INQUESTS INTO THE DEATHS ARISING FROM
THE FISHMONGERS' HALL AND LONDON BRIDGE TERROR ATTACK

WRITTEN SUBMISSIONS OF COUNSEL TO THE INQUESTS ON DETERMINATIONS AND DIRECTIONS TO THE JURY

Introduction

1. These written submissions are prepared in order to assist the Coroner in directing the jury with a view to eliciting their determinations in respect of the deaths of Saskia Jones and Jack Merritt in the terror attack at Fishmongers' Hall on 29 November 2019.

2. This document is structured as follows. First, it summarises relevant legal principles governing determinations in inquests. Secondly, it addresses the issue of law whether the procedural obligation under Article 2, ECHR, is engaged in these Inquests and with what effect. Thirdly, it sets out our provisional submissions on how the Coroner should elicit the conclusions of the jury as to the deaths. Finally, it proposes a process whereby representations may be made on the content of any Prevention of Future Deaths Report ("PFD Report").

3. Our submissions at this stage are provisional for two reasons. As a matter of practical necessity, this document is being circulated before the conclusion of the evidence. It is also being circulated without sight of the representations Interested Persons may make. We shall address the additional evidence and submissions of others as necessary in oral submissions.

4. In outline, our submissions are as follows:

a. The procedural obligation under Article 2, ECHR, is engaged in relation to both the death of Jack Merritt and the death of Saskia Jones, on the basis that it is at least arguable that there was a breach by state agents of operational duties to prevent Usman Khan from carrying out a lethal attack on members of the public and/or on attendees of the Learning Together event.

b. In those circumstances, it is not necessary to decide also whether there is an arguable case that there was a breach by the state of the general duty to have in place systems and practices designed to protect the lives of citizens.

c. For each of Jack Merritt and Saskia Jones, a short-form conclusion ought to be directed to be given, to the effect that they were unlawfully killed. Each Record of Inquest should record the uncontroversial but important fact that each of these young people was murdered.

d. For each of Jack Merritt and Saskia Jones, the jury should be invited to approve or amend a short passage summarising the means and immediate circumstances of death.

e. The jury should be invited to answer further questions indicating whether or not they consider that the deaths of Saskia Jones and Jack Merritt were or may have been contributed to by any of the following (i) failures or omissions in the management of Usman Khan in the community; (ii) failures or omissions in the investigation of Usman Khan; and/or (iii) deficiencies in the security arrangements at the event.

f. As regards the content of any PFD Report, Interested Persons should be directed to file submissions setting out what (if any) matters they suggest the Coroner might include in such a report. We propose that the Coroner directs responses to those suggestions before deciding whether to produce a report and on what matters.

5. In these submissions, references in the format "DC/pp" and "WS/pp" are to pages in documents and witness statements which have been disclosed on the electronic document management system. References in the format "T/dd/pp" are to days and page numbers in the transcript of the Inquests.

The Law

Statutory Provisions and Legal Principles concerning Determinations

6. The statutory provisions governing determinations in inquests are contained in sections 5 and 10 of the Coroners and Justice Act 2009 ("CJA"), which state as follows:

> **5 Matters to be ascertained**
>
> (1) The purpose of an investigation under this Part into a person's death is to ascertain –
>
> (a) who the deceased was;
>
> (b) how, when and where the deceased came by his or her death;
>
> (c) the particulars (if any) required by the 1953 Act to be registered concerning the death.
>
> (2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.
>
> (3) Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than –
>
> (a) the questions mentioned in subsection (1)(a) and (b) (read with subsection (2) where applicable);
>
> (b) the particulars mentioned in subsection (1)(c).
>
> This is subject to paragraph 7 of Schedule 5 [which addresses PFD Reports].
>
> **10 Determinations and findings to be made**
>
> (1) After hearing the evidence at an inquest into a death, the senior coroner (if there is no jury) or the jury (if there is one) must –
>
> (a) make a determination as to the questions mentioned in section 5(1)(a) and (b) (read with subsection (2) where applicable);
>
> (b) if particulars are required by the 1953 Act to be registered concerning the death, make a finding as to those particulars.

(2) A determination under subsection (1)(a) may not 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.

7. Rule 34 of the Coroners (Inquests) Rules 2013 ("the Rules") provides:

> A coroner or in the case of an inquest heard with a jury, the jury, must make a determination and any findings required under section 10 using Form 2.

Form 2 is headed "Record of an inquest" and it contains the following headings:

1. Name of the deceased (if known);

2. Medical cause of death;

3. How, when and where, and for investigations where section 5(2) of the [CJA] applies, in what circumstances the deceased came by his or her death (see note(ii);

4. Conclusion of the coroner / jury as to the death (see notes (i) and (ii));

5. Further particulars required by the Births and Deaths Registration Act 1953 to be registered concerning the death…

The Notes to that Form identify a number of long-established short-form conclusions, including that of unlawful killing. The Notes, which came into force on 25 July 2013, are now out of date in one respect, stating that the standard of proof applicable to most conclusions in an inquest determination is the civil standard (i.e. balance of probabilities) but that the standard of proof required for the short form conclusions of "unlawful killing" and "suicide" is the criminal standard. The Supreme Court has more recently determined that the civil standard of proof applies to all short form conclusions, as well as all narrative conclusions (see *R (Maughan) v HM Senior Coroner for Oxfordshire* [2020] 3 WLR 1298 at [97]).

8. The following legal principles have been developed by the higher Courts to guide coroners and juries in conducting inquiries and returning determinations:

a. An inquest is a fact-finding inquiry conducted by a coroner, with or without a jury. The primary objective of an inquest, provided by section 5 of the CJA, is to produce determinations answering four factual questions: who the deceased person was; and when, where and how he/she came by his/her death. Proceedings and evidence must be directed solely to ascertaining these matters. The jury (or coroner sitting alone) are forbidden from expressing opinion on any other matters, save for supplying the formal particulars required for death registration (and subject to the coroner's power to make a PFD Report) (see *R v North Humberside Coroner, Ex Parte Jamieson* [1995] QB 1 at 23 (general conclusion (1))).

b. The question of "how" the deceased came by his or her death is both the most difficult question and the most important, being described as a coroner's "over-riding duty" (see *R v East Sussex Coroner, Ex Parte Homberg* (1994) 158 JP 357).

c. Before the Human Rights Act 1998 came into force, incorporating the ECHR into domestic law, the "how" question was always to be read as meaning "by what means the deceased came by his/her death". That interpretation focuses attention on the physical means of death, albeit it is wider than simply identifying the medical cause of death. The question was usually answered by the coroner or jury choosing between the recognised short-form conclusions and completing a short entry for the immediate circumstances of death. However, there was no objection to a short-form conclusion being supplemented or replaced with a brief factual narrative (see *Ex Parte Jamieson; R (Longfield Care Homes) v Blackburn Coroner* [2004] EWHC 2467 (Admin)).

d. Article 2 of the ECHR (the right to life) encompasses a positive procedural obligation on member states which includes a requirement to establish effective and independent investigations into deaths in certain circumstances (see *R (Amin) v SSHD* [2004] 1 AC 653 at [20]). In addition to specific categories of case where the obligation is "automatically" engaged (e.g. suicides in prison and deliberate killings by state agents), the obligation to establish such an investigation is engaged where on the evidence it is arguable that the state or its agents committed a breach of a substantive Article 2 duty in relation to the death (see *R (Humberstone) v Legal Services Commission* [2011] 1 WLR 1460 at [52]-[68]; *R (Letts) v Lord Chancellor*

[2015] 1 WLR 4497 at [71]-[91]; *R (Parkinson) v Kent Senior Coroner* [2018] 4 WLR 106).

e. The threshold of an "arguable" breach is low: "anything more than fanciful" or "a credible suggestion" (see *R (AP) v HM Coroner for Worcestershire* [2011] EWHC 1453 (Admin) at [60], *R (Maguire) v Blackpool and Fylde Senior Coroner* [2020] 3 WLR 1268 at [75], *R (Skelton) v West Sussex Senior Coroner* [2021] 2 WLR 413 at [63]).

f. In *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182, the House of Lords held that, where the Article 2 obligation to establish an independent investigation into a death is engaged in connection with an inquest, the ordinary approach to inquest conclusions must be modified in one respect to satisfy Convention standards. The expression "how the deceased came by his/her death" in the statutory provisions is to be interpreted as meaning "by what means and in what circumstances the deceased came by his/her death": see [35]-[38]. In practice, this may require the coroner to return, or elicit from the jury, expanded narrative conclusions (see below). The decision in *Middleton* has now been given statutory force by section 5(2) of the CJA.

g. The decision as to whether the Article 2 procedural obligation is engaged will have little, if any, effect on the scope of inquiry at an inquest or the conduct of the hearing (see *R (Smith) v Oxfordshire Asst Deputy Coroner* [2011] AC 1 at [152]-[154]; *R (Sreedharan) v Manchester City Coroner* [2013] EWCA Civ 181 at [18(vii)]; *Maguire* (cited above) at [77]).

h. The "how" question requires an inquiry into acts and omissions which are directly responsible for the death. Other matters too may be lawfully recorded in box 3 of the Record of Inquest as part of the answer to how the death occurred, if the Record would be deficient without them (see *R (Worthington) v HM Senior Coroner for the County of Cumbria* [2018] EWHC 3386 (Admin) at [46]-[47]).

i. It is a matter of judgment for the coroner conducting an inquest to determine the parameters of the inquiry. In determining scope, it is a question of judgment (and often a difficult one) how far back to trace chains of events and causes. By

extension, the question of which witnesses to call is a matter for the coroner. Although he/she should conduct a sufficient inquiry to answer the statutory questions, the evidence will often cover a wider scope than is strictly necessary for that purpose. A coroner is entitled to exclude from consideration matters which cannot even arguably be said to have contributed to the death (see *R v Inner West London Coroner, Ex Parte Dallaglio* [1994] 4 All ER 139 at 155b and 164j; *R (Takoushis) v Inner North London Coroner* [2006] 1 WLR 461 at [43]-[48]; *McDonnell v HM Asst Coroner for West London* [2016] EWHC 3078 at [28]; *Coroner for the Birmingham Inquests (1974) v Hambleton* [2018] EWCA Civ 2081; *R (Speck) v York Coroner* [2016] 4 WLR 15 at [28])

j. Section 10(2)(a) of the CJA precludes the coroner or jury from making findings which appear to determine any question of criminal liability of a named person. This form of words legitimises a coroner or jury returning in suitable cases the well-established conclusion that a death was due to unlawful killing. That conclusion may be given if it is found that death was due to an offence of murder, manslaughter or infanticide (see *R (Wilkinson) v HM Coroner for Greater Manchester South District* [2012] EWHC 2755 (Admin)). It will commonly be necessary to consider specifically whether a particular person committed the relevant offence. That person will not be named in the conclusions, although it may be obvious from the circumstances, evidence and/or summing-up who has been identified as responsible (see *R (Anderson) v HM Coroner for Inner North London* [2004] EWHC 2729 (Admin) at [21]; *R (Evans) v HM Coroner for Cardiff and Glamorgan* [2010] EWHC 3478 (Admin) (upheld on appeal: [2011] EWCA Civ 719)). It is proper that, where it is clearly the case that the deceased was unlawfully killed, there may be evidence of how the deceased came by his or her death which implicates identified individuals (see *Hambleton* at [53]).

k. In *Worthington* (cited above) at [35], the Divisional Court explained that there is a three-stage process to making a determination at the end of an inquest (whether or not Article 2 is engaged). First, the coroner or jury should make findings of fact on the evidence (which a coroner sitting alone may include in a summing-up and/or a ruling). Secondly, the answer to the question "how" the deceased person came to die should be distilled from those findings (which may be recorded in box 3 of

the Record of Inquest and/or within a narrative conclusion). Thirdly, a conclusion should be given as to the death which flows from and is consistent with the findings.

Principles concerning Article 2 Duties

9. The legal principles governing substantive duties of the state under Article 2, ECHR, may be summarised as follows:

   a. Article 2 imposes a negative obligation on the state and its agents not to take life save in certain specified situations. It also imposes positive obligations to protect life, which fall into two categories: (i) a general duty on the state; and (ii) operational duties which are owed by state agents and agencies in certain types of case.

   b. The general duty has been described as requiring the state to –

      > "establish a framework of laws, precautions, procedures and means of enforcement which will, to the greatest extent reasonably practicable, protect life."

      This general duty arises in a wide range of contexts as diverse as environmental protection, public health and police / military operations. See: *Middleton* at [2]; *Savage v South Essex NHS Foundation Trust* [2009] 1 AC 681 at [18]-[19]; *Oneryildiz v Turkey* (2005) 41 EHRR 20 at [89]-[90]; *Budayeva v Russia* (20.3.08, at [140]-[141]); *Parkinson* (cited above) at [49]-[50] and [82]-[92]. In *Parkinson*, the Court identified the distinguishing feature of any breach of the general duty as being a "systemic failure"; a dysfunction in systems and practices rather than "ordinary negligence" of individuals. In *Lopes de Sousa Fernandes v Portugal* (2018) 66 EHRR 28 at [188], the ECtHR pointed out that an allegation of breach of the general duty requires a "concrete assessment of the alleged deficiencies rather than an abstract one."

   c. The general duty may extend beyond written procedures, to encompass the planning and control of operations (including police operations) and the training of staff: see *Kakoulli v Turkey* (2007) 45 EHRR 12 at [106]; *Savage v South Essex Partnership NHS Foundation Trust* [2009] 1 AC 681 at [45] ("ensuring that

competent staff are recruited, that high professional standards are matinained and that suitable systems of working are put in place"). It may, for instance, extend to instructions to armed police officers: see *Makaratzis v Greece* (2005) 41 EHRR 49 at [57]-[59].

d. A determination of whether that general duty has been complied with involves assessing the adequacy of legislation, policies, procedures and systems at a relatively high level of generality, taking into account their overall effect and the resources available to support them. See the discussion in *R (AP) v HM Coroner for Worcestershire* (cited above) at [52] and [65]-[74].

e. Most recently, in *Kotilainen v Finland* (application no.62439/12, judgment 17.12.20) the ECtHR has recognised that Article 2 creates a "special duty of diligence" in certain circumstances where there is a "particularly high level or risk": see [89]. In that case, the Court found "that the duty to provide general protection to society against potential criminal acts of one or several individuals may be engaged in respect of persons, notably dangerous prisoners, who are in the charge of State authorities, or in circumstances where the imminent danger emanating from them has become apparent in connection with an intervention by the police". The Court held, in the context of firearms licensing, that "[t]he particularly high level of risk to life which is inherent in their use must entail a duty for the authorities to intervene when alerted to facts that give rise to concrete suspicions regarding compliance with such requirements": see [85].

f. In certain types of case, it has been held that state agents / agencies may owe an operational duty to protect an individual citizen or group of citizens against specific kinds of danger. This type of duty was first recognised by the ECtHR in *Osman v UK* (2000) 29 EHRR 245, a case concerning the duty of the police to protect individuals against reported threats. Where the duty applies, the Court formulated the critical test for breach of the duty as follows (at [116]):

> "It must be established to [the] satisfaction [of the Court] that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of the individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk."

g. In this test, the word "real" is to be interpreted as a risk more than remote or fanciful (a low threshold), and the word "immediate" as "present and continuing" (rather than sudden or topical): see *Rabone v Pennine Care NHS Trust* [2012] 2 AC 72 at [38]-[39]. Breach of Article 2 duties in relation to a death may be established without proof that a relevant failure probably caused the death. It is only necessary to prove that the deceased lost a substantial chance of surviving as a result of the breach: see *Van Colle v Chief Constable of Hertfordshire* [2009] 1 AC 225 at [138].

h. The *Osman* operational duty to take reasonable steps to prevent an appreciable "real and immediate risk to life" has been incrementally extended by the ECtHR to other classes of case. In *Keenan v UK* (2001) 33 EHRR 38 from [88], the Court found that the duty was owed to those in state custody. It has also been held to apply where police operations have given rise to a risk of people being killed or killing themselves (e.g. *Makaratzis* [49]-[72]; *Mammadov v Azerbaijan* (2014) 58 EHRR 18 at [113]-[116]).

i. In *Rabone* (cited above), the Supreme Court extended the *Osman* duty to the situation of a mental patient admitted voluntarily to hospital. Lord Dyson (from [22]) identified indicia which might assist in considering whether the *Osman* duty would exist in a novel situation. These included: (i) assumption of responsibility for welfare of the deceased; (ii) vulnerability of the victim; and (iii) whether the risk involved is an ordinary one for individuals in a particular category. However, Lord Dyson stressed that these were merely factors which might be relevant, and that they did not provide "a sure guide" to whether the duty should be found to exist.

j. In recent years, specific consideration has been given to the operational duty in the context of the fight against terrorism. The *Osman* duty has been found to apply to the authorities in taking steps to prevent acts of terrorism. In *Tagayeva v Russia* (Application 26562/07, judgment 13.4.17), the ECtHR considered the terrorist attack on a school in Beslan, North Ossetia. At [481]-[492], the Court concluded that the authorities had had sufficient information that there was a terrorist threat to educational facilities in the district to trigger the obligation to take sufficient protective action (even though the targeted individuals had not been identified with precision – see [486]).

k. The operational duty has been extended over recent years to encompass situations where a threat arises from an identifiable source (e.g. from specific individuals) to the public at large. It has been held by the Strasbourg and domestic Courts that state agents may owe a duty to take reasonable steps to protect the general public in that situation. In considering the case of two prisoners who committed a murderous bank robbery during a short period of prison leave, the ECtHR observed that "what is at issue is the obligation to afford general protection to society against the potential acts of one or several persons serving a prison sentence for a violent crime": see *Mastromatteo v Italy* (App. No. 37703/97, 24.10.02) at [69]. That approach has been confirmed in a number of further cases, including *Maiorano v Italy* (App. No. 28634/06, 15.12.09) at [107]; *Choreftakis and Choreftaki v Greece* (App. No. 46846/08, 17.1.12) at [48]; *Guiliani and Gaggio v Italy* (2012] 54 EHRR 10 at [247]; and *Bljakaj v Crotia* (2016) 62 EHRR 4 at [108].

l. In *Griffiths v (1) Chief Constable of Suffolk Police and (2) Norfolk and Suffolk NHS Trust* [2018] EWHC 2538 (QB), Ouseley J considered that line of Convention authority. He concluded as a matter of principle that the operational duty under Article 2 extended to requiring relevant state agents to take reasonable steps to protect society at large where an identifiable individual posed a threat to the public. Addressing the case of *Bljakaj*, Ouseley J (at [499]) identified the breach of duty which had been found by the ECtHR in that case as a failure "to protect the general public". He said that in *Bljakaj* the reasonable steps required to protect the general public would have been to make use of powers for a deranged individual to be committed to hospital.

m. Hallett LJ gave a written ruling following a pre-inquest hearing in the London Bombings Inquests in April 2010,[1] in which argument had been heard regarding the extent of the *Osman* duty (with reference to *Mastromatteo*): see [71]-[83]. At that time, the question whether the operational duty could be owed in respect of the public at large was debatable. Hallett LJ said that she did not need to resolve the issue, but indicated that she was attracted to a solution of construing the duty as covering two situations in the counter-terrorism context: (i) a duty to take

[1] The ruling is available at:
- https://webarchive.nationalarchives.gov.uk/20120216081134/http://7julyinquests.independent.gov.uk/docs/orders/dec-april-2010.pdf

reasonable protective action arising from information as to a target; and (ii) a duty to take reasonable preventive action arising from information as to a potential attacker: see [82]. In our submission, subsequent case law has confirmed that the operational duty can be owed to the public at large and has given support to the analysis suggested by Hallett LJ.

Principles concerning Narrative Conclusions in Article 2 Cases

10. Over the years since the *Middleton* case, the Courts have provided the following relevant guidance on the approach of coroners to eliciting and returning narrative conclusions in inquests in which the Article 2 procedural obligation is engaged:

    a. The objective of the narrative conclusion is for the coroner or jury to express findings on the key factual issues in the case, which might go beyond the immediate physical means of death. In particular, they may deal with underlying and contributory factors. Lord Bingham gave this further guidance in *Middleton* (at [36], in the context of a jury case):

    > "If the coroner invites either a narrative verdict or answers to questions, he may find it helpful to direct the jury with reference to some of the matters to which a sheriff will have regard in making his determination under section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976: where and when the death took place; the cause or causes of such death; the defects in the system which contributed to the death; and any other factors which are relevant to the circumstances of the death."

    He went on to say that interested persons could make submissions on the appropriate means by which a coroner could return, or elicit from a jury, conclusions on the key issues. However, he stressed that "the choice must be that of the coroner and his decision should not be disturbed by the courts unless strong grounds are shown." Accordingly, a coroner has a considerable margin of judgment in deciding how to formulate or elicit a narrative verdict.

    b. On the facts of the *Middleton* case (a prison suicide case), the House of Lords (at [45]) suggested an appropriate wording for a narrative in that case: "The deceased took his own life, in part because the risk of his doing so was not recognised and appropriate precautions were not taken to prevent him doing so". Lord Bingham explained (at [37]) that this embodied "a judgmental conclusion of a factual nature, directly relating to the circumstances of death".

c. A narrative conclusion must not contravene the provisions of section 10(2), which prohibit any conclusion that appears to determine any question of criminal liability of a named person or any question of civil liability. See: *Middleton* at [37]. Since contravention of substantive obligations under Article 2 gives rise to civil liability under the Human Rights Act 1998, an express finding of breach of those obligations is prohibited. See: *R (Smith) v Asst Deputy Coroner for Oxfordshire* [2008] 3 WLR 1284 at [24].

d. The means of eliciting or stating appropriate conclusions on the key factual issues concerning means and circumstances of death will vary from case to case. In *R (P) v HM Coroner for Avon* [2009] EWCA Civ 1367 at [25]-[26], Maurice Kay LJ explained that the first task of a coroner is to identify the central issues, and the next is to devise a means for those issues to be resolved, which may be by a combination of (i) a choice of short-form conclusions and (ii) a supplementary narrative. See also *R (Bodycote HIP Ltd) v HM Coroner for Herefordshire* [2008] EWHC 164 Admin (at [23]), where Blake J found that, in the circumstances of the case before him, it might be appropriate to return a narrative either as well as, or as an alternative to, a short-form conclusion.

e. When addressing in a narrative conclusion whether a factor was causally relevant to death, the test is whether it more than minimally contributed to death: see *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] 4 WLR 157 at [41]; *R (Chidlow) v Coroner* [2019] EWHC 581 (Admin) at [37].

f. Any narrative conclusion must be limited to matters relevant to the death(s) under investigation. Where an event or circumstance <u>may have</u> caused or contributed to the death(s) but cannot be proved <u>probably</u> to have done, the coroner has a power to return or elicit conclusions about that event or circumstance.

    i. In *R (Allen) v HM Coroner for Inner North London* [2009] EWCA Civ 623, at [40], the Court said that a coroner conducting an inquest in which Article 2 was engaged "was only obliged to investigate those issues which were, or at least appeared arguably to be, central to the cause of death."

ii. In *R (Lewis) v Mid and North Shropshire Coroner* [2010] 1 WLR 1836, the majority of the Court (Sedley and Rimer LJJ) concluded that a coroner has the power to seek the conclusions of a jury on matters which did not probably cause the death of the deceased. However, there was no duty to seek such conclusions: see [28]-[29]. See also *R (Le Page) v HM Asst. Deputy Coroner for Inner South London* [2012] EWHC 1485 Admin; *Chidlow* (cited above) at [37].

iii. In *Tainton* (cited above), the Divisional Court held that serious failings (there admitted) ought to have formed part of a narrative conclusion given that they formed part of the circumstances of the death, even though the jury could not find them to be causative.[2]

g. A narrative conclusion may also express conclusions on matters properly featuring in the circumstances of death and state that they were not causative of death. This was determined recently in *R (Worthington) v HM Senior Coroner for Cumbria* (cited above). There, the Divisional Court held that the coroner had been entitled to state in his determination that the deceased child had suffered abuse shortly before death and that it had not been causative of death: see [43]-[52].

h. A narrative conclusion should not deal with abstract matters, such as matters of high policy.

i. In *R (Scholes) v SSHD* [2006] EWCA Civ 1343 at [70], Pill LJ expressed concern that a coroner had sought to elicit a narrative conclusion by a jury questionnaire which addressed issues of broad policy, rather than concrete issues arising in the particular case.

ii. In *R (Smith) v Oxfordshire Assistant Deputy Coroner* [2011] 1 AC 1 at 100G-H, Lord Philips said that inquests were fact-finding inquiries and would not

[2] There is arguably a tension between this decision and those in *Lewis* and *LePage*, which has not been explored in any cases since *Tainton*.

be the right forum for resolving questions of policy (e.g. the overall competence with which military manoeuvres had been executed).

i. There is no objection to a narrative conclusion in a *Middleton* inquest identifying relevant failures (see *Tainton*, cited above), or describing such failures as "serious": see *R (Smith) v Asst Deputy Coroner for Oxfordshire* [2008] 3 WLR 1284, Collins J.

j. A narrative conclusion ought not to be too long or complicated.

i. In *Coroner for the Birmingham Inquests (1974) v Hambleton* (cited above) the Court of Appeal stressed (at [18]) that a finding of a failure by the authorities to act appropriately would be made by means of a "brief factual conclusion" similar to the short conclusion suggested in *Middleton* itself.

ii. In *Clayton v South Yorkshire Coroner* [2005] EWHC 1196 Admin at [31], the Court doubted the appropriateness of a three-page questionnaire put before it, apparently on the basis that it was disproportionate or overly complex.

iii. *R (de Menezes) v Assistant Deputy Coroner for Inner South London* [2008] EWHC 3356 (Admin) involved a challenge to decisions of the coroner hearing the Stockwell shooting inquest regarding the drafting of a verdict questionnaire. In rejecting the challenge, Silber J said (at [26]-[27]) that the coroner had been justified in taking an approach designed to minimise the risk of confusion or undue complexity in the conclusion.

Article 2 in these Inquests

11. In these Inquests, the Coroner has previously declined to rule that Article 2 is engaged in the sense considered in the *Middleton* case. In the Court's June 2020 and October 2020 Rulings the Coroner determined to keep the matter under review and indicated that it

would be considered at the following PIR hearing.[3] Given the extent to which matters had progressed, we submitted that Article 2 should not be addressed at the February 2021 PIR hearing.[4] The decision was put over until the main Inquests, and it has been thought sensible to address it at the conclusion of the evidence.

12. Having adopted this approach, the Court is now much better informed about the actions of the agencies and individuals involved in the management and investigation of Usman Khan in the period before the attack. In particular, the Court has explored in evidence the extent to which probation officers, police officers and the Security Service gave consideration to whether (and on what conditions) Usman Khan should attend the London event. In contrast, when the arguments were first advanced in writing in April 2020, the Coroner recorded in his Ruling that the submissions did not "identify particular features of the evidence supporting their position that breaches were arguably committed" (see [84]). That was not because of any failure of ingenuity or advocacy, but limitations in the evidence then available.

13. There has been no harm to the Coroner's inquiry in the matter being kept under review until now. The scope of the Inquests has been broad enough to enable proper conclusions to be returned on any view, whether or not Article 2 is engaged.

14. For the reasons given below, our submission is that the procedural obligation under Article 2 is engaged on the basis that it is arguable that there were breaches by state agents / agencies of an operational duty to protect life. We should stress the point made above, that the threshold of whether a breach is arguable is low (described in the authorities as more than fanciful or a credible suggestion).

15. The effect of Article 2 being engaged means that the determination in each of the Inquests should address the circumstances as well as the means of death. It may be more judgmental and may address underlying contributory causes. However, it should still be concise and must still comply with the statutory requirements. In these Inquests, as we explain below, we propose that given the factual complexity of this case that determination is best elicited by way of a questionnaire.

[3] First Ruling on Case Management and Directions, 5 June 2020 [86]; Second Ruling on Case Management and Directions, 22 October 2020 [48].
[4] T/PIR3/45.

Prevention of the attack

16. In our submission, it is arguable that there was a breach of the Article 2 operational duty in that one or more of the agencies responsible for managing Usman Khan knew or ought to have known that he posed a threat to the lives of (a) attendees of the Learning Together event on 29 November 2019 at Fishmongers' Hall and/or (b) the general public in the area, and that they failed to take measures which, judged reasonably, might have been expected to avoid a real and immediate risk to life. There is in particular an arguable case that steps could have been taken either to prevent Usman Khan from travelling to London or to add safeguards which may realistically have prevented the deaths in this case.

17. Taking the following six propositions together, it is arguable that agents of the state breached the Article 2 operational duty:

    a. First, Usman Khan was a very dangerous man with a longstanding commitment to an extremist cause and violent tendencies. Throughout his time in prison and in the period between his release and the attack, he was consistently assessed by the State to pose (at least) a high level of risk of serious harm to the public.

    b. Secondly, those who attended the MAPPA meetings for Usman Khan, including those in August,[5] October[6] and November 2019,[7] recognised and agreed that he posed such a risk. In addition, there were a series of risk factors giving cause for concern in late 2019.

    c. Thirdly, Usman Khan was subject to a licence condition which, without variation, would have prevented him from attending the event in London on 29 November 2019.[8] The variation of that licence condition required the permission of his probation service offender manager, and those attending the MAPPA meetings could have prevented permission being given.

    d. Fourthly, Usman Khan's proposed attendance at the event in London did arguably present a real and immediate risk to the lives of attendees and/or others in the

[5] DC6415/9.
[6] DC6416/7.
[7] DC6417/8.
[8] DC5644.

vicinity. The Security Service and/or those responsible for managing Khan (including those who attended the MAPPA meetings) arguably knew or ought to have known this.

e. Fifthly, those who attended the MAPPA meetings did not discuss whether Usman Khan's attendance at the event in London presented any particular risk. The arguable risk was not recognised and addressed in the course of those meetings or otherwise within or between the responsible agencies. The Security Service and the MAPPA agencies arguably did not take any reasonable steps to mitigate that risk.

f. Sixthly, instead, the offender manager made a decision to allow Usman Khan to attend the London event. It is arguable that the decision reflected a failure to take reasonable action to avert an appreciable risk.

18. In the following paragraphs we address each of those propositions in detail and outline the evidence which would allow the Coroner to reach these conclusions.

A. Usman Khan was a very dangerous man with a longstanding commitment to an extremist cause and violent tendencies. Throughout his time in prison and in the period between his release and the attack, he was consistently assessed by the State to pose (at least) a high risk of serious harm to the public.

19. Usman Khan was convicted in 2010 of offences of acts preparatory to terrorism.[9] The basis of his plea was that he had sought to establish a militant training camp in Kashmir, from which in future terrorist attacks might be launched against the UK.[10] He discussed attacks on the UK, including with the use of IEDs. He had a history of involvement in incidents of violence as a teenager in 2004 and 2009.[11] As set out below, he spent practically all his adult life in high security prisons among violent and terrorist

[9] DCI Dan Brown, T/1/35.
[10] Sumeet Johal, T/15/126.
[11] DCI Dan Brown, T/11/4-7.

offenders.[12] While there, he was consistently reported to be a leading extremist figure, involved in bullying,[13] violence,[14] radicalising others and serious disruption.[15]

20. The risk posed by Usman Khan at the time of his release from HMP Whitemoor on 24 December 2018 was well recognised.

    a. HMPPS carries out Extremism Risk Guidance assessments ("ERG 22+") at various intervals. Each such assessment provides a structured means of psychologically assessing an extremist offender's risk of engaging with extremism by reference to specified risk factors.[16] Dr Ieva Cechaviciute, a registered forensic psychologist who worked within prisons, prepared such an assessment on 30 April 2018, following approximately six and a half hours of interviews with Usman Khan.[17] She reported that his engagement with extremism could increase on release for a number of specific reasons, including risk factors such as his needs for status and for comradeship.[18]

    b. Dr Cechaviciute recorded that Usman Khan's intent to commit an extremist offence could also increase on release because of various risk factors such as justifying offending, harmful "means to an end thinking", and the partial presence of factors such as "us and them thinking".[19] Dr Cechaviciute was "very clearly worried"[20] about Usman Khan and took steps to convey this at Pathfinder case management meetings within the prison. Furthermore, Dr Cechaviciute had a degree of scepticism about Usman Khan's self-reporting "from the very beginning".[21]

    c. The conclusion of her ERG 22+ assessment was that a number of engagement and intent factors were "strongly present", and several more were found to be "partly present". Among those factors which were "strongly present" were "need for status", "excitement, comradeship & adventure", "attitude that justify offending"

[12] William Styles, T/14/78.
[13] Philip Bromley, T/15/18; Witness A T/22/59.
[14] Sumeet Johal, T/15/127.
[15] Kenneth Skelton, T/16/33; MAPPA F DC6406/5.
[16] Steve Machin, T/12/110-111.
[17] T/18/51.
[18] DC5322/32.
[19] DC5322/33.
[20] T/18/14.
[21] T/18/17.

and "harmful means to an end".[22] She concluded that there was a medium risk that Usman Khan would engage in extremist activity and that there was a prospect this would increase to a high risk upon Usman Khan's release into the community. Upon release, Dr Cechaviciute found it to be quite likely that his intent to engage in such activity would increase.[23]

d. When asked the extent to which her ERG 22+ report indicated some real concerns, the psychologist replied "that was very worrying to me, and I was really very… worried how to communicate this in my report, so therefore I went into a lot of detail explaining the pattern of his behaviour and tried to communicate to whoever was reading the report that his risk is likely to increase, when he's released."[24]

e. Dr Cechaviciute said that "I was quite certain that there was little honesty in what he was telling me"[25] and that "he was saying the right things… I did not see his self-report as honestly reflecting what he was really thinking".[26] When asked about the significance of a subject denying his offending after such a period of time, she said:

> "So that is quite significant, because firstly that could indicate that he does not have insight into to his offence, therefore he would not know what to do in order to stop himself or he may not want to, because he does not believe he has done anything wrong. So there would not necessarily be a motivation there for him to – kind of to participate in anything genuinely or to stop doing what he was doing because he's not interested."[27]

f. This ERG 22+ assessment included a non-exhaustive list of "warning signs and offence paralleling behaviours that could indicate a vulnerability to increased risk of reoffending" which were specific to Usman Khan.[28] This list included:

   i. "Feeling of lack of purpose in life and loss of focus on pro-social goals";

   ii. "'Us and them' thinking";

[22] DC6506/1.
[23] T/18/20.
[24] T/18/22.
[25] T/18/26.
[26] T/18/27.
[27] T/18/23.
[28] DC5322/37-38.

iii. "Boredom, feeling lost about what to do"; and

iv. "Distancing himself from his own actions, minimising or denying that his actions have impacted on or supported a particular negative outcome not thinking about the long-term consequences of his behaviour".

g. Dr Cechaviciute emphasised the importance of assessing Usman Khan's reporting "in the context of all the other information I know about him".[29] A lot was known about Usman Khan by HMPPS,[30] WMCTU,[31] Staffordshire Special Branch[32] and MI5[33] at the time of his release, from prison intelligence. The available intelligence included:

i. In January 2011, Usman Khan suggested that he had access to a weapon and was going to "do someone in the eye" or in the neck;[34]

ii. In March 2011, Usman Khan and others were reported to have been involved in an attack on another prisoner during which shouts of "Allah Akbar" were made;[35]

iii. In June 2012, Usman Khan entered the netting area on the wing and recited a poem, which included the words "cut off the kuffar's head";[36]

iv. In May 2013, Usman Khan was reported to be radicalising or rallying and influencing other Muslims, encouraging them to wear Muslim dress and threatening prisoners who questioned Muslim prayer;[37]

v. In June 2015, Usman Khan was suggested by intelligence to be a "Muslim enforcer" in the prison;[38]

[29] T/18/65.
[30] Mercury Intelligence Record, DC6503.
[31] T/26/16.
[32] DS Jon Stephenson, T/24/42.
[33] Witness A, T/22/59.
[34] DC6503/823, T/11/22.
[35] DC6503/742; T/11/22.
[36] DC6503/171, T/11/23.
[37] DC6503/1081, T/11/26.
[38] DC6503/1564, T/11/35.

vi. In December 2016, Usman Khan was said to be seen as a "leadership figure" amongst terrorist inmates at HMP Whitemoor;[39]

vii. In July 2017, intelligence indicated that Usman Khan was one of the main prisoners for promoting extremist views in HMP Whitemoor;[40]

viii. In August 2018, Usman Khan was said to have been regularly huddled together with other extremists (including Brusthom Ziamani, who was later to an attack in early 2020), preaching and causing other prisoners to be uncomfortable.[41] This intelligence was communicated to the MAPPA panel, and was minuted on 15 August 2018;[42] and

ix. In October 2018, an intelligence report read "Khan has said that he will return to his old ways, believed to be related to terrorism when he is released next year" and that "Khan tells those who he tries to radicalise that Muslims have to stick together".[43] A separate strand of intelligence from the same period stated that Khan had said he intended to carry out an attack after his release.

h. The Prevent team gained their knowledge of intelligence in relation to Usman Khan through MAPPA meetings.[44] PS Forsyth knew that Usman Khan had been (in his rather diplomatic phrase) "a problematic individual in prison".[45]

i. The MAPPA security information form[46] and MAPPA F form[47] prepared before the meeting of June 2018 referenced the troubling intelligence on Khan and they highlighted the risk that his recent relatively compliant conduct was deceptive.

j. The subject profile prepared on Usman Khan by Staffordshire Special Branch in the period leading up to his release summarised the offending background and the

[39] DC6503/1122, T/11/41.
[40] DC6503/2002, T/11/47.
[41] DC6503/1855, T/11/61.
[42] DC6407/6.
[43] DC6503/2242-2243, T/11/63.
[44] T/20/176.
[45] T/20/55.
[46] DC6433/2.
[47] DC5668/6.

intelligence outlined above. Analyst comments in the profile stressed the danger posed by Usman Khan and his manipulative and dishonest tendencies.

k. DCI Ryan Chambers, the SIO of the covert investigation established in November 2018, considered from the available intelligence and the background of Usman Khan's offending that he was a dangerous man who presented significant risks.[48]

21. Against that background, Usman Khan was to be released from being a Category A (High Risk) prisoner at HMP Whitemoor on 24 December 2018. Probation officer Kenneth Skelton held the role of Usman Khan's Offender Manager from May 2017 until the time of his death.[49] Prior to Usman Khan's release, Mr Skelton completed an OASys assessment dated 6 August 2018 in the following terms:

> "Mr Khan has done little over the term of his sentence to demonstrate his commitment to making the necessary changes and only six months ago November 2017 information was received confirming his negative behaviour and attempts to influence others. Until Mr Khan has demonstrated that he means what he says and distanced himself from anti-social others, engaged GENUINELY with all those responsible for him and presented as fully open and honest then the risks posed by him will I feel remain very high." [50]

22. Mr Skelton confirmed in evidence that this was his own assessment: that Usman Khan posed a very high risk to the public in the community. This assessment meant that a seriously harmful event was more likely than not to happen.[51] Upon a further assessment on 27 November 2018, one month before Usman Khan's release, Mr Skelton maintained that Usman Khan posed a very high risk to the public when released into the community.[52]

23. Mr Skelton gave evidence that it would not be appropriate for a probation officer to reduce their assessment of a person's risk in these circumstances "until the individual had been in the community for a period of time and demonstrated consistently that there was some… positive behaviour within that period of time, and only then would we look at having a conversation around reducing that" assessment.[53] This accords with the

[48] T/26/18.
[49] T/16/3.
[50] DC5660/38.
[51] T/16/27.
[52] DC5663/54.
[53] T/16/30.

evidence of Dr Cechaviciute, who was asked what she would need to see from an offender in the community before she might reach an assessment that the offender "had changed". She responded that "in the community the task would become much more difficult" on account of the lack of information available in relation to a person under strict licence conditions. Dr Cechaviciute noted that the training for ERG 22+ assessors is that where there is a lack of information, a cautious assessment should be made.[54]

24. The risk posed by Usman Khan was reassessed by Mr Bromley and Mr Skelton in May 2019. Mr Skelton recorded that Usman Khan posed a "high risk" of serious harm to the public, where previously he had posed a "very high risk".[55] He did so without completing an ERG 22+ or OASys assessment.[56] A "very high risk" assessment indicated that the risk of serious harm to the public was "imminent". Even the assessment of "high risk" indicated that Mr Skelton and Mr Bromley believed that "there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious."[57]

B. Those who attended the MAPPA meetings for Usman Khan in August, October and November 2019 recognised and agreed that he posed a high risk of serious harm to the public. In addition, there were a series of risk factors giving cause for concern in late 2019.

25. MAPPA meetings were attended variously by representatives of the National Probation Service, West Midlands Police CTU, Staffordshire Police Prevent officers, Staffordshire Police Special Branch Officers and (for the relevant time) HMP Whitemoor staff.

26. MI5 officers attended some but not all of the MAPPA meetings relating to Usman Khan. Witness A, a Deputy Director of the Security Service, could not confirm which meetings MI5 officers had attended but did say that MI5 was represented at fewer than half of the twelve panel meetings which took place.[58] Her evidence was that MI5 did not take part in MAPPA panel discussion but did give "advice to police colleagues and they briefed that in to the MAPPA meeting[s]".[59]

[54] T/18/35.
[55] DC6063/9.
[56] T/17/3.
[57] T/15/78.
[58] T/22/174.
[59] T/22/107.

27. The MAPPA panel understood, throughout the time that it was managing Usman Khan, that he posed a "very high" risk of serious harm to the public,[60] albeit in some document it was erroneously recorded as a "high" risk in certain places.[61]

28. PS Forsyth spoke with Usman Khan on 2 July 2019, noting that he appeared to have few friends and was lacking a support network.[62] However, PS Forsyth was not concerned about this giving rise to any increased risk at that time.[63]

29. The evidence from the Prevent officers, though, is that it was not for that team to assess the risk posed by Usman Khan. PS Forsyth was aware that MI5 would likely retain an interest in any on-going investigation into Usman Khan, but he did not know that there was a continuing priority investigation.[64] He knew that WMP CTU had an SIO, and that they held the role of "investigative oversight".[65] PS Forsyth was new to managing TACT offenders in the community, being trained as a Prevent officer; as PS Forsyth said "it wasn't Prevent work".[66] PC Craig Hemmings said that the Prevent team "often spoke about that we shouldn't be doing this role", on account of their lack of training.[67] DCI Hessell, of Staffordshire Special Branch, described the reason that Usman Khan was allocated to the Prevent team as "a legacy issue".[68] Staffordshire Special Branch were aware that PS Forsyth and his team had no experience of managing TACT offenders in the community.[69]

30. On 31 October 2019, PS Forsyth observed that Usman Khan was "struggling to find employment" and that he was spending "a lot of his time playing" Xbox games.[70] He recorded these concerns on ViSOR, in the knowledge that this behaviour correlated with specific risk factors in respect of Usman Khan. PS Forsyth wanted to bring these facts to the attention of others,[71] although he did not personally think that Usman Khan's behaviour around 14 November 2019 indicated that he was posing any increased risk as

[60] Nigel Byford, T/23/50.
[61] DC6415/9; DC6416/7; DC6417/8.
[62] DC7538/43.
[63] T/20/111.
[64] T/20/51.
[65] T/20/68.
[66] T/20/167.
[67] T/21/171-172.
[68] T/25/7.
[69] T/25/7, 127.
[70] DC7538/34.
[71] T/20/161.

compared to the preceding period.[72] By contrast, DS Stephenson (who attended the final MAPPA meeting on 14 November 2019) was concerned enough about Usman Khan's apparent social isolation to raise the matter by email of 6 November 2019 with West Midlands CTU and with MI5, seeking that a JOT meeting be set.[73] There was no suggestion in any of the MAPPA minutes that Usman Khan's level of risk should be any lower than "high".

31. Mr Skelton did not know after Usman Khan's release from prison that he was the subject of an MI5 investigation run jointly with counter-terrorism police.[74] When Mr Skelton attended MAPPA meetings which were also attended by officers of the West Midlands CTU, he was not aware that they had any involvement in the monitoring or management of Usman Khan, save as members of the MAPPA 3 panel.[75]

32. Nigel Byford, the chair of the panel, was not aware of whether there was an "active on-going investigation"[76] being carried out by West Midlands Police and MI5 and was not clear on the role of DS Marc Jerromes.[77]

33. The fact that there were these silos of knowledge underlines the importance of full and frank exchanges of views at MAPPA meetings. As provided in MAPPA guidance, "the invitation letter should make it clear that it is expected that all those invited will come to the meeting, having reviewed the information available to their agency on the offender, and should make clear the potential consequences of failing to share vital information".[78]

34. Notwithstanding the absence of an up to date OASys or ERG 22+ assessment (save for a draft ERG 22+ assessment which had been prepared by Mr Skelton),[79] the panel was able to assess the risk of serious harm to the public which Usman Khan presented. Moreover, in the 14 November 2019 meeting the MAPPA panel was aware of some specific indicators of risk as to Usman Khan's behaviour. For example, the panel noted a number of risk factors which were cited in the OASys assessment which had been prepared on

[72] T/20/162.
[73] DC7443/135; T/24/81.
[74] T/16/46.
[75] T/16/46.
[76] T/23/33.
[77] T/23/32.
[78] DC6511/13; T/17/97-98.
[79] DC6417/4.

27 December 2018.[80] In the same meeting, following PS Forsyth's observations from 31 October 2019, the panel noted that "some concern was raised in relation to UK potentially isolating himself and this behaviour requires some further investigation and ongoing monitoring".[81] Nigel Byford accepted that he knew at the time that "certainly some of those [risk factors or concerns] were present".[82] The panel concluded that "further investigation is needed into what UK is doing during his time spent at home."[83] DCI Ryan Chambers described the concern about isolation as follows:

> "So isolation suggests that somebody -- if they're not actively engaging with people, they're not having regular contact, they're not putting themselves forward to actively engage with life, it's quite concerning that if they're not doing that, then what is their thought process, what are they thinking and what are they doing is the concerns that I would have."[84]

35. It should be noted here that the MAPPA panel was also aware of the previous ERG 22+ assessment conducted by Dr Cechaviciute, in which conclusions were reached about risk indicators which were specific to Usman Khan.[85] These included "[f]eeling of lack of purpose in life and loss of focus on pro-social goals" and "[b]oredom, feeling lost about what to do". It is more than arguable that these risk indicators were present at the time of the Autumn 2019 meetings, demonstrated in part by the behaviour which PS Forsyth recorded and reported to the MAPPA panel. In short, by the time of the October and November meetings, members of the panel knew that Usman Khan had practically no social interaction (other than weekly visits to his family) and had been entirely unsuccessful in finding work for a year. He was a dangerous man, becoming increasingly isolated and without apparent prospects.

36. Another risk indicator which Dr Cechaviciute had identified was "[d]istancing himself from his own actions, minimising or denying that his actions have impacted on or supported a particular negative outcome not thinking about the long-term consequences of his behaviour".

[80] DC6417/7.
[81] DC6417/8.
[82] T/23/63.
[83] DC6417/6.
[84] T/26/64.
[85] DC5322/37-38.

a. Usman Khan repeatedly gave accounts to those managing him concerning his past offending which were either implausible or demonstrably untrue.[86] He claimed on one occasion to have fallen for a dodgy business scheme,[87] and on many other occasions to have been intending to set up a mosque or a genuine religious school.[88] These claims were at odds with his basis of plea. He claimed to have stood up to and challenged extremists in prison,[89] when in fact he had remained a leading extremist figure throughout his time there.[90]

b. The MAPPA panel was aware that this was a specific concern in respect of Usman Khan, arising from intelligence. The MAPPA F Offender Information Sharing Report prepared in August 2018 included the warning that "he may be behaving in a deceptively compliant manner in order to facilitate his release".[91] Mr Skelton knew this.[92] Moreover, this was noted as a specific concern in the Subject Profile maintained by Staffordshire Special Branch in December 2018, of which DS Jon Stephenson was aware:

> "Of Note – The intelligence suggests that some TACT prisoners use 'Taqiyya', which is a permissible form of telling lies to advance the cause of Islam. This means they will progress through their sentences by lying when doing intervention courses, to enable them to leave prison to commit further Terrorism offences. It is reported that Usman KHAN did this at HMP Woodhill. He worked with a psychologist and stated to another prisoner that he was just 'ticking boxes' showing that he is progressing."

c. DCI Robert Hessell, an experienced counter-terrorism officers, gave evidence that "terrorist offenders by nature of what they are, are probably duplicitious individuals".[93] However, Mr Skelton was never sceptical that Usman Khan might be putting on "an act", presenting as changed and improved where really he held the same extremist views which had led to his conviction.[94] In contrast, when asked whether a probation officer is expected to challenge an offender's accounts, so as to understand distinctions between their presentation and objective truth, Sonia

[86] E.g. Kenneth Skelton, T/16/106-7.
[87] M2, T/18/132.
[88] Sumeet Johal, T/15/163-4.
[89] Theological Mentor's notes, DC6488/1; TM, T/17/144.
[90] Dr Ieva Cechaviciute, T/18/16.
[91] DC6420/6.
[92] T/16/35.
[93] T/25/57.
[94] T/16/38-39.

Flynn (Chief Probation Officer) said it was "absolutely… the role of a probation officer… to test them".[95]

d. In the interview which Mr Skelton carried out for the ERG 22+ report which he was preparing in the second half of 2019, Usman Khan described that he now felt the motivation for his earlier offending had been "how he felt personal injustice in that his own property had been raised by the authorities"[96] and that his intention to have weapons at his planned camp in Pakistan was for "self-defence"[97] rather than as a terrorist training camp, which is the basis on which he pleaded guilty in 2012.[98] Mr Johal was aware that Usman Kahn was expressing "inaccurate views of the index offence and his own perceptions of why he's engaged".[99] However in the 4 November 2019 draft ERG 22+ which Mr Skelton completed, he attached very little weight to the clear inconsistencies between Usman Khan's description of his offending, and the basis on which he had pleaded guilty.[100]

37. At no time after Usman Khan's release did the MAPPA panel have the benefit of an ERG 22+ assessment prepared by a forensic psychologist. Although professional guidelines for the completion of an ERG 22+ assessment specify that such an assessment may be completed by "a fully qualified professional who has experience of working in forensic settings for example, a registered forensic psychologist/clinical psychologist or an experienced probation officer", the evidence of Dr Cechaviciute was that in completing an ERG 22+ she relied upon training which probation officers do not undertake.[101] She recognised that there would be a benefit in forensic psychologists attending MAPPA to explain their conclusions in order to assist the panel; something which did not happen in this case.[102]

38. Mrs Flynn expressed concerns about a probation officer such as Mr Skelton carrying out an ERG 22+ assessment in respect of an individual such as Usman Khan. Mr Skelton's suitability to prepare the assessment was not aided by Mr Bromley's "fairly limited" time

[95] T/19/42.
[96] DC5323/4; T/15/160-161.
[97] DC5232/5,; T/15/163.
[98] Sentencing remarks of Wilkie J DC5000/5; T/11/17.
[99] T/15/166.
[100] T/16/110.
[101] T/18/76.
[102] T/18/76.

to supervise Mr Skelton.[103] Mrs Flynn recognised that there was some "imbalance in the way the ERG was being formulated".[104] She acknowledged that Mr Skelton did not have the "psychologist's support" that others would now have, following a change in the system. When asked whether the ERG 22+ should have been carried out by a specialist offender manager, with more time, a less onerous case load and closer supervision, Mrs Flynn readily agreed.[105]

39. In today's system, an ERG 22+ assessment would be carried out by an offender manager, from a specialist hub, with specialist support. Moreover, those completing OASys and ERG 22+ assessments in the community now would have more time to devote to the task, with there being a cap on the number of offenders who can be managed at one time by probation officers and senior probation officers. Sonia Flynn described that this allows additional time for important assessments, and allows for there being "more than one pair of eyes"[106] on an individual.

40. Moreover, Mrs Flynn considered that Mr Skelton's decision[107] not to undertake the OASys assessment until after the ERG 22+ assessment was complete was a "missed opportunity".[108]

C. Usman Khan was subject to a licence condition which, without variation, would have prevented him from attending the event in London on 29 November 2019. The variation of that licence condition required the permission of his probation service offender manager. Those attending the MAPPA meetings in late 2019 could have prevented permission being given.

41. Usman Khan was subject to a licence condition "[n]ot to attend or organise any meetings or gatherings other than those convened solely for the purposes of worship without the prior approval of your Supervising Officer."[109] The effect of this condition was that Usman Khan needed the approval of Mr Skelton in order to attend the event in London.[110]

[103] T/19/48.
[104] T/19/68.
[105] T/19/26.
[106] T/19/26.
[107] T/17/32, 117-118.
[108] T/19/79.
[109] DC5193/2.
[110] T/16/90.

A further condition restricted Usman Khan from travelling through a train station. He needed the permission of his offender manager to be released from this condition as well.

42. Chief Probation Officer Sonia Flynn stated that "it was a significant decision to relax those licence conditions for one day".[111] Mr Skelton accepted that "the execution of that decision was [his] alone on the terms of the licence" and it was up to him whether to refer a permission decision to the MAPPA.[112] However in practice he "would always defer to MAPPA".[113] He graded the decision as a very important one.

43. PS Calum Forsyth, on behalf of the Prevent team, says that, had he been asked, he would have adopted his "default stance" that this was a matter for Mr Skelton, with the oversight of the MAPPA panel.[114]

44. Sonia Flynn believes that Mr Skelton and PS Forsyth should have discussed the matter in conversation, rather than it being largely by email.[115] Ms Flynn believed there should have been "some sort of one-off risk assessment"[116] before permission was given. Moreover, Mr Skelton "would have been expected to record his rationale"[117] for giving permission.

D. Usman Khan's proposed attendance at the event in London did arguably present a real and immediate risk that he would pose a threat to the lives of attendees and/or others in the vicinity. The Security Service and/or those who attended the MAPPA meeting arguably knew or ought to have appreciated this risk.

45. Under this heading, we make three points: first, that it was recognised in the Autumn of 2019 that Usman Khan posed a high risk of serious harm to the public; secondly, that the MAPPA agencies knew or ought to have known that Usman Khan's attendance at an event in London without escort or surveillance presented a particular risk; thirdly, notwithstanding that the MAPPA agencies believed that Usman Khan's involvement with Learning Together was a "protective factor", that was no reason for complacency.

[111] T/19/42.
[112] T/17/65.
[113] T/17/69.
[114] T/20/126.
[115] T/19/49-50.
[116] T/19/50.
[117] T/19/50.

46. First, the MAPPA panel recognised in the period between August and November 2019 that Usman Khan posed a high risk of serious harm to the public. As set out above, there were present a number of risk indicators which had been identified as specific to him in Dr Cechaviciute's ERG 22+ assessment and Mr Skelton's December 2018 OASys assessment. Although there was no intelligence after his release to indicate any attack planning, MI5 and counter-terrorism police acknowledged that they had limited insight into Usman Khan's mindset and they specifically planned at the JOT meeting of 18 November 2019 to step up monitoring for this purpose. Furthermore, as noted above, there were specific concerns, voiced by DS Stephenson of Staffordshire Special Branch in emails of 6 November 2019, that Usman Khan was becoming isolated such that closer observation was needed.[118]

47. Secondly, the London visit was to be Usman Khan's first unaccompanied trip outside the Stafford / Stoke area (his first trip outside the area being to a high security prison). It was to be a trip to a significant building in the capital next to the site of a previous terror attack. It was to be a trip to a high-profile event attended by important people in the criminal justice system. As Sumeet Johal explained, when asked whether an attack in central London is "more attractive than an attack on the streets of Stoke-on-Trent", "symbolism of an offence is very important for individuals".[119] Mr Pitchers QC suggested to Mrs Flynn that London Bridge is an iconic location. She responded that, since the Fishmongers' Hall attack, an additional licence condition has been added for every TACT offender in the country preventing them from going to "iconic places" because "that hadn't been identified in this case".[120] Nigel Byford accepted Mr Armstrong's characterisation of the Fishmongers' Hall location as a "trophy landmark".[121] If DCI Hessell had been told that it was intended that Usman Khan would travel alone to the event he "probably would have wanted some more assurances about what was being proposed" on account of the risks which he recognised.[122] When asked whether his concern about the visit was that sending somebody such as Usman Khan to an event might give rise to a risk of an attack, DCI Hessell responded "those issues… would be apparent, but obviously the detail of what that proposal was at that point in time

[118] DC7443/133, 135; T/24/80.
[119] T/15/182.
[120] T/19/72.
[121] T/23/123.
[122] T/25/36, 45-46.

wasn't known, as that's what we needed to try and establish." However he didn't recall "expressing those explicit concerns at that time".[123] Likewise, in response to a question by Mr Pitchers QC, put on the basis that DS Jerromes had not obtained the details of the London event, the officer accepted that he was in no position to give any sort of informed consideration to the risk associated with Usman Khan's attendance.[124]

48. Thirdly, although the MAPPA agencies regarded Usman Khan's continued involvement in the Learning Together programme as providing him with both social interaction and a purpose in life, it was not safe to be complacent about the London visit because of its connection with the programme. It was not clear that Usman Khan remained actively committed to the programme, since Mr Skelton knew, in about October 2019, that Usman Khan had not been completing any work on the Chromebook computer which he had been given for the purposes of involvement in Learning Together.[125] Moreover, the MAPPA panel noted, and Mr Skelton agreed, that there was a risk that Usman Khan's association with "a very prestigious University" was "feeding UK's self-entitlement", and that Usman Khan continued to have a "desire for status".[126] In May 2019 the MAPPA Panel was concerned by the risk that his "bubble could burst",[127] noting in August 2019 that Usman Khan was "becoming frustrated by blocks;… this frustration will likely be vented".[128]

49. DS Stephenson accepted that, knowing what they did about Usman Khan's record in prison, the conclusions of various risk assessments, and that he was about to undertake his first unaccompanied trip and that it was to Central London via a train station, he and his colleagues should have recognised that Usman Khan's planned trip was concerning, and ought to have given some advice to MAPPA.[129] As noted above, DI Hessell also expressed caution about the visit.

[123] T/25/46.
[124] T/26/202.
[125] T/16/115.
[126] DC6415/6.
[127] DC6413/5; T/17/109.
[128] DC6415/6; T/16/76,
[129] T/24/97, 100-101.

E. Those who attended the MAPPA meetings did not discuss whether Usman Khan's attendance at the event in London presented any particular risk. The arguably meaningful risk of the event was not recognised and addressed. Arguably, the Security Service and the MAPPA agencies did not take any reasonable steps to mitigate that risk.

50. The minutes for the August, October and November 2019 meetings are silent as to the discussion of any particular risk posed by Usman Khan's proposed attendance at the London event. The London event is recorded in the MAPPA minutes only to the following extent:

    a. On 22 August 2019, it is noted that "UK continues to have contact with Cambridge University on an almost weekly basis. He has applied for a bursary to support his attendance on a short course beginning next April. The course will last 1-day and will entail an overnight stay. The University are also hosting another 1-day Event in November – UK will be invited however will have likely moved on from the AP by this point and will need to source his own means of travel."[130] PS Forsyth attended the meeting and said he "genuinely" doesn't know whether there was any further discussion, and that he "can't recall whether there was any formal 'yes/no' discussion" as to whether permission ought to be given, albeit he assumes there would have been.[131]

    b. Mr Skelton said "if I remember rightly, there was no concerns raised about the visit, or about the attendance at the Fishmongers' Hall. The whole… conversation was, you know, in terms of risks, there was nothing at that particular point that identified any particular risks in relation to him, so at that meeting when we had that conversation, the attendance was raised and there was no particular concerns raised about his attendance" [132] Mr Skelton's evidence was that the MAPPA panel neither approved or denied Usman Khan's attendance at the London event and he "didn't necessarily take it as acceptance, but then again [he] didn't take it as a refusal."[133] He accepted that "in terms of the actual event at the Fishmongers' Hall, there were no discussions… because at that point there were no risks identified in his

[130] DC6415/4-5.
[131] T/20/130.
[132] T/16/71.
[133] T/16/72.

behaviour."[134] He later said that "the decision… for him to go there was made at some point" but that owing to the passage of time he was unable to say who contributed to the decision or what other views were expressed.[135]

c. When asked about his "independent recollection of the discussion at that meeting", the chair Nigel Byford said "I believe there was some additional discussion" although he "could not recall the detail of that".[136] He accepted that that "[i]f it had been a long discussion, I would have expected it to be minuted, even the bit that I've referred to should have been minuted".[137]

d. There is no mention of the London event in the minutes for 3 October 2019.[138] Mr Skelton initially gave evidence that this was not correct because there would have been some discussion "reiterating the point that he's been offered the opportunity to got to the event"[139] but later accepted that there was no significant discussion of the London visit or else it would have been minuted.[140]

e. In the 14 November 2019 minutes, the following is recorded:

> "UK is scheduled to attend an event in London on 29/11/2019 through Cambridge University. He will be travelling via train from Staffordshire to Euston, at which point he will be met by colleagues from Cambridge whom will then take him in a taxi to the event location. He will then be transported back to Euston Station via taxi, and from here he will catch the train back to Staffordshire. Calum Forsyth noted that the logistics for the trip need to be discussed and confirmed. Ken Skelton noted that UK has not had much contact with Cambridge recently – he was given his Chromebook but does not appear to be doing much with it…"[141]

f. PS Forsyth's recollection is that this is indicative of the nature of the discussion on 14 November 2019. The conversation was limited to "logistics".[142] Sumeet Johal does not recall any specific discussions concerning the trip to London and the risks arising from it in any MAPPA meetings.[143] Lois Gell says that the MAPPA panel's

[134] T/16/72.
[135] T/16/84.
[136] T/16/67.
[137] T/23/68.
[138] DC6416.
[139] T/16/78.
[140] T/16/80.
[141] DC6417/5.
[142] T/20/159.
[143] T/15/178.

approval of Usman Khan's attendance at the event was "implied"[144] as part of an "on-going discussion" but could not recall the specific discussions.[145] Ms Gell herself did not express any concerns about Usman Khan's attendance, and was in agreement with the decision that he should be permitted to travel to London.[146] Ms Gell accepted that "in retrospect" the London location was not sufficiently considered, and it should have been minuted specifically.[147] DS Stephenson that no consideration was given to terrorist risk at the 14 November 2019 MAPPA meeting:[148] "I'm not aware of any objections raised by anybody as to reason why he shouldn't or couldn't attend".[149] DS Marc Jerromes said that people had the opportunity to object, because his attendance was raised, but accepted there was no express decision taken that Usman Khan should be allowed to go to London.[150]

51. MAPPA guidance of 2012[151] provides that MAPPA minutes must be written in a way which allows those not present at a meeting to understand the nature of the discussion and issues, whilst demonstrating defensible decision making. The minutes in this case suggest that the visit to London was not the subject of critical consideration and discussion in the relevant meetings (August, October and November 2019).

    a. There is an express requirement in the guidance for MAPPA minutes to be distributed to attendees within a set period of time after the meeting, and the chair should confirm that the minutes are correct at the following meeting. The minutes are usually to be circulated by secure email after each meeting, so that attendees can approve or disagree with them.[152] In this case, the minutes would be circulated by being uploaded to the ViSOR system and would be considered at the start of the next meeting.[153]

    b. Mr Skelton accepted that MAPPA minutes ought to cover any significant decision-making, that MAPPA minutes are circulated to all attendees after each meeting,

[144] T/17/187.
[145] T/17/189.
[146] T/17/190.
[147] T/17/191.
[148] T/24/101.
[149] T/24/94.
[150] T/26/160.
[151] DC6511.
[152] Phil Bromley, T/15/35-36.
[153] T/23/47.

and that if any significant discussion had not been minuted it is likely that one of the participants who received the minutes would pick up on such an omission.[154]

c. That there is no record of a discussion in any of the August, October or November 2019 MAPPA minutes as to whether or not Usman Khan should be permitted to attend the London event, nor of any risks associated with his attendance at the event, or any measures to mitigate such a risk, contrasts with the extent to which other MAPPA minutes thoroughly record comparable discussions and decisions. For example, on 22 August 2019, the panel determined that Usman Khan should not be permitted to train to operate a dumper truck,[155] this being a matter on which Mr Skelton sought the panel's opinion because he "didn't necessarily make decisions alone".[156] On the basis of the extent of minuted discussion concerning the London event, it is at least properly arguable that no such discussion took place. It is also noteworthy that the notes made by others in relation to the meetings contain no account of such a discussion.[157] In this connection, see the well-known remarks of Leggatt J in *Gestmin SGPS SA v Credit Suisse (UK) Ltd* [2013] EWHC 3560 (Comm) at [15]-[23] concerning the value of recollections of meetings by comparison with contemporaneous documentation.

52. Furthermore, the way in which the MAPPA panel approached consideration of the London event was (at least arguably) not consistent with the way that Mr Skelton and the others managing Usman Khan through MAPPA approached previous events arranged by Learning Together.

a. Mr Skelton formed the view, without reference to the MAPPA panel (because it was such a clear decision), that Usman Khan should not attend an event at Cambridge University in March 2019, since he had been out of prison for fewer than three months.[158] On that occasion, Mr Skelton informed the MAPPA agencies at the next meeting that he had declined permission "stating it was too soon".[159] In evidence, Mr Skelton accepted that this was "in part, because he remained a very

[154] T/16/79.
[155] DC6415/6-7.
[156] T/16/66.
[157] DS Marc Jerromes' notes, DC7527/6, 10-11; DS Jon Stephenson's Major Incident Disclosure Book, DC7490-T/13; Emma Hartill's email 4/10/2019, DC7475/36; DC Emma Hartill's Disclosure Book, DC7487/37.
[158] T/16/52.
[159] DC6441/4.

high risk individual, based on the various assessments, and that this was going to be a prominent event at Cambridge University", answering "it was, yes".[160]

b. Usman Khan was invited to an event at HMP Whitemoor in June 2019. His proposed attendance was discussed at the MAPPA, where it was agreed that he could attend with two police officers escorting him.[161] Although there was evidence that the primary motivation for arranging the escort was to help Usman Khan make his way to an out of the way place, it appears that the visit was always to take place with an escort and was presented as such to the MAPPA panel.[162] Furthermore, all present knew that the visit was to be to a high security prison.[163]

53. Mr Byford accepted that the MAPPA guidance for the relevant time was that the chair of the meeting should give an update on an individual's risk at the beginning of each meeting. In response to Mr Pitchers QC, Mr Byford recognised that the Autumn 2019 meetings did not include such a memory refresher.[164]

54. PS Forsyth recognised that it would be quite a serious problem if nobody in the MAPPA meetings thought that it was their responsibility to assess terrorist risk.[165] His evidence was that he thought he had raised the question of Usman Khan's attendance at the London event but maybe the other participants had missed it.[166] When shown that there was no record in the MAPPA B minutes of any discussion of the risk posed by the London visit, PS Forsyth said:

> "Well, I can't argue with that. I was convinced it had taken place, but clearly, according to the minutes, it hasn't and, as I say, it's because we'd been talking about potential for future courses and future events, none of which had been objected to, apart from the March one, my assumption is that the lack of objection would have been taken as permission within that, but I take your point entirely and I can't argue against that."[167]

55. In failing to discuss whether the London visit presented any specific risk, the MAPPA panel deprived itself of the opportunity to consider whether any measures were necessary

[160] T/16/52.
[161] T/16/58.
[162] Philip Bromley, T/15/45.
[163] DC6413/4.
[164] T/23/85.
[165] T/20/117.
[166] T/21/142.
[167] T/20/133.

or appropriate in mitigation. In the following subparagraphs we consider the options which might have been available to the MAPPA agencies in the circumstances that they wished to manage such a risk.

a. One option open to the MAPPA panel, this being the status quo of Usman Khan's licence conditions, was that permission to attend the event could have been refused. If permission were granted, it could be subject to precautionary measures. Sonia Flynn accepted "there were other things that could have been done".[168] The evidence of DCI Chambers was that, if there was recognised to be a risk, "we should be mitigating against it and the only way to do that is to stop him going".[169] Other witnesses believed that measures could have been considered in mitigation.

b. Sumeet Johal gave evidence that, in his professional experience, his "expectation… would be that police in London are notified of that trip, and I would expect that between Staffordshire and West Midlands Police colleagues that would be arranged… as is normal police practice".[170]

c. As well as contacting the police in London, the MAPPA agencies could have made contact with Learning Together and/or the Fishmongers' Company, to ascertain what security checks and measures would be in place and to request that further measures would be taken, such as a bag search or a metal detector.[171]

d. In addition to liaison with the police in London, the MAPPA panel might have decided that there should be some liaison with the Fishmongers' Company or with Learning Together, so as to understand whether the security checks at the event would be sufficient.[172]

e. No consideration was given to whether Usman Khan should be accompanied or escorted on his trip in order to monitor him.[173] This would have given officers an

[168] T/19/74.
[169] T/26/56.
[170] T/15/180.
[171] T/25/51-2.
[172] Sonia Flynn, T/19/73.
[173] PS Calum Forsyth, T/20/147.

opportunity to assess whether Usman Khan was behaving suspiciously, or perhaps whether he had any items with him such as a bag.[174]

f. The possibility of Usman Khan being met by one or more police officers at Euston station was not considered by the MAPPA panel. This may also have presented the opportunity for a police officer to check or search Usman Khan's bag.[175]

g. It is arguable that, had the MAPPA panel determined that some or all of these measures should be adopted and that Usman Khan's attendance at the London event should either be prevented or allowed subject to restrictions, the arguable real and immediate risk to life might realistically have been avoided (i.e. that there would have been a real chance of preventing the attack).

F. Instead, offender manager Kenneth Skelton made a decision to allow Usman Khan to attend the London event. It is arguable that the decision reflected a failure to take reasonable action to avert an appreciable risk.

56. When Mr Skelton informed the MAPPA panel that he had refused Usman Khan permission to attend the March 2019 event at Cambridge, it was minuted that Mr Skelton would "table all dates for future attendance at Cambridge events and each will be reviewed at the time".[176] DS Stephenson, at the same meeting, asked for information on all future events[177] "to ensure that we would be sighted on his ongoing progress, engagement with authorities, and if he continued to comply".[178]

57. Mr Skelton was aware, in the context of the 12 March 2019 event at Cambridge University which he ruled out without MAPPA consideration, that decisions should be taken in conjunction with MAPPA. Mr Skelton described the decision-making process in this way:

> "Generally the decision-making process is, in terms of Usman Khan was, I would give consideration myself, then I would have a conversation with my line manager, I would then have a conversation with the police, and then, and only then, if it was

[174] T/20/150.
[175] DS Jon Stephenson, T/24/96.
[176] DC6441/5.
[177] DC6411/5.
[178] T/24/51.

> that we thought that it was a feasible option, only then would it be taken to MAPPA."[179]

He later gave evidence that he "can't be held responsible for everything, that's the whole point of the MAPPA panel."[180] Mr Skelton said that "on a scale of 1 to 10", the importance of referring the question of permission to the MAPPA panel was a "10".[181] Nigel Byford agreed that "it was significant… and obviously there had to be thought given to that."[182]

58. On 21 August 2019 (before referring the matter to the MAPPA panel on any view), Mr Skelton sent an email to Dr Amy Ludlow stating, regarding Usman Khan's attendance at the London event, that "I cannot see that being a problem".[183] Mr Skelton, in oral evidence, explained that this did not mean that he had granted permission to Usman Khan at that time, and he might still have changed his mind after discussing the matter with the MAPPA: it was not "written in stone"[184] when he sent the email. Sonia Flynn did not think that a decision should be made before the MAPPA panel has been consulted.[185]

59. As set out above, there had been no detailed discussion of the visit to London in the MAPPA meeting of August 2019 and no discussion of it at all in the meeting of October 2019. Against that background, Mr Skelton confirmed approval of the visit. He made an entry on the Delius system following contact with Usman Khan on 5 November 2019, recording "[d]iscussed attendance at the Illumni event in November he stated that he is happy to do the journey alone as long as someone can meet him at Euston station"[186] recording a further similar conversation on 12 November 2019.[187]

60. The evidence of Mr Skelton was that where "a proposal was clearly made and attracts no objection or adverse observations" that can be taken as "permission".[188] Mrs Flynn confirmed that it "should have been a multi-agency decision. It should not have been left with a lone probation officer. That's the purpose of MAPPA".[189] DCI Chambers

[179] T/16/51.
[180] T/17/37.
[181] T/17/67.
[182] T/23/96.
[183] DC5635/2.
[184] T/17/110-111.
[185] T/19/110.
[186] DC5635/15.
[187] DC5635/17; T/16/85.
[188] T/17/74.
[189] T/19/59.

recognised that it was a decision which would have required careful thought and careful balancing.[190] However, the Court has not seen or heard any evidence from any witness who can confirm with any confidence that a decision was positively taken that Usman Khan should be permitted to attend the event, still less that the merits of the decision were subject to any consideration in a meeting.

Article 2 Engagement – Other Grounds

61. We are not at present aware of any other basis on which any Interested Person might seek to argue that the Article 2 procedural obligation is engaged on the basis of an arguable breach of an operational duty. If any such argument is made, we shall address it in our oral submissions.

62. We acknowledge that there may be some grounds for an argument that the procedural obligation is engaged on the basis of an arguable breach of the general duty. This argument, in our submission, is less straightforward, for three important reasons: (a) because a breach of the general duty requires a failure of systems and processes (as opposed to individual error); (b) because such a breach requires a "concrete" manifestation of the systemic failure with the relevant causal effect; and (c) because in the context of crime prevention the primary duty of the state is to put in place an appropriate legal and administrative framework to deter the commission of offences, backed up by law enforcement machinery (see *Makaratzis* at [57]).

63. Given that, in our submission, the procedural obligation is clearly engaged on the basis of an arguable breach of the operational duty as set out above, we shall not address the general duty in the same detail in writing.

64. In the following subparagraphs we give some examples of possible grounds for making that general duty argument:

    a. The ERG 22+ assessment informs the OASys assessment, which was the principal agency's risk assessment for the purposes of MAPPA management.[191] Both documents are used as the key structured assessments of the risk which a terrorist offender poses upon their release into the community. Upon his release from

[190] T/26/57.
[191] Sonia Flynn, T/19/21.

prison, Usman Khan's offender manager Kenneth Skelton was responsible for preparing the ERG 22+ assessment. There was evidence that such an assessment should have been completed in advance of the attack. Mrs Flynn accepted that it is beneficial for a forensic psychologist to prepare an ERG 22+ assessment, as opposed to a probation officer, and that Mr Skelton did not have the "support" which he needed, nor more than two days' training.[192] After the attack, the probation service introduced psychological support in the community, to assist specialist offender managers in their preparation of ERG 22+ assessments of terrorist risk.[193] If an updated assessment had been prepared using the skills of a psychologist, it may be arguable (based on the evidence of Dr Cechaviciute) that this would have called into question the positive views being formed of Usman Khan's progress and that it may have led to a more rigorous consideration of the risk attaching to the prospective visit to London.

b. This is not the only respect in which the Coroner has heard evidence that individuals responsible for managing Usman Khan did not have the training and expertise which would have best assisted them to do their jobs. As we have noted above, PS Forsyth was new to managing TACT offenders in the community, being trained as a Prevent officer; as PS Forsyth said "it wasn't Prevent work".[194] PC Craig Hemmings said that the Prevent team "often spoke about that we shouldn't be doing this role", on account of their lack of training.[195] Mr Johal too had very limited experience of practically dealing with terrorist offender cases, as a new member of staff who had recently joined the team.[196]

c. The chair of the MAPPA meetings in respect of Usman Khan was Nigel Byford. He held CTC vetting clearance. This is one level below Security Check ("SC") and two levels below Developed Vetting ("DV"). Under the recently amended system, MAPPA meetings relating to serious terrorist offenders are now co-chaired by both a probation services professional and also by a senior counter-terrorism police officer.[197] This assists in ensuring that the full intelligence picture is before

[192] T/19/24.
[193] T/19/25.
[194] T/20/167.
[195] T/21/171-172.
[196] T/23/15.
[197] Sonia Flynn, T/19/32.

the panel. In the case of Usman Khan, Mr Byford did not know that Usman Khan was subject to an "active" investigation by MI5 and WMPCTU.[198] Mr Skelton did not know either,[199] nor was PS Forsyth aware.[200]

d. There are other examples of arguable failures to share information which apparently derive from systems and practices, rather than from one-off decisions. In MAPPA minutes, intelligence is referenced which states that Usman Khan "intends to return to his old ways" when he is released.[201] It is described in the minutes as "low graded" but was, at least in principle, reliable. Mr Skelton did not know this.[202] Mr Byford, like some other MAPPA participants, was unaware of the second strand of intelligence to the effect that Usman Khan had an aspiration to carry out an attack.[203] PS Forsyth recognised that intelligence such as this was particularly significant,[204] but he only knew what was on the face of the MAPPA minutes.[205] DCI Hessell accepted that this was important intelligence which those managing Usman Khan should have known[206] and D/Insp Nicholas Powell said that he was aware that those making the decisions in MAPPA did not know this crticical information.[207] DCI Chambers believed it should have been shared with PS Forsyth's team, and he understood (wrongly, as it transpired) that it had in fact been shared.[208] The MAPPA participants did have the facility for a pre-meeting, included in the guidance, in which security sensitive information could be exchanged between suitably vetted and informed individuals. There was no timetabled pre-meeting in the MAPPA panel's agendas concerning Usman Khan.[209]

e. The Court heard competing evidence on whether or not there had been a discussion in MAPPA as to whether Usman Khan should be permitted to travel to London in November 2019. Mr Byford's evidence was that he could "certainly recall our

[198] T/23/33.
[199] T/16/46.
[200] T/20/51.
[201] DC6422/5.
[202] T/16/176.
[203] T/23/80.
[204] T/20/63.
[205] T/20/64.
[206] T/25/22.
[207] T/25/137.
[208] T/26/80.
[209] T/23/24.

conversation around objections, but it's not been recorded".[210] Although minutes for meetings were circulated on ViSOR after each meeting, this was a system to which some meeting participants did not have access.[211] Furthermore, there was no clear guidance as to what decisions needed to be the subject of specific discussion and MAPPA panel approval. If there had been such guidance, then it would have required the panel members to provide views on the proposed visit to London, which may have prompted a discussion about risk.

Determinations

65. Our proposal is that for each of Jack Merritt and Saskia Jones, a Record of Inquest should be produced with all sections completed (including medical cause of death, as given by the relevant pathologist) and the following entry in each of sections 3 and 4: "See attached Questionnaire". The Questionnaire should then contain the determination as to how the person died.

Short-Form Conclusion: Unlawful Killing

66. There is no doubt that both Jack Merritt and Saskia Jones were murdered in a terrorist attack. The civil standard of proof is clearly met (and exceeded). The jury's determinations should record this straightforward fact as to how Jack Merritt and Saskia Jones came to be killed, both (a) because primary responsibility for their deaths lies with the murderer and (b) coroners are encouraged by Chief Coroner's guidance[212] to ensure that an apposite short-form conclusion is returned in each inquest. The **First Question** in the questionnaire should therefore ask whether Jack Merritt and Saskia Jones were both unlawfully killed. The jury should be directed to answer "yes" to this question. It is well established that a coroner may properly direct a conclusion: see *R v HM Coroner for West Berkshire, Ex Parte Thomas* (1991) JP 681 at 697-698 (Bingham LJ); *Bubbins v UK* (2005) 41 EHRR 24 at [163] (see also [94]-[95] for the account of the coroner's direction in that case).

[210] T/23/156.
[211] T/23/47.
[212] Chief Coroner's Guidance No. 17, *Conclusions: Short-Form and* Narrative, p6 https://www.judiciary.uk/wp-content/uploads/2020/08/guidance-no-17-conclusions.pdf

67. We reach this conclusion on the basis of the extensive evidence from many eye witnesses and the pathologist Dr Fegan-Earl, who described the extent of the injuries which both sustained and the manner in which those injuries were caused. It is clear that Usman Khan intended to kill both Jack Merritt and Saskia Jones, or at least to inflict very serious injuries on each of them, using high levels of force.[213] The Court has also heard evidence as to Usman Khan's attack on three further victims, one of whom was in cardiac arrest,[214] appearing to be critically injured and bleeding very heavily[215] before she received medical care.

Supplementary Narrative / Questionnaire

68. In light of our submissions in respect of the engagement of Article 2, the jury should be enabled to reach an extended judgmental conclusion. If the Coroner does not find that Article 2 is engaged, the jury may still legitimately provide some narrative conclusions in relation to each of those who died.

69. We propose that in any event the **Second Question** in the questionnaire should present the jury with a short statement setting out the basic facts of the attack and the way in which each victim came to be killed, describing only the means of death of each deceased. Each victim should be the subject of their own version of this question (i.e. question 2(a) and 2(b)). For question 2(a), the jury should be asked "do you agree with the following statement which is intended to summarise the basic facts of the death of Jack Merritt?" being invited to answer "yes" or "no". The questionnaire will provide that the jury may amend the statement in a separate box.

70. In determining the form of words which should be proposed in the second question, the Coroner will no doubt wish to consider any amendments or alternative forms of words, particularly those provided by the bereaved families. We should stress that these are being suggested as the first parts of the narratives for the Records of Inquest. We are aware that a much more detailed factual account will be given in relation to each deceased person in the Coroner's summing-up to the jury.

[213] Dr Ashley Fegan-Earl, T/10/11, 27.
[214] Laura Pugsley, T/4/87.
[215] Dr Samy Sadek, T/6/14.

71. The following is our proposal for the short statement for each deceased person which the jury will be invited to adopt or amend:

    a. Jack Merritt: On 29 November 2019, Jack Merritt was at an event at Fishmongers' Hall in London. The event was held for the five-year anniversary of the Learning Together programme. Jack was at the event as an employee of Cambridge University, and worked for the Learning Together programme. An attendee of the event, who was on licence having been convicted of an offence under the Terrorism Act 2000, armed with two knives, attacked Jack in the gentlemen's toilets at Fishmongers' Hall. This was part of a terrorist attack. The attacker moved from the toilets and began attacking further attendees of the event and a member of staff at Fishmongers' Hall. Jack suffered a number of injuries when stabbed. He moved to a different room at Fishmongers' Hall and was later removed from the building. His injuries were not survivable. Jack was treated by members of the public, police officers, ambulance staff and HEMS doctors. He was assessed as dead at the scene by a doctor.

    b. Saskia Jones: On 29 November 2019, Saskia Jones was at an event at Fishmongers' Hall in London. The event was held for the five-year anniversary of the Learning Together programme. Saskia was at the event as a supporter of the Learning Together programme, having previously volunteered for it. An attendee of the event, who was on licence having been convicted of an offence under the Terrorism Act 2000, armed with two knives, attacked Saskia near to the cloakroom at Fishmongers' Hall. This was part of a terrorist attack. The attacker moved from that area and began attacking attacked further attendees of the event and a member of staff at Fishmongers' Hall. Saskia suffered a single stab wound to her neck, and she collapsed near to the place where she was attacked. Her injury was not survivable. Saskia was treated by attendees of the event, police officers and ambulance staff. She was assessed as dead at the scene by a paramedic.

72. If the Coroner concludes that Article 2 is engaged in the inquest of either of the deceased (for whatever reason), we submit that the narrative conclusions in that inquest may be made up of further parts, with further questions being posed in the jury's questionnaire. These further questions would allow the jury to express further conclusions on the broader circumstances.

73. We set out below possible questions which might be posed. In each case, in the draft Questionnaire, we have included considerations and issues which the jury may wish to take into account in responding to each question. We have not included those proposals in this document, so as to avoid repetition.

    a. **Third Question:** Was there any omission or failure in the management of Usman Khan (as an offender in the community) by agencies of the state which contributed to the deaths of Jack Merritt and Saskia Jones?

    b. **Fourth Question** Was there any omission or failure in the investigation of Usman Khan by agencies of the state which contributed to the deaths of Jack Merritt and Saskia Jones?

    c. **Fifth Question** Was there any omission or deficiency in the security measures for the event at Fishmongers' Hall which contributed to the deaths of Jack Merritt and Saskia Jones?

74. We consider that each of these three questions is justified on the grounds that each reflects (a) an important aspect of the investigation and (b) a key factual issue as to which the jury could properly conclude that the evidence supports a finding that a failing of the relevant kind contributed to the deaths. We reach that second conclusion for the following reasons, which we set out briefly in light of the significant overlap with the evidence identified in previous sections of this document:

    a. The management of Usman Khan: The Chairman of the MAPPA panel was not vetted past CTC level, and accordingly did not have access to all of the intelligence which could have informed an assessment of the risk which Usman Khan posed to the public.[216] As a result he did, for example, not know that Usman Khan was subject to an "active" investigation by MI5 and WMPCTU.[217] Likewise, other key decision makers (such as Mr Skelton and PS Forsyth) were ignorant of some important intelligence, including the "attack aspiration" intelligence which was a focus of the priority investigation. Furthermore, most relevant witnesses have accepted[218] that the MAPPA discussion of whether or not Usman Khan should be

[216] T/23/76-77.
[217] T/23/33.
[218] E.g. PS Calum Forsyth, T/20/159; Sumeet Johal, T/15/78; Lois Gell, T/17/91; DS Jon Stephenson, T/2/94.

allowed to attend the London event did not consider any risks arising from his attendance. The jury could properly conclude that the panel should have refused approval for the visit or recommended security measures (such as an escort, a meeting en route or security checks on the venue), given (i) Usman Khan's history of extremism and violence; (ii) the risk ratings previously attached to him; and (iii) the risk assessments made by MI5 through 2019. DS Jon Stephenson recognised that, knowing what he knew, he ought to have given some advice to MAPPA.[219] Other witnesses have accepted that the location of the event was "iconic" and that this was not properly addressed by MAPPA.[220] In the event, the MAPPA panel did not discuss any measures which might be put in place to mitigate any risk from Usman Khan travelling to London. In all the circumstances, the jury could properly conclude that any or all of these potential failures, amongst others, contributed to the deaths of Jack Merritt and Saskia Jones or that they may have done so.

b. The investigation of Usman Khan: The jury could also properly conclude, for example, that there were failures in the information sharing between state agencies, as we have described above in respect of an arguable breach of the general duty (notably the failure of the policing bodies collectively to pass on the "attack aspiration" strand of intelligence to the MAPPA panel, for which there was apparently no good reason).[221] Although there was no intelligence as to Usman Khan being engaged in attack planning during 2019, the jury heard evidence that MI5 and WMPCTU had limited insight into Usman Khan in the run-up to November 2019,[222] and this did not prevent MI5 continuing to attach significant risk to Khan in formal documents. In all the circumstances, the jury could properly conclude that those responsible for the investigation into Usman Khan should have considered that he continued to present a serious risk to the public and that firm advice needed to be given in relation to the prospective visit to London (whether to refuse permission for the visit or to recommend security measures).[223]

[219] T/24/97, 100-101.
[220] Sonia Flynn, T/19/72.
[221] T/26/70-71.
[222] T/26/129.
[223] DS Jon Stephenson, T/24/97.

c. Security measures for the Event at Fishmongers Hall: The jury may properly conclude that deficiencies in the security measures in place at Fishmongers' Hall contributed to the deaths of Saskia Jones and Jack Merritt and/or that the information given to the Fishmongers' Company by one or both of Learning Together and/or those managing Khan was so insufficient as to be a contributory factor. For instance, Commodore Toby Williamson, the clerk of the Fishmongers' Company, did not know that some of those attending the event had been in prison for serious offences including violent offences.[224] If the Fishmongers' Company were to host the event again, Commodore Williamson accepted that there would be many other security measures in place, including "not less than a police escort of… prisoners"[225] and searching procedures.

75. In respect of each of the four questions above, the jury should be asked, in the alternative, whether there was any act or omission which "may have caused" the deaths. In all cases, the jury should be given the opportunity to provide an explanation for their answer(s).

76. The passages set out above are proposed for comment by others and further discussion. We are open to considering amendments.

PFD Report

Legal Background

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

> (1) Where –
>
> (a) a senior coroner has been conducting an investigation under this Part into a person's death,
>
> (b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and

[224] T/10/76.
[225] T/10/125.

(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,

the coroner must report the matter to a person who the coroner believes may have power to take such action.

Further provision is made at paragraph 7(2)-(3), for (i) the recipient of a report to reply in writing and (ii) both the report and reply to go to the Chief Coroner.

78. Part 7 of the Coroners (Investigations) Regulations 2013 contains provisions for the making of PFD Reports. Regulation 28 provides as follows:

(1) This regulation applies where a coroner is under a duty under paragraph 7(1) of Schedule 5 to make a report to prevent other deaths.

(2) In this regulation, a reference to "a report" means a report to prevent other deaths made by the coroner.

(3) A report may not be made until the coroner has considered all the documents, evidence and information that in the opinion of the coroner are relevant to the investigation.

79. Before July 2013, the power to make such reports was contained in rule 43(1) of the Coroners Rules 1984. That provision was in terms similar to those of paragraph 7(1) of Schedule 5 to the CJA, but it provided that if the coroner considered that preventive action should be taken, then he/she "may" make a report.

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

a. As the Court of Appeal observed in the *Lewis* case (cited above), the regime makes it mandatory for a coroner to make a report if he/she forms the view that the relevant action needs to be taken. A coroner may no longer conclude that action ought to be taken but decide for some extraneous reason not to make a report. That is the effect of the words "must report" in paragraph 7(1).

b. However, the power and duty to make a report only arise where the coroner forms the opinion, based on evidence relevant to his/her inquiry, that particular risks of death exist for which preventive action is required. In *R (Cairns) v HM Deputy Coroner for Inner West London* [2011] EWHC 2890 (Admin) at [74], Silber J

explained that the statutory expression "in the coroner's opinion, action should be taken…" reflects a discretionary judgment by the coroner.

c. The jurisdiction to make PFD Reports is not limited to the reporting of circumstances and risks which were causally relevant to the particular deaths under investigation: see *Lewis* at [14]-[19]; Rule 43 Report of Hallett LJ following the London Bombings Inquests, [161]; Chief Coroner's Guidance No. 5, [17]. However, it does require that the material in the particular investigation has highlighted systemic risks or failures which may recur or continue, with potentially fatal consequences: see *R (Francis) v HM Coroner for Inner South London* [2013] EWCA Civ 313 at [7]-[8], Davis LJ.[226]

d. A coroner may properly decide not to make a PFD report on an issue on the basis that he/she is not satisfied that further action is necessary. If, for example, it appears that a risk or issue has likely been addressed by action of some kind, or if circumstances have changed substantially since the death in question, the coroner may reasonably say he/she is not satisfied further action is required. Equally, a coroner may decide that he/she simply has insufficient material to form a view that there are particular risks of future deaths and/or that further action is required. See, for example, the approach taken by Hallett LJ to various issues in her Rule 43 Report after the London Bombings Inquests (e.g. [70] and [217]). See also *Jervis on Coroners (13th ed.)* at [13]-[125].

e. The purpose of death investigation in both domestic and Convention law includes a concern to identify systemic failures and risks. See, for example *R (Amin) v SSHD* [2004] 1 AC 653 at [31]; *R (Sacker) v West Yorkshire Coroner* [2004] 1 WLR 796 at [11]. The domestic law scheme deliberately confers on a professional adjudicator (the coroner) the judgment whether such risks exist and whether they need to be addressed by action: see *Lewis* at [40]; *Middleton* at [38].

[226] Note also that a PFD Report should be made by reference to the material gathered and evidence given during the coronial inquiry. The jurisdiction to make a report is thus ancillary to the inquiry, and a coroner should not radically expand the scope of his/her inquiry in order to provide the foundation for a possible PFD Report. See: *R (Butler) v HM Coroner for the Black Country* [2010] EWHC 43 (Admin) at [74], Beatson J; Chief Coroner's Guidance at [14].

81. Chief Coroner's Guidance No. 5 also addresses PFD Reports. That document makes the following relevant points, with which we respectfully agree:

a. PFD Reports are important, and their importance has been emphasised by Parliament modifying the rules in the way described above. See Guidance at [2]-[3].

b. "Broadly speaking reports should be intended to improve public health, welfare and safety. They should not be unduly general in their content; sweeping generalisations should be avoided. They should be clear, brief, focused, meaningful and, wherever possible, designed to have practical effect." See Guidance at [5].

c. If a report is made, it need not (and generally should not) prescribe particular action to be taken. It need not (and generally should not) apportion blame or be prejudicial (see, to the same effect, *Jervis* at [13-123]). The content of the report should be focussed and limited to the statutory remit. See Guidance at [24]-[27].

82. In summary:

a. A coroner should make a PFD report if (but only if) satisfied of two propositions: (i) that there is a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and (ii) that in his/her opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances. In making a judgment on these issues (especially the second), the coroner is exercising a judicial discretion.

b. The coroner must form his/her judgment based on the information revealed by the coronial investigation.

c. It is not necessary for the coroner to conclude that the particular death under investigation was caused by the circumstances or risks which may be the subject of the report. However, it is necessary for the coroner to find that systemic risks or failures have been highlighted by the material in the particular investigation.

d. It is perfectly proper for a coroner to say that a risk or issue has apparently been addressed, or that on the available material he/she cannot be satisfied that preventive action need be taken. In making a decision, the coroner is entitled to take account of the passage of time and changes of circumstances since the deaths.

e. Before deciding whether to make a report, the Coroner should consider whether it would be directed to improving public health, welfare or safety and whether it would be focussed, practical and within the statutory remit.

83. We would finally stress the point that PFD Reports will often draw attention to matters of concern or to risks, rather than prescribing particular solutions. A coroner is often not qualified to propose specific action and may not be aware of all the consequences of taking such action. A coroner may be unaware of exactly what remedial action is practicable and/or unaware of competing demands for resources. These considerations should not, of course, lead to paralysis. A coroner may raise a concern and be properly told that the problem cannot be perfectly solved.

Proposed Approach in this Case

84. In our submission, it would be appropriate in this case to adopt the following approach:

a. Interested Persons who wish to make submissions that a PFD Report should be made, and the points which they consider might usefully be included in such a report, should make those submissions in writing within a period of (say) 28 days from the conclusion of these Inquests (i.e. by 28 June 2021).

b. Other Interested Persons should then be given the opportunity to respond to those submissions in writing, again within 28 days (i.e. by 26 July 2021), making observations on the proposed points. Those submissions should so far as possible be provided in open form (which can and will be circulated to all Interested Persons), but may if absolutely necessary include a closed annex.

c. There should be a final round of responses in writing if necessary, within a period of 14 days (i.e. by 9 August 2021).

d. The Coroner should then consider the original submissions and any responses, before preparing and issuing any PFD Report. The issuing of any Report would then trigger the process of responses in the way laid out in the statutory provisions.

85. We propose this sequence of submissions, responses and Report for the following reasons. Given the subject-matter of these Inquests, it may be that representations are made for a PFD Report to address very complex subject-matter (e.g. the management of TACT offenders in the community, the structure and records of MAPPA meeting and sensitive information sharing between state agencies). In some cases, the points raised may address subjects which have already been covered by reviews undertaken before or since the attacks. In order that the Coroner can ensure that any PFD Report serves its proper purposes (as identified above), it would be best to allow public authorities to make observations on suggested points before the content of any Report is decided.

Jonathan Hough QC
4 New Square, Lincoln's Inn

Aaron Moss
5 Essex Court, Temple

21 May 2021