those who were killed, and he thanked them for the role they played in that process.

#### **4 CORONER'S VERDICT**

- 4.1 On 6 May 2011, the Coroner returned a verdict of unlawful killing and that the 52 victims died as a result of injuries received in the blasts. The Coroner did not consider that any of the deceased might have survived had the victim received suitable medical intervention at an earlier stage. She did not consider that there were any failings in the Emergency Response which contributed to the deaths.

#### **5 CORONER'S RULE 43 REPORT**

- 5.1 Under the Coroners Rules, the Coroner may make a report if the evidence she has heard gave rise to a concern that circumstances created a risk that other deaths will occur and that action should be taken to eliminate or reduce the risk of death in such circumstances. The Coroner produced a 65 page report addressed to all the institutional interested parties, the NHS and the London Resilience Team. A summary of the recommendations is attached at Appendix 1.
- 5.2 The Coroner made the following recommendation to TfL:
- (a) To reconsider whether it is practicable to provide first aid equipment on underground trains, either in the driver's cab or at some other suitable location, and carry out a further review of station stretchers to confirm whether they are suitable for use on both stations and trains.
- 5.3 TfL stated in evidence and in its legal submissions that such a reconsideration and review would be undertaken if recommended.
- 5.4 The following recommendations were made to TfL and the London Resilience Team:
- (a) To review the protocols by which TfL (i) is alerted to major incidents declared by the emergency services that affect the underground network, and (ii) informs the emergency services of an emergency on its own network (including the issuing of a 'Code Amber' or a 'Code Red', or the ordering of an evacuation).

- (b) To review the procedures by which (i) a common initial rendezvous point is established, and its location communicated to all the arriving emergency services (ii) the initial rendezvous point is permanently manned by an appropriate member of LU.
  - (c) To review the procedures by which confirmation is sought on behalf of any or all of the emergency services that the traction current is off, and by which that confirmation is disseminated.
- 5.5 In making these recommendations, the Coroner said that while she accepted that significant improvements have been made, she still remained concerned that shortcomings may persist in the way in which LU informs, and is informed by, the emergency services speedily and accurately of any incident on the network.
- 5.6 The Coroner heard evidence that emergency responders had difficulty liaising at the Underground stations and encountered difficulties locating each other's initial responders. She considered that this could be remedied by there being one common rendezvous point where necessary. However, she did accept that the problem may be less acute now by virtue of improved underground communications and identification of locations.
- 5.7 It was already well known that there was uncertainty among some first responders as to whether the traction current had been discharged. While the Coroner accepted that LU was currently in discussions with the London Fire Brigade about how confirmation of discharge of traction current may be sought, she considered that more could be done to disseminate this information rapidly to emergency personnel.
- 5.8 The following recommendation was made to the London Resilience Team:
  - (a) To review the provision of inter-agency major incident training for frontline staff, particularly with reference to the LU system.
- 5.9 The Coroner noted that there had been some misunderstandings between the emergency services as to their respective roles and operations. She considered that such training was vital in helping to reduce confusion at an incident.
- 5.10 The report was considered by the Safety Health Environment Assurance Committee (SHEAC) and the Rail and Underground Panel at a special meeting held on 25 May 2011.

## **6 BROADER SCOPE OF RULE 43 REPORT**

- 6.1 The Coroner broadened the scope of her Rule 43 Report due to the public interest in the Inquests. This was not only to set the context for the recommendations but also to explain the improvements made since 7 July 2005 so that no recommendation was made.
- 6.2 The Coroner commented that while a certain level of chaos was inevitable, it was one of the main functions of the first responders (such as in LU's control centres) to create order out of such chaos. She found it surprising that the NCC was not sure of the facts at an earlier stage. However, despite those pressures, she acknowledged that during the early stages, the NCC took appropriate steps to contact the emergency services.

- 6.3 Implementation of new technology, including the Nimrod digital logging system and improved telecommunications systems through CONNECT meant that the Coroner made no recommendations.
- 6.4 The Coroner also said that on the evidence, TfL could not be criticised for allowing London bus services to continue to operate prior to the explosion on the Number 30 bus. There were no reasonable grounds for suspecting that the bus network would be subject to an attack even if CentreComm (the control room for London Buses Services Limited) had known at an earlier stage that bombs had been detonated on the Underground.
- 6.5 Difficulties that resulted in emergency responders having duplicate address data and attending the wrong LU locations have now been resolved by the introduction of a unique reference number system to identify the exact location.
- 6.6 The Coroner had particular concerns about the use of 'jargon' and lack of plain English but did not consider it appropriate to make a recommendation, leaving it instead to the 'good sense' of organisations as part of their continuing review process.

## **7 LEGAL ISSUES**

- 7.1 The function of an Inquest is essentially a fact finding enquiry to ascertain who has died together with when and by what means they came by their death. TfL must respond to the Coroner within 56 days (that is, by 30 June 2011) with details of any actions that have been taken or which it proposes will be taken whether in response to the Coroner's report or otherwise; or an explanation as to why no action is proposed.

## **8 RECOMMENDATION**

- 8.1 The Board is asked to NOTE the paper.

## **9 CONTACT**

- 9.1 Contact: Howard Carter, General Counsel  
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## Summary of Coroner's Recommendations

No.	Recommendation	Addressee
R1	Consideration be given to whether the procedures can be improved to ensure that "human sources" who are asked to view photographs are shown copies of the photographs of the best possible quality, consistent with operational sensitivities.	Secretary of State for the Home Department Director General of Security Service
R2	Procedures be examined by the Security Service to establish if there is room for further improvement in the recording of decisions relating to the assessment of targets.	Secretary of State for the Home Department Director General of Security Service
R3	The London Resilience Team reviews the provision of inter-agency major incident training for frontline staff, particularly with reference to the London Underground system.	London Resilience Team
R4	TfL and the London Resilience Team review the protocols by which TfL (i) is alerted to major incidents declared by the emergency services that affect the underground network, and (ii) informs the emergency services of an emergency on its own network (including the issuing of a 'Code Amber' or a 'Code Red', or the ordering of an evacuation).	TfL/London Resilience Team
R5	TfL and the London Resilience Team review the procedures by which (i) a common initial rendezvous point is established, and its location communicated to all the arriving emergency services (ii) the initial rendezvous point is permanently manned by an appropriate member of London Underground.	TfL/London Resilience Team
R6	TfL and the London Resilience Team review the procedures by which confirmation is sought on behalf of any or all of the emergency services that the traction current is off, and by which that confirmation is disseminated.	TfL/London Resilience Team
R7	TfL (i) reconsider whether it is practicable to provide first aid equipment on underground trains, either in the driver's cab or at some other suitable location, and (ii) carry out a further review of station stretchers to confirm whether they are suitable for use on both stations and trains.	TfL
R8	The London Ambulance Service, together with the Barts and London NHS Trust (on behalf of the London Air Ambulance) review existing training in relation to multi casualty triage (that is, the process of triage sieve) in particular with respect to the role of basic medical intervention.	London Ambulance Service/Barts and London NHS Trust
R9	The Department of Health, the Mayor of London, the London Resilience Team and any other relevant bodies review the emergency medical care of the type provided by London Air Ambulance and Medical Emergency Response Incident Teams and, in particular (i) its capability and (ii) its funding.	Secretary of State for Health/London Resilience Team