Coroner's Inquests into the London Bombings of 7 July 2005

Government response to the Report under Rule 43 of the Coroner's Rules 1984

HM Government

Introduction

1. On 6 May 2011, Lady Justice Hallett handed down her verdicts on the deaths of those who were tragically killed on 7 July 2005. Concluding that "the evidence I have heard does not justify the conclusion that any failings on the part of any organisation or individual caused or contributed to any of the deaths", the Coroner issued a report under Rule 43 of the Coroner's Rules 1984, making nine recommendations in the areas in which she believes that the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur or will continue to exist in the future. A full list of the recommendations is provided at Annex A.

2. Two of the recommendations relate to the preventability of the event and are directed to the Secretary of State for the Home Department and Security Service. The Government accepts these two recommendations. Seven recommendations, primarily London focused, relate to the emergency response, with recommendations directed to the Secretary of State for Health, Transport for London, London Resilience Team, London Ambulance Service, and the Barts and the London NHS Trust. The Government accepts the recommendation directed to it relating to the emergency response.

3. Accepting the three recommendations directed at it, this document provides the Government's formal response to these recommendations as required under Rule 43A(1) of the Coroner's Rules.

4. This response also seeks to provide comment on the broader narrative made by the Coroner where, although there is not a formal Rule 43 recommendation, there is a need for Government to address a concern. This response also seeks to address wider UK implications of those recommendations directed specifically towards London.

5. Responses to the 6 recommendations directed towards the London response community are being separately addressed by the organisations concerned.

6. This response mirrors the structure and sequence of that used by the Coroner in her report.

Preventability

7. The Coroner made two recommendations directed to the Director General of the Security Service and the Home Secretary which relate to the handling of photographs and the recording of assessment decisions. The Coroner also made some observations which stopped short of full recommendations that related to the handling of photographs and the way in which draft reports by the Intelligence and Security Committee (ISC) are checked. These are all considered in detail below.

8. The Home Secretary and the Director General of the Security Service have carefully considered the two recommendations in the report directed to them and they accept them both. Given the recommendations relate to Security Service processes, the Director General has commissioned separate reviews for each of the two recommendations. These reviews were conducted by senior managers with responsibility for the areas of business that are the subject of the recommendations and have informed our response. The reviews have:

- compared the Security Service's current systems in these areas with the systems in 2004 (the period that has given rise to the Coroner's concerns);
- considered the improvements that have been made to these systems between 2004 and 2011; and
- considered whether further improvement is required in the Security Service's systems.

9. The outcome of the reviews is reflected in the responses provided below.

Photographs

10. The most acute criticism of the Security Service by the Coroner related to the "cropping" of a photograph of Man E before it was passed to the Federal Bureau of Investigations to be shown to the cooperating witness Mohammed Junaid BABAR. This photograph was not shown to BABAR, possibly because of its poor quality, although, as the Coroner noted, the failure to show the cropped photograph to BABAR did not cause any failure to identify Man E as other good quality photographs were shown to BABAR shortly afterwards. The Coroner made the following recommendation:

1. I recommend that consideration be given to whether the procedures can be improved to ensure "human sources" who are asked to view photos are shown copies of the best possible quality, consistent with operational sensitivities.

11. In 2004, the majority of Security Service photographs were taken using 'wet film' and the process of cropping a photograph involved scanning a 'wet film' print onto a flatbed scanner, uploading the image onto the corporate IT system and cropping it, and/or removing the background, using the software available in the Service at the time. The quality of the image was reduced during the scanning process and the cropping software available at the time reduced the quality of the image even further.

12. The Security Service accepts that, whilst the quality of this photograph of Man E was not representative of the overall standard of photographs in 2004, the cropping of this photograph was unsatisfactory. However, as set out below, the current system for the cropping of photographs has now been improved significantly so that the risk of recurrence of such an error has been substantially reduced.

13. In 2011 the system and technologies have improved as follows:

- all the photographs taken by the Security Service are taken using digital equipment and the Security Service has the necessary links with most of the external agencies with whom the Security Service deals to ensure that the best quality, high resolution images can be exchanged;

- the Security Service has a digital processing and production IT system for the photographs taken by Security Service operational teams, which enables specialist officers to 'crop' or remove background using up to date commercially available software;

- the photographs that the Security Service will normally need to crop are those which are collected covertly. All photographs collected covertly are taken digitally and there is therefore no requirement for the photograph to be scanned separately onto an IT system, mitigating any potential degradation of the photograph through any scanning process;

- the photograph editing software that the Security Service now uses is a substantial improvement on the software available to it in 2004. There is therefore significantly less risk that the poor cropping of the photograph of Man E that took place in 2004 could reoccur in 2011; and

- the Security Service has also invested in an IT system for enabling the electronic transfer of photographs to encrypted electronic devices used by our agent handlers when showing photographs to agents. This has improved the overall quality of the photographs we show to our agents.

14. The system is not yet perfect. The Security Service still needs to improve the connectivity between it and some of those partners with whom it shares images. As noted above the quality of photographs degrades when they are received in hard copy and have to be scanned into the Security Service's IT systems. The Security Service is therefore reviewing IT connectivity with its most important partners with an eye to the routine digital transfer of the best quality images. This is in parallel to the ongoing investments in Security Service IT capabilities and that of the wider police counter terrorism network to improve interoperability and to keep pace with technological developments.

Other comments by the Coroner about photographs

15. Whilst the Coroner did not make this a specific recommendation she also commented (at paragraph 72) that she hoped that a proper record would be kept of the circumstances of the identification or otherwise of a photograph by an agent. Record keeping of identifications from photographs by sources has improved.

16. The current process in the International Counter Terrorism Section is that once an image has been returned to the investigator with the sensitive background removed (if necessary to avoid revealing information on how or where it was taken) the investigator requests that the agent running section shows the photograph to an agent or agents. This request will include a copy of the photograph and some background on the subject of the photo (address, telephone numbers, provenance of the photo etc). A specialist tasking officer in the agent running team receives the request and enters the details onto a database

17. This database, set up in 2008, records the details of all requests to show photographs to agents reporting on international counter terrorist targets. Improvements are being trialled to the design of this database to ensure that there is a complete record of which photographs have been shown to which agents, and the results of this tasking.

18. At paragraphs 75-77 the Coroner commented on the procedures for reviewing old photographs to be shown to agents. The Security Service relies on its investigative processes to identify those photographs assessed to be relevant in the context of a particular investigation, and its agents are tasked accordingly. These processes are more sophisticated and comprehensive than they were in 2004. First the Security Service has better technology, and the Security Service now has specialist officers to join up the agent collection effort with the investigative requirements to ensure that the right photographs are shown to the right agents.

19. It is likely that of the many thousands of photographs in the possession of the Security Service there is a small percentage in the Service's records that could be shown to agents who may then be able to recognise or identify persons of interest. However, it is not possible to identify photographs that an agent might be able to use to identify persons of interest out of the total database of many thousands other than by the investigative processes referred to above.

Recording of assessment decisions

20. The Coroner heard evidence about the way in which individuals were categorised in 2004/5 as potential targets for further investigation by the Security Service. She examined whether there were any weaknesses in the assessment and categorisation system that could mean individuals who should be prioritised for investigation, were not. The Coroner also examined whether there were any deficiencies in record-keeping which made it more difficult for decisions about prioritisation to be reviewed. The Coroner made the following recommendation:

> 2. I recommend that procedures be examined by the Security Service to establish if there is room for further improvement in the recording of decisions relating to the assessment of targets.

21. The Security Service's current system for prioritisation of targets and the recording of those decisions is significantly changed and more comprehensive than in 2004/5.

In 2004, documents summarising each investigation were produced on a quarterly basis. These reviewed the principal threats under investigation and were an aide for prioritisation and the allocation of resources. The daily decisions around prioritisation of investigations and the relative priority of individual targets within an investigation were made by desk officers in conjunction with their management but these operational decisions were not formally recorded as a matter of routine.

22. The Security Service has made considerable investment in recent years in technology to strengthen its information handling and processing capability. This goes much wider than just how photographs are handled and extends to how the huge amount of data that the Security Service holds is recorded and how to make it easier for it to be searched and analysed. Given technology is constantly developing, the Security Service has an ongoing programme of investment to upgrade its IT capability. This complements similar programmes in the police to enhance their ability to share information across the police's counter-terrorism network and with the Security Service.

Current Prioritisation and Records Management Systems

Investigations

23. The Security Service's current prioritisation system has evolved to a more sophisticated one since 2004, and has been upgraded several times. Each investigation is given a strategic priority that reflects the overall level and nature of the threat carried. The prioritisation of investigations is now recorded within the Security Service's new investigative IT system (introduced in 2009).

24. Strategic priority definitions for investigations are as follows:

- P1: Attack Planning
- P2: Terrorist Facilitation and other Threats
- P3: Uncorroborated Reporting
- P4: Risk of Re-Engagement

25. Proposed changes to the strategic priority of an investigation are independently audited by a specialist section within the Security Service's International Counter Terrorism Investigation Section, to ensure consistency across investigative groups. When any priority change is made on the Investigative IT system, the system requires reasoning for this change to be provided. The level of detail supplied here will be at the discretion of the investigator, but is verified by the specialist section and by investigative managers, and must provide sufficient information to explain the change.

Individuals

26. In addition to recording the priority attached to an investigation, the Security Service will assess the relative importance of an individual in whom it has an interest when a record is created for that individual. Further explanation must be recorded each time the assessment changes. This provides a record of the Service's changing assessment of an individual of interest.

27. In addition, within high priority investigations each target is allocated a tier reflecting their centrality to the activities under investigation, enabling easier comparison and ranking of targets across and between investigations.

28. Furthermore, proposed intrusive investigative actions against a target are graded for the anticipated intelligence dividend of the proposed action. This system assists in ensuring that resources are appropriately directed, with an understanding of the whole investigative picture.

29. By a combination of these different developments a more comprehensive system of prioritisation has been achieved:

    - every investigation has a strategic priority which is regularly reviewed to ensure parity appropriate to the understanding of the threat posed;

    - every individual of interest on whom a record is opened will be associated with an investigation, and if the investigation is of a high enough priority, will be placed on a tier within it; and

    - the level of investigative and intelligence collection resource allocated to a target is based on i) the combination of strategic priority and target tier; and ii) time sensitivities and the assessed intelligence dividend of a specific investigative action.

30. The Security Service's internal review of how it records prioritisation decisions has concluded that there is a far more formal structure to capture an improved decision making process concerning prioritisation. The Security Service now captures in more detail than in 2004 the decisions to prioritise investigations and individuals within investigations.

31. There are still limits on what it is feasible for the Security Service to record about its decision making processes, as resources deployed on record keeping of decisions below a certain threshold of importance would be better deployed elsewhere. This is particularly the case in respect of decisions not to take specific actions. This is an area that the Security Service is keeping under review.

32. The Security Service is also planning to introduce a new investigative record in the coming year, to record more easily key investigative decisions, including prioritisation choices. Guidance for the use of this capability is being prepared, but it is likely to add context to the decision making process within an investigation at any given time. This investigative record will further assist managers review investigations.

Coroner's observations on the Security Service and the Intelligence and Security Committee (ISC)

33. Whilst these are not formal recommendations, the Coroner notes at paragraph 116 of her report that consideration should be given to whether procedures could be improved to ensure the accuracy and completeness of information provided by the Security Service to the ISC, and to whether procedures could be improved to allow the Security Service to review draft reports of the ISC more effectively, with a view to ensuring that it has not inadvertently included any inaccurate or potentially misleading information. These comments stem from evidence given to the Inquests by Witness G (the Security Service witness), during the course of which it became clear that in the process of the ISC's investigations into the 7/7 bombings some inaccurate evidence had inadvertently been provided. In addition, a misunderstanding had arisen between the ISC and the Security Service, regarding the terms used by the Service for the "categorisation of individuals" of interest, which had not been explained to the Committee as clearly as they might have been.

34. As set out above, the Security Service has made considerable investment in technology to strengthen its information handling and processing capability. The Security Service is therefore confident that it is already in a stronger position today to reduce the risk of such errors and omissions arising in future ISC investigations of intelligence-based topics. However, in any future similar exercise the Service will work with the ISC to ensure that all relevant material is placed at the ISC's

disposal. In addition, it is, and will continue to be, standard practice for the ISC to provide copies of draft reports to the Security Service, and the other intelligence agencies, in advance of publication to allow them to be checked for accuracy.

35. The Government and the Security Service take seriously matters of factual accuracy in the evidence it provides to the ISC. The Service co-operated fully with the ISC's two separate investigations into the 7 July attacks and shared an unprecedented amount of intelligence detail for consideration by the Committee and its staff. It is therefore a matter of regret that inadvertent errors were present in evidence provided to the ISC. The Security Service recognises the serious impact of such mistakes, whatever their overall substance, and has made this clear to both the Coroner and the ISC. The Government considers that, despite the errors identified, the core narrative and conclusions of the ISC's second report ('Could 7/7 have been Prevented?') remain sound. In finding that the Security Service was not a contributory cause of 7/7 the Coroner reached the same conclusion.

36. The factual accuracy checking process for ISC reports must be rigorous and its importance has been re-emphasised by the ISC following the Coroner's comments. The Government recognises this and has emphasised its importance, and the need for the involvement of senior officials in the process of checking the accuracy of draft ISC reports.

37. As announced by the Prime Minister in July 2010, a Green Paper on Justice and Security is being produced that will, amongst other things, review the full range of independent intelligence oversight mechanisms and will consult on options to strengthen such oversight to ensure it is robust and effective. As an important part of this work, the role and powers of the ISC will be examined, including the ISC's ability to obtain wide-ranging information from the intelligence agencies on a particular issue. The Coroner's findings in this case will be valuable input for the Government, alongside the responses to the Green Paper consultation, as it develops intelligence oversight policy for the future. The ISC is playing an important role in the formulation of these proposals.

38. The ISC has taken a close interest in the Inquests and the Coroner's findings, and will itself be pursuing with the Government the issues raised by the Coroner in her Rule 43 Report.

Hydrogen Peroxide

39. The Coroner raised concerns around the ease with which the four bombers were able to purchase and store the hydrogen peroxide required to build their explosive devices, without raising any suspicion. Evidence was given during the inquest on the measures the UK has put in place to mitigate access to these substances by terrorists. The Coroner also welcomed the proposed EU Regulation on the marketing and use of explosives precursors which is currently under Parliamentary Scrutiny.

40. Since 2005, significant effort has been made to understand and respond to the risks presented by terrorists in manufacturing home made explosives. The Government has assessed the lifecycle of hazardous chemicals, including hydrogen peroxide, and identified areas of vulnerability within the UK and is working to implement proportionate means to address these vulnerabilities.

41. Working with partners in law enforcement and industry, the priority is to reduce the accessibility of hazardous substances for terrorist use. The National Counter-Terrorism Security Office (NaCTSO) directs an awareness raising campaign to ensure products of potential interest to terrorists

are only supplied to trusted customers. The campaign, Know your Customer, advises retailers on suspicious transactions and action to take if an attempt is made at a suspicious transaction. Simple security guidance encouraging good stock and access control is also being issued to business and education users of dual use chemicals.

42. The Government continues to work at national and European Union (EU) level to increase the security around hydrogen peroxide and other explosives precursor chemicals through both voluntary and regulatory measures. The UK is currently negotiating a new EU Regulation on the marketing and use of explosives precursors which once agreed, will become UK law. This legislation aims to prevent terrorists acquiring explosives and their precursors, and act as a deterrent to those who wish to obtain the chemicals for criminal or terrorist purposes. It will introduce a formal regulatory system across the EU that will identify and restrict sales of a number of substances while allowing those with a legitimate need to continue to obtain and use them.

Emergency Response

43. In the second half of the Rule 43 report, the Coroner set out a detailed analysis of the emergency response on 7 July 2005. Noting upfront that the demands on the emergency responders were great, and that each organisation should be proud of their employees who "when presented with an uncertain, complex and traumatic set of circumstances did all that they could to ensure that lives were saved", the Coroner provided a comprehensive assessment of the emergency response, including seven formal recommendations.

44. The majority of these recommendations were London focused and directed at London organisations, and as such, the formal response to these are set out in their replies to the Coroner's report coordinated by the Mayor. However, many of these recommendations may still be applicable to emergency services nationwide, including those that fall within the competence of devolved administrations. Within the devolved administrations, the relevant bodies will consider the implications of this report.

45. One of the seven recommendations related to the emergency response was directed at the Secretary of State for Health, whose formal response is included in this section.

46. One area in which the Coroner made a number of observations, but did not make formal recommendations was how the emergency services and other key responder organisations had worked together and shared information in the initial stages of the response. The Coroner noted the importance of effective inter-agency liaison, good communications and information sharing at the earliest opportunity. Specific shortfalls highlighted in the Coroners report are addressed in this response.

47. The Government is clear that emergency responders must be able to work effectively with one another where an incident poses a threat to life, is protracted in nature or complex, where the consequences dictate that a single agency response is inadequate. In these demanding scenarios, the need for speed, efficiency and effectiveness of the emergency service response is at a premium. The Government is therefore committed to improving the way the emergency services work together and with other key partners - such as transport operators - in an emergency. That is why the Government made a commitment in the Strategic Defence and Security Review to improve the ability of the emergency services to work together during emergencies. Improved

interoperability will also be one of the Government's objectives for the Prepare strand of CONTEST, the UK's Counter Terrorism Strategy, which will be published later this summer. Programmes are already underway to develop the multi-agency response to a range of high impact risks and lessons identified and good practice from these are shared across the emergency services and applied across the UK. But there are significant legislative, structural and operational differences and nuances of governance in the devolved administrations that might give rise to different ways of doing things.

Inter-agency Training

48. The Coroner expressed concern that communications both within and between the emergency services were not as effective as they could have been and recommended a review of the extent and scope of interagency training for front-line or "bronze" responders.

3. I recommend that the London Resilience Team reviews the provision of inter-agency major incident training for frontline staff, particularly with reference to the London Underground system.

49. London resilience partners accept this recommendation and have committed to review each individual agency's current training packages to identify any gaps. Once this review is complete, London resilience partners - through London Resilience Team - will collectively agree the most appropriate way to fill these gaps.

50. In line with London, the Government recognises that further improvements to training are required at the "bronze" level, acknowledging that it is for emergency responders at a local level to satisfy themselves that their staff understand the importance of and approach to multi-agency joint working. In particular, the Government believes that the key issue is about building a basic appreciation of other services' ways of working in high risk environments. To support this effort, the Government will emphasise the need for responders to engage and support multi-agency exercising in exercises of all tiers in a revised publication of Emergency Preparedness (the statutory guidance on Emergency Planning that supports the Civil Contingencies Act) later this year, and will coordinate a wider review of multi-agency considerations in single-service training outside of London, consistent with that to be conducted within London. The Government will ensure ensuring that results of both reviews are shared across the UK and that work to address any shortcomings is coordinated across all relevant organisations.

The use of Plain English

51. The Coroner noted that acronyms and mnemonics in some instances may confuse and impede communication. The Coroner asked that a sensible approach be applied to use of language. Some organisations have already endeavoured to re-write their procedures with a view to simplifying operational jargon.

52. The Government recognises that commonly understood terminology both within and between organisations is critical to ensuring effective communications. Since 2007 the Cabinet Office has worked with all key responder organisations to develop and maintain a lexicon of civil protection terminology, which acts as a single point of reference to ensure that organisations understand the meaning of specific terms. This lexicon is considered best practice, and although not mandated, uptake of

the lexicon has been widespread amongst government departments, the emergency services and local responders.

53. This lexicon is available on the Cabinet Office website (www.cabinet-office.gov.uk/cplexicon) and is cascaded through courses delivered at the Emergency Planning College. To support shared understanding and use of common terminology, the lexicon is already embedded in Emergency Response and Recovery (the non-statutory guidance underpinning the Civil Contingencies Act), and it will be included in the revisions later this year of both Emergency Preparedness, the statutory guidance that supports the Civil Contingencies Act and the Counter Terrorism Contingency Planning Guidance (published by the Home Office), which assists organisations in preparing to respond to a terrorist incident. Work will continue to promote and develop the lexicon as new terms emerge and as we update the lexicon we endeavour to ensure that where possible definitions are in plain English. We will also consider how to encourage its use further at the operational ("bronze") level and work is also underway to develop a set of commonly defined map symbols to complement the lexicon"

Declaration of Major Incidents and Network Code Amber / Code Red

54. The Coroner made a formal recommendation in this area:

4. I recommend that 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).

Declaration of Major Incidents:

55. The Coroner remained concerned that shortcomings may persist in the way in which major incidents are declared and communicated by the emergency services including how the London Underground informs and is informed by the emergency services (as well as its own staff) speedily and accurately of any crisis breaking across its network.

56. Transport for London and London resilience partners accept this recommendation. They will conduct a review of the arrangements for informing Transport for London and other transport operators of a major incident that affects a transport network. These arrangements will be documented in to a protocol that will be shared with all London resilience partners.

57. The Government notes that it is for individual transport operators to agree appropriate procedures with their local emergency services so that they are alerted to the declaration of major incidents. The Government will draw the attention of this requirement to rail operators.

58. The Coroner had also been told that, as a Category 2 responder under the Civil Contingencies Act, London Underground Limited is unable to declare a major incident itself. In fact, Category 2 responder status does not exclude organisations from declaring a major incident, and there might be some circumstances in which it might be appropriate for them to do so.

59. When revising Emergency Preparedness and Emergency Response and Recovery later this year, the Government will ensure better clarity about what the regulations in the Act set out in relation to the declaration of major incidents nationally. In addition Cabinet Office will liaise with the London Emergency Services Liaison Panel about the wording of their major incident procedure manual to ensure that there is clarity around local London arrangements.

Network Code Amber / Code Red:

60. The report noted that there is no formal system in place for the alerting by Transport for London of the emergency services or others to the existence of a network Code Amber, Code Red or evacuation on the underground.

61. Transport for London will review the way in which the emergency services are informed of an incident on their network that will require an emergency services response, and will share the outcomes of this review, and any revisions made to processes with London resilience partners as appropriate.

62. It is important that other transport operators should put in place appropriate and proportionate local arrangements with the emergency services when dealing with alerting mechanisms or a major evacuation of their networks. The Government will ensure that rail operators are aware of this requirement by drawing their attention to it either directly or through trade organisations.

63. The Coroner noted two further areas in relation to liaison and communications, which did not receive a formal recommendation. These are:

The transmitting capacity of AIRWAVE radios underground

64. The Coroner noted that since 2005 the analogue radio systems in use have been replaced by digital systems. AIRWAVE is now used by the emergency services and CONNECT by London Underground, providing a dedicated communications network for emergency responders across the UK and on London's tube network respectively. This has provided not only improved coverage, clarity of communications and resilience, but also increased capacity.

65. The Coroner raised a concern that at a number of priority sub-surface tube stations that have just one AIRWAVE base radio there is a risk that the communications structure could become overloaded in the event of a major incident, if the emergency services do not quickly start to manage their radio traffic.

66. Government is working to address the Coroner's concerns. Government is considering options to improve the capacity of Airwave in the London Underground at priority sub-surface stations and is taking this forward with the British Transport Police and other emergency services. It is also working with the emergency services on improving the understanding of and adherence to operating protocols designed to manage the information flows.

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1 www.npia.police.uk/en/15922.htm

67. A 'Standard Operating Procedure Guide on Multi-Agency Airwave Interoperability'[1] was published by the Government in March 2010. Good progress has been made in these areas and in responding to the Government request that Local Resilience Forums identify Senior Responsible Owners for Airwave interoperability to develop and embed local versions of this approach.

68. Looking ahead, an emergency services mobile communications project has been established by the Home Office to consider options for any future capability including consideration of a successor to the AIRWAVE system across the country for the police, ambulance and fire services. Planning for the future communications requirements across all three blue light services will ensure that the specification meets the requirement of multi-agency working, as well as ensuring best value for the taxpayer. The requirements for capacity and coverage in the London Underground and all other sub-surface parts of the transport network will inform this programme of work.

The ability of the police and the emergency services to share information simultaneously about an emerging incident

69. The Coroner raised a concern that despite the emergency services using electronic information capturing systems, such as the computer aided dispatch system (CAD) used by the police, there is no means by which either agency can see the other's information system, and no comparable electronic links between the London Fire Brigade and any other emergency service, or between the London Ambulance Service and the British Transport Police or City of London Police.

70. The Coroner welcomed current initiatives by the British Transport Police to integrate their computer aided dispatch systems with those of other regional forces, and of a project being piloted in Wales involving the Cabinet Office, Joint Emergency Services Group, Welsh Government and local authorities, which is investigating the potential to share basic incident details between different emergency responders via a central data repository.

71. Nationally, work is continuing to investigate the most efficient and effective ways of sharing information, both voice and data, between responders during a crisis response. This will consider existing and evolving technologies, such as:

- the National Resilience Extranet – which, for the first time, provides all emergency responders with the capability to share information up to and including that classified Restricted – after 12 months of operation, there are already 2645 users across 595 organisations now able to share information in this way with these numbers increasing each week ; and

- the Public Sector Network – which will provide a single holistic telecommunications infrastructure for all public sector organisations improving efficiency and facilitating inter-organisation information sharing.

72. As well as updating the relevant parts of the statutory guidance for the Civil Contingencies Act on Information Sharing, Cabinet Office is also developing a guide which will consolidate all the existing guidance on data handling and information sharing from across Government. The Government will consult in the summer on the proposed changes to the Civil Contingencies Act, which will have the effect of encouraging responders to enter into information sharing protocols to support the flow of information both during a crisis and at the planning stage.

Initial Rendezvous Point

73. The Coroner noted that more could be done to streamline and simplify the way in which the emergency services liaise with each other at major incident scenes. The Coroner made a formal recommendation stating that:

> 5. Transport for London 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.

74. Transport for London and the Emergency Services in London accept this recommendation. Following discussion with London resilience partners, they have agreed that those rendezvous points at Underground stations that have already been identified by the London Fire Brigade will (subject to the dynamic risk assessment that they are suitable) act as the initial rendezvous point for all responders in the case of an emergency.

75. London Underground accepts the recommendation (and already have procedures in place) that the rendezvous point should be manned by a member of staff as far as is reasonably practicable.

76. Emergency Response and Recovery also identifies the designation of common rendezvous points for all responders. The Government will ensure that this is emphasised, when this guidance is reviewed later this year.

77. Transport operators are responsible for making their own arrangements with local emergency services, that are appropriate to their networks and the incident, regarding rendezvous points. The Government will ensure that rail operators are aware of this responsibility/duty by drawing their attention to this requirement either directly or through trade organisations.

Traction Current

78. The Coroner outlined a sense of confusion had been experienced at the scene between the emergency services about whether the electric current on the rail lines had been officially confirmed as discharged.

79. London Underground is currently discussing with London Fire Brigade how this confirmation might be sought, however the Coroner was also concerned that more could be done, once confirmation had been obtained, to disseminate that fact rapidly to all emergency personnel.

80. To take this work forward, the Coroner made a formal recommendation:

> 6. I recommend that 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.

81. Transport for London and London resilience partners accept this recommendation and have confirmed that discussions have already taken place with London Fire Brigade about how best confirmation might be sought that traction current is off. Following these discussions, procedures have been reviewed and the

London Resilience Team will share these as appropriate with London resilience partners.

82. At the national level, to ensure that next steps are implemented in other rail systems across the UK, the Government will draw the recommendations to the attention of Network Rail, Train Operating Companies and other light rail operators, and encourage them to review their procedures accordingly, on a cross industry basis and in liaison with other key partners such as the British Transport Police, so that they can make their own arrangements with their local emergency services.

LFB Operational Discretion

83. The Coroner noted that the late arrival of a second fire appliance to the scene at King's Cross station resulted in a delay to the deployment of fire crew to the platform. The Coroner asked that London Fire Brigade continue to review their protocols, procedures and training on a regular basis to ensure lessons from operational experience are learned, and that due to the dynamic nature of many situations, which may change rapidly, that protocols may be approached with a degree of flexibility, without putting fire crews at risk.

84. The Government notes that Fire and Rescue Authorities are responsible for the deployment of their operational resources to meet the risks within the authority area. Guidance from the Department for Communities and Local Government and the Chief Fire and Rescue Advisor assist Fire and Rescue Authorities to develop their mobilisation and operational policies and protocols. The National Operational Guidance on Railways, Tunnels and Underground has been reviewed and revised to incorporate lessons from 7 July and other operational incidents and is planned to be published later this year. The Government will draw the attention of this guidance to all Fire and Rescue Authorities who, in turn, have a responsibility to regularly review protocols, procedures and training to ensure lessons from operational experience are learned.

First Aid Boxes and Specialist Stretchers

85. The Coroner was concerned that no first aid kits are available on underground trains. In addition, the Coroner asked that the suitability and provision of stretchers provided by London Underground be re-examined.

7. I recommend that 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

86. Transport for London accepts this recommendation and will undertake a further review of the provision of first aid equipment on underground trains. Following a recent review of stretchers with health professionals, London Underground replaced all of its stretchers with those considered to be the most appropriate, however following this recommendation, London Underground will undertake a further review of this provision with the relevant experts.

87. The next steps taken in London should also be considered at a national level, both in terms of how this policy is applied to other light rail systems, and also whether there are any implications for the broader transport network. The Government will ensure that rail operators are aware of this requirement by drawing their attention to it.

88. Since 2005 there have been a number of national improvements that may help the provision of medical care to patients involved in major incidents, where the working environment is challenging.

89. Additional training and equipment has been provided to dedicated teams of ambulance personnel with the aim of responding more immediately to casualties involved in incidents in hazardous areas (Hazardous Area Response Teams), and emergency dressing packs have been supplied to major transport hubs, providing quick access to medical equipment needed to treat up to 100 casualties per pack. The Department of Health continues to review the distribution of these packs to ensure availability at all necessary major transport hubs.

90. In addition, Mass Casualty Equipment Vehicles (MCEV) have been deployed to all ambulance trusts nationally. These vehicles are designed to facilitate emergency clinical care at the primary incident site by delivering enough medicines, consumables and equipment to treat up to approximately 350 casualties, by those ambulance personnel already on scene.

The Public as First Responders

91. The Coroner noted that the first to respond to the dead and dying were often fellow passengers.

92. Ensuring public awareness of the risks they face is a priority for Government and to support this there is a regular publication of a National Risk Register of civil emergencies. This is complemented by work to support community and individual resilience which can help the public be prepared for the risks they face. A series of online resources are available on the Cabinet Office and Directgov websites, which enable individuals, communities and the organisations that support them in getting involved in emergency preparedness activities, in a way that complements the work of emergency responders. The Cabinet Office supports organisations such as Local Authorities, the Environment Agency and the Red Cross, to deliver help and advice to communities and individuals.

93. Part of this work also involves working with providers of community resilience, such as The Red Cross, who run a number of first aid programmes, offer a range of resources and support services to assist and enhance local front line (Category 1) responders.

Triage

94. Concern was raised that some paramedics carrying out the role of bronze triage did not carry their medical equipment with them when triaging patients. The Coroner recommends that:

> 8. The London Ambulance Service, together with the Barts and London NHS Trust (on behalf of the LAA) review existing training in relation to multi casualty triage (i.e. the process of triage sieve) in particular with respect to the role of basic medical intervention.

95. The London Ambulance Service, together with Barts and London NHS Trust accepts this recommendation and will undertake a review of the triage process. Any changes to procedures implemented as a result of this review will be shared with London resilience partners as appropriate.

96. The Government supports recommendation eight in principle, and recognises the importance of closer inter- agency working to better enhance the delivery of triage and medical intervention. The Government would expect training needs in relation to

multi casualty triage and medical intervention as highlighted in the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines to be considered by all of the Ambulance Services across England, and not just by London Ambulance Service in isolation. The Government will therefore invite both Barts and The London NHS Trust and London Ambulance Service to review existing training in relation to multi casualty triage, particularly with respect to the role of basic intervention. If this review suggests changes to current ambulance staff protocol, the Government will work, with the NHS, JRCALC and the relevant professional bodies to facilitate these changes nationally.

97. The Coroner also commended the integration of lessons learned in military trauma care in to the basic paramedic training course. The Department of Health works closely with the Ministry of Defence and other parties to learn as many suitable lessons as possible from the military. The National Institute for Health Research (NIHR) Centre for Surgical Reconstruction and Microbiology was opened in January 2011. The facility brings both military and civilian trauma surgeons and scientists together to share advanced clinical practice in the battlefield, and innovation in medical research to benefit all trauma patients in the NHS at an early stage of injury. The centre also forms a central point in England for trauma research where knowledge can be translated into real improvements in care for all NHS patients.

98. During a major incident involving significant blast and trauma injuries the NHS response can be enhanced by assistance from Defence Medical Services. This support would be provided through the Department of Health's normal military assistance procedures.

99. In addition to these measures, advisors from the Ministry of Defence also work with the Department of Health to ensure that lessons learnt in the military are used to aid the continuous emergency preparation work done by both the Department of Health and the NHS.

Recognition of pre-hospital care as a sub-specialty

100. The Coroner lent her support to the application currently before the General Medical Council (GMC) to accredit pre-hospital care as a sub-specialty. The Government would support the accreditation but would not want to pre-empt the findings of the GMC.

Formal recognition of MERIT & Public funding for LAA

101. Concern was raised that London Air Ambulance and MERIT is a limited capability which currently relies upon professional volunteers giving up their limited free time in order to provide life saving emergency medical care. The fact that London Air Ambulance rely on corporate funding and charitable donations was also raised. The Coroner considered that an increased yet proportionate capability be required, to be directly funded by the Department of Health.

102. The Coroner made a formal recommendation stating that:

> 9. 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 LAA and MERIT and, in particular (i) its capability and (ii) its funding.

103. The Department of Health and the London Resilience Team accept the recommendation

to review the emergency medical care of the type provided by LAA and MERIT. The Department will therefore work with the necessary partners, including the NHS, to conduct this review.

Air Ambulances

104. Currently the Department of Health recognises that air ambulances, which operate across the country, play an important role in delivering emergency care, and provide an effective means of ensuring better and faster access to hospitals, supporting transfers between hospitals, and help to bring resources to the scene. The Department of Health believes that air ambulances should be appropriately targeted to cases where they can make most impact, and this is why the Department supports charities and ambulance trusts working together to agree how these services can maximise their contribution to high quality patient care in their areas.

105. The Department has, since 1 April 2002, been clear that the NHS should meet the salary costs of clinical staff on air ambulances. The NHS Trusts, at their discretion, determine whether to make a further contribution to the air ambulance charities towards operational costs.

Medical Emergency Response Incident Teams (MERITs)

106. The Department of Health supports in principle the concept of MERITs, and has released development and deployment guidance[2]. This recommended that SHAs ensure that Ambulance Trusts and Acute Trusts, including Foundation Trusts, work together to provide a model for immediate medical care at the scene and the organisation of MERITs or their equivalents appropriate to the area.

107. The Department of Health also recognises that to ensure the best possible pre-hospital care arrangements are in place, the MERIT models developed may need to vary around the country to take into account the provision of emergency care services as a whole within the local health economy.

108. SHAs are implementing Regional Networks for Major Trauma care throughout NHS England with support from the Department of Health and these are intended to be operational by April 2012. These networks of acute hospitals grouped around an identified Major Trauma Centre will ensure that seriously injured patients are taken to the hospital that is equipped to give them the best outcomes and chance of survival. These hospitals and networks will also increase the resilience of the NHS to a mass casualty incident ensuring that individual hospitals are less likely to be overwhelmed by seriously injured patients.

109. Given that MERITs are financed through a commissioning process and operate in the context of sub-national commissioning by SHAs to meet local needs and priorities, the Department of Health, with necessary partners such as SHAs and the London Resilience Team, will review the funding and capabilities of emergency medical care of the type provided by air ambulances and MERITs.

110. Furthermore, under the changes proposed in the Health White Papers[3], it will be the responsibility of the NHS Commissioning Board going forward to ensure that healthcare needs, including the provision of

[2] Department of Health, January 2010, NHS emergency planning guidance: planning for the development and deployment of Medical Emergency Response Incident Teams in the provision of advanced medical care at the scene of an incident

[3] Department of Health, July 2010 Equity and excellence: Liberating the NHS and Department of Health, November 2010, Healthy Lives, Health People

emergency medical care, continue to be met. These changes also reflect the Government's proposal for closer working between the NHS and local government.

London Air Ambulance as a Category 1 Responder

111. It was noted by the Coroner that organisations designated as Category 1 Responders under the Civil Contingencies Act 2004 are primarily limited to local authorities, the emergency services and health bodies. Because of its charitable trust status, LAA falls outside of the health sector's cohort of category 1 responders.

112. The Civil Contingencies Act currently states that category 1 responders must "have regard to" the activities of the voluntary sector in maintaining their emergency and business continuity plans. The Government recently considered the potential for assigning responder status to voluntary organisations as part of a programme of work to review the provisions of the Civil Contingencies Act. It was concluded that it would not be appropriate to assign this status as it undermined the essence of the sector; however work has taken place to strengthen references to the voluntary sector in statutory guidance (Emergency Preparedness). The Government will ensure specific reference is made to Air Ambulance Services, when the revised version of this guidance is published later this year.

Conclusion

113. Lady Justice Hallett's inquests have been more wide ranging than any previous reports on the 7 July bombings, considering both whether the attacks were preventable and the emergency service response to the attacks. We now have a comprehensive picture of what happened in the lead up to that terrible day and on the day itself.

114. The Government, the Security and Intelligence Agencies and emergency responder communities are constantly seeking to learn lessons and to improve the response to national emergencies, including from terrorist related incidents. This includes identifying and learning the lessons from the 7th July attacks, from other incidents and through training and exercising. There have been a considerable number of improvements made to these arrangements since 2005, including much closer working in the counter-terrorism and law enforcement communities and a significantly greater investment of resources to tackle terrorism. The UK's counter-terrorism strategy has continued to develop in response to the evolving terrorist threat and the Government intends to publish a revised version of that strategy later in the year.

115. This report has set out in detail the next steps that the Government will take to address the concerns raised in the Coroner's report. The Government will review progress by the end of March 2012, to ensure we have learned the lessons from 7 July 2005 and improved our preparedness and ability to respond to any future terrorist attack against a complex and evolving threat picture.

Annex A: Summary of recommendations and Government action

	Recommendation	Govt Action
1	I recommend that 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. (**Home Office / Security Service**)	Formal Government response pages 4-5
2	I recommend that procedures be examined by the Security Service to establish if there is room for further improvement in the recording of decisions relating to the assessment of targets. (**Home Office / Security Service**)	Formal Government response pages 6-8
3	I recommend that 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**)	National considerations pages 12-13
4	I recommend that 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**)	National considerations pages 13-14
5	I recommend that 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**)	National considerations page 16
6	I recommend that 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**)	National considerations pages 16-17
7	I recommend that 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**)	National considerations pages 17-18
8	I recommend that the LAS, together with the Barts and London NHS Trust (on behalf of the LAA) review existing training in relation to multi casualty triage (i.e. the process of triage sieve) in particular with respect to the role of basic medical intervention. (**LAS and Barts & London NHS Trust**)	National considerations pages 18-19
9	I recommend that 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 LAA and MERIT and, in particular (i) its capability and (ii) its funding. (**Department of Health / London Resilience Team**)	Formal Government response pages 19-21