BEFORE HHJ LUCRAFT QC (RECORDER OF LONDON)

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

SUBMISSIONS ON BEHALF OF THE FAMILY OF JACK MERRITT:
CONCLUSIONS

---

1. These submissions are provided to try to assist the learned Coroner on the approach to conclusions[1]. They have been drafted having regard to the submissions provided by CTI, as well as the welcome indication from the Secretaries of State that they will not resist the argument that Article 2 is engaged at least in respect of its operational aspect.

2. Save where alternative or additional points are made below, Jack's family agree with the approach proposed by CTI.

The position of Jack's family in response to CTI's outline submissions

3. CTI set out their outline submissions at §4 of their document. For ease, the response of Jack's family to each of those points is set out here, in the same order:

   a. **The Article 2 procedural obligation is engaged under the operational duty limb**. Jack's family agree.

   b. **It is not necessary to decide whether the Article 2 procedural obligation is engaged by an arguable breach of the general/systems obligation**. Jack's family agree with CTI's submission. It is not strictly necessary to determine the systems duty issue, because once the Article 2 procedural duty is engaged, it applies with general effect[2], including to the inquests' conclusions. The jury would therefore be permitted to provide a *Middleton*

[1] In these submissions the term "conclusions" is used to refer to the "determinations" required under s.10(1)(a) CJA 2009, read with s.5(1)(a) and (b) and s.5(2) CJA 2009.
[2] R *(Sreedharan) v HM Coroner for the County of Greater Manchester* [2013] EWCA Civ 181, §23.

narrative, including judgmental conclusions, in respect of any matter (provided doing so complied with the applicable directions on causation, language, etc); their narrative conclusion would not be confined solely to those factual matters giving rise to the arguable breach of the operational duty. However, there are arguments in favour of determining, now, whether or not the general duty is engaged (the evidence has been heard; submissions have been made; it would be helpful were there to be onwards challenges). If there is to be a determination, Jack's family will submit that the general duty is engaged. They set out why below.

c. **The jury should be directed to record a short-form conclusion of unlawful killing**. Jack's family agree.

d. **The jury should be invited to approve or amend a short passage summarising the means and immediate circumstances of Jack's death.** Jack's family agree. The short statement set out at §71(a) of CTI's submissions is also agreed, subject to one proposed amendment (the exclusion of the word "programme": see further below).

e. **The jury should be invited to answer further questions indicating whether or not they consider that Jack's death was 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**. Jack's family agree. At paragraph 27 below they have suggested some additional or alternative points that they consider the jury should be invited to consider (amending or supplementing CTI's proposed questionnaire).

f. **IPs should be directed to file submissions setting out what matters they suggest the Coroner should include in a PFD report**. Jack's family are content with that approach and with the timetable proposed at §84(a) of CTI's document. They raise now (below) a particular point about a possible PFD report: see paragraphs 40-42 below.

Summary of the submissions of Jack's family

4. At the outset, Jack's family wish to make clear what they hope for from the conclusions at his inquest: first, the fullest possible understanding of the circumstances of Jack's death and the

failings, deficiencies and inadequacies that led to it; second, an opportunity for the jury to express their conclusions on those matters; and third, through that expression, public accountability and recognition of what went wrong in this case so that meaningful reflection and changes can take place to prevent future deaths.

5. Jack's family would also add this: they are acutely aware of the risk that this inquest, and the findings it may reach, could be used by some to suggest that educational and rehabilitative activities of the kind which Learning Together was providing, should be substantially reined in. That is not what Jack would have wanted. His family have put criticisms of what happened in this case, and in particular how Learning Together was rolled out to HMP Whitemoor with limited if any evaluation or thought to whether it should include someone like Usman Khan. However, that is not to say that Jack's family have wavered in their commitment to such matters, especially given the benefits they have brought to two of the heroes of this case: Steve Gallant and John Crilly. Jack's family believe that these activities have to be properly safeguarded, and this did not happen in the present case. But such activities must continue. To do otherwise would be to allow Khan's attack on liberal democracy, and the values which underpin it, to have won.

6. In order to satisfy these wishes, in summary, Jack's family invite the Coroner to adopt the following approach to the inquests' conclusions:

Short-form conclusion

7. The jury should be directed to find that Jack was unlawfully killed. That is the only short-form conclusion available on the evidence. Applying the civil standard of proof for an unlawful killing conclusion[3] to the evidence, unlawful killing is a conclusion that must be returned in this case. It is also appropriate for the short-form unlawful killing conclusion to be accompanied by a short narrative explaining the immediate circumstances of Jack's death. This approach was properly adopted by the Coroner in the London Bridge and Borough Market Attack Inquests[4] and it is suggested by CTI in this case.

Narrative conclusion

[3] *R (Maughan) v HM Senior Coroner for Oxfordshire* [2020] UKSC 46, §97.
[4] For example: https://londonbridgeinquests.independent.gov.uk/wp-content/uploads/2019/06/Determinations-CA.pdf

8. In light of the evidence heard during these inquests, and as properly recognised by both CTI and the Secretaries of State, s.5(2) of the Coroners and Justice Act 2009 applies. That is because it is at least arguable that the circumstances of Jack's death give rise to a breach of Article 2 ECHR. The conclusions concerning Jack's death must therefore ascertain and record how and in what circumstances Jack came by his death. In order to meet that purpose, the jury should be asked to determine the central and important underlying issues in the case, including any systemic defects, practices or regulatory shortcomings that contributed to the death and any other factors which are relevant to the circumstances of the death. The significant public interest engaged in this case requires the same. The jury should therefore be asked to consider the adequacy of Khan's management in the community, the adequacy of the investigation into him, and the decisions and security arrangements in the lead up to and at the Learning Together event at Fishmongers' Hall on 29 November 2019.

9. When determining the central issues, the jury should be permitted to indicate whether a particular matter caused or contributed to Jack's death (in the sense that it made a more than minimal, negligible or trivial contribution), or possibly caused or contributed to Jack's death. The jury should be directed that they may use appropriate judgmental language in their narrative conclusion.

10. Jack's family anticipate that their position on the short-form conclusion will be uncontroversial. It is not therefore addressed further below. They hope that their position on the narrative will be similarly uncontroversial, particularly in light of CTI's submissions and the indication helpfully given by the Secretaries of State. In case that does not prove to be the case, however, the remainder of these submissions address the proposal of Jack's family as to the approach to the jury's narrative conclusion.

Article 2 ECHR

11. The Article 2 investigative duty is engaged by the circumstances of Jack's death. That is for the following reasons:

The investigative duty

12. The investigative duty arises for any death occurring in circumstances in which it appears that the substantive obligations to protect life under Article 2 have been, or may have been, violated, and it appears that agents of the State or systemic defects in a State system are, or may be, in some way implicated.[5]

13. It follows that the investigative duty will arise where there is an arguable breach of one or more of the substantive obligations to protect life. An arguable breach is one that is more than merely fanciful; the authorities indicate that this is a low threshold.[6] The threshold has recently been described by Lord Burnnett CJ as a *"credible suggestion"*.[7] In another, recent formulation, the Court of Appeal indicated that the investigative duty will arise where the circumstances of death indicate *"possible state responsibility"*.[8]

14. In this case, the investigative duty will arise if the evidence heard during the inquests has disclosed an arguable breach of the Article 2 operational duty and/or the Article 2 systems duty. It is respectfully submitted that, for the reasons below, it has done so in respect of both the operational and (if it is necessary to determine it) the systems duties.

The operational duty

15. The following principles are relevant:

    a. The State is under an obligation to take preventative measures to protect an individual whose life is at risk where the authorities know, or ought to know, of the existence of a real and immediate risk to life.[9]

    b. In assessing whether the authorities ought to have known of a real and immediate risk to life, *"stupidity, lack of imagination and inertia do not afford an excuse to a national authority which reasonably ought, in the light of what it knew or was told, to make further enquiries or investigations: it is then to be treated as knowing what such further enquiries or investigations would have elicited."*[10]

---

[5] *R (Middleton) v HM Coroner for the Western District of Somerset* [2004] 2 AC 182, §§3, 19; *Savage v South Essex Partnership Trust* [2009] 1 AC 681, §4; *Rabone v Pennine Care NHS Foundation Trust* [2012] 2 AC 72, §12(ii).
[6] *R (AP) v HM Coroner for Worcestershire* [2011] EWHC 1453, §60; *R (Skelton) v Senior Coroner for West Sussex* [2020] EWHC 2813 (Admin), §63.
[7] *R (Maguire) v HM Senior Coroner for Blackpool and Fylde* [2020] 3 WLR 1268, §75.
[8] *R (Hambleton) v Coroner for the Birmingham Inquests (1974)* [2018] EWCA Civ 2081, §47.
[9] *Rabone*, §12.
[10] *Van Colle v Chief Constable of Hertfordshire Police* [2009] 1 AC 225, §32.

c. Importantly in the present case, the individual whose life is at risk need not be identified for the operational duty to arise. The victim can come from a broader group which can be drawn widely. The authorities make clear that the operational obligation can be owed to the public at large.[11] In *Sarjantston* the Court of Appeal (per Lord Dyson MR) observed that *"a duty may be owed to the public at large"* (§18) and that *"the ECtHR has not limited the scope of the article 2 duty to circumstances where there is or ought to be known a real and imminent risk to the lives of identified or identifiable individuals"* (§22).

d. In cases where the individual victim is not identified, the operational duty may nonetheless arise where the authorities know, or ought to know, of the existence of a real and immediate risk to life posed by an individual. This is apparent from a number of authorities, both domestic[12] and in Strasbourg[13] (including where the threat is from terrorism[14]).

e. The Supreme Court has held that a "real" risk is not as high as a *"likelihood or fairly high degree of risk"*.[15] The threshold is one of risk, not probability. A risk of 5-20% has been held to be "real" for Article 2 purposes.[16]

f. An immediate risk to life means one that is *"present and continuing"* as opposed to *"imminent"*. The risk need not be apparent just before death.[17]

g. The operational duty can be breached where a significant period of time has passed between the risk arising and the death occurring.[18] In *Tomasic v Croatia* the risk posed by a dangerous man who had threatened his partner and child five months earlier gave rise to a breach of the operational duty when he subsequently attacked and killed them. There had been no positive evidence of increased risk in the intervening period; instead, the pre-

---

[11] *R v Blackman* [2017] EWCA Crim 326, §21; *R v Marines A, B, C, D & E* [2014] 1 WLR 3326, §§76, 78; *Sarjantson v Chief Constable of Humberside* [2014] QB 411, §§18, 22; *Griffiths v Chief Constable of Suffolk* [2018] EWHC 2538 (QB), §502.
[12] *Blackman*, §21; *Sarjantson*, §22; *Griffiths*, §502.
[13] *Maiorano v Italy* (App. No. 28643/06), §107; *Mastromatteo v Italy* (App. No. 37703/97), §74; *Bljakaj v Croatia* (2016) 62 EHRR 4, §§121-133.
[14] *Tagayeva v Russia* (App. No. 26562/07), §§482, 486.
[15] *Rabone*, §38.
[16] *Rabone v Pennine Care NHS Foundation Trust* [2010] EWCA Civ 698, §73 (this conclusion was not varied or criticised by the Supreme Court in *v Pennine Care NHS Foundation Trust* [2012] 2 AC 72, §§33-43); *Skelton*, §53(i).
[17] *Skelton*, §53(ii); *Rabone*, §§39-40.
[18] *Tomasic v Croatia* (App. No. 46598/06), §58; *Cevrioğlu v Turkey* [2017] Inquest LR 37.

existing risk was present and continuing for a significant period of time before materialising, resulting in death.

h. It follows from the above that a risk to life can give rise to an arguable breach of the operational duty where the percentage likelihood of it materialising is low (5-20%), where it is present and continuing but not apparent just before death (*Rabone*), and where a significant period of time has passed between the risk arising and the fatal act (*Tomasic*).

i. Where the authorities know, or ought to know of a risk to life, they are under a duty to take those measures within the scope of their powers which, judged reasonably, might be expected to avoid or minimise that risk.[19] There is no requirement to show *"that the failure to perceive the risk to life in the circumstances known at the time or to take preventative measures to avoid that risk must be tantamount to gross negligence or wilful disregard of the duty to protect life."* It is sufficient *"to show that the authorities did not do all that could reasonably be expected of them to avoid a real and immediate risk to life of which they had or ought to have had knowledge."*[20]

j. To establish a breach of the operational duty, there is no requirement to show that life would probably have been saved if the relevant measures had been taken. Under the operational duty it is only necessary to show a real prospect or substantial chance of a different outcome to establish a breach.[21] It follows that for present purposes, it is only necessary to show that it is arguable that had the relevant measures been taken, there might have been a different outcome.

16. Applying the principles set out above to the circumstances of Jack's death, the evidence discloses an arguable breach of the operational duty. Jack's family agrees with the points made by CTI. The following is just their own formulation. The evidence shows that it is at least arguable that:

a. The authorities knew or ought to have known that Khan posed a real and immediate risk to the lives of others throughout 2019 and in the lead up to the Learning Together event in November 2019. That is because:

[19] *Osman v UK* (2000) 29 EHRR 245, §116.
[20] *Van Colle*, §30.
[21] *Van Colle*, §138; *R (Long) v Secretary of State for Defence* [2015] 1 WLR 5006, §32; *Daniel v St George's Healthcare NHS Trust* [2016] 4 WLR 32, §§30, 140.

i. Khan had been convicted of a serious terrorist offence, he had done little or no meaningful work to address the thinking underlying his offending over a number of years in prison[22], his behaviour in prison confirmed that (Ms Cechaviciute's unchallenged conclusion was that his risk had in fact increased in prison[23]), and he had therefore been properly assessed as a very high risk throughout his time in custody, and up to the date of his release. To the end he remained in the top 0.1% of the prison population in terms of dangerousness. The authorities were fully aware of all these matters.

ii. The authorities had assessed Khan as posing a very high risk of serious harm to the public. That was the conclusion of the only completed structured risk assessments of Khan[24]. In the absence of any completed OASys or ERG throughout 2019 that remained the position right up to the Learning Together event. However, that was or should have been clear in any event given the absence of any work on Khan's underlying offending behaviour patterns; the continuation of offence paralleling behaviour (status seeking; minimisation; deception); and the clear manifestation, in October and November 2019, of many of the warning signs identified by Ms Cechaviciute's ERG (see further below).

iii. MI5 and CTP maintained a covert investigation into Khan up to the attack because they assessed that Khan continued to pose a threat to national security.

iv. The nature of the risk of which the authorities were aware included that Khan would carry out a terrorist attack, causing death and/or suffering to large numbers of individuals.[25]

v. MAPPA highlighted the risk that Khan's compliant behaviour was deceptive. MI5 shared a similar concern during 2018 and throughout 2019 that Khan's compliance was an attempt to avoid scrutiny; so much so that this was used to justify ongoing intrusive measures. The Staffordshire SB subject profile on Khan throughout 2019 identified that Khan had manipulative tendencies.

vi. In the months leading up to November 2019, the authorities had held discussions and taken decisions which demonstrated their knowledge of the real and immediate risk

[22] See *eg* Mr Vince at T/19/180.
[23] DC5322/§8.3.1. Please note: Jack's family believes "Ms" rather than "Dr" is right because Ieva Cechaviciute is a chartered forensic psychologist not a clinical psychologist and her report and statement do not describe her as "Dr". But apologies if this is wrong.
[24] OASys: DC5660 and DC5663. This meant that a seriously harmful event was more likely than not to happen: T/16/27. The OASys was of course informed by the April 2018 ERG.
[25] MAPPA minutes for 14 November 2019: DC6417/7.

that Khan posed: he was prevented from attending the event in Cambridge in March 2019; a detailed discussion was conducted about whether Khan would be allowed to attend HMP Whitemoor (a high security prison) in June 2019; and in July and August 2019 it was decided that Khan posed too great a risk to be allowed access to a dumper truck as part of a construction course, the identified risk being the use of a vehicle as a weapon in a terrorist attack.

vii. The authorities were or ought to have been aware that Khan's behaviour and circumstances in the weeks leading up the Learning Together event, including his move into private rented accommodation on 24 September, the sudden cancellation of all forms of mentoring, his increased isolation and withdrawal, his ongoing lack of employment, and his reaction to the Prevent visit on 14 November 2019, indicated an increased risk. They were consistent with the trigger factors identified in the ERG. As a result, the authorities ought to have identified the very high risk that Khan posed.

b. The risk that Khan posed was "real" as understood in the Article 2 authorities: it was, certainly, a *"fairly high degree of risk"*[26] (in fact, substantially more than that), and higher than a 5-20% risk.[27]

c. The risk was also "immediate": it was present and continuing because it had been correctly identified, it had not changed, and it was increasing towards the date of the attack.

d. In those circumstances, the authorities were under a duty to do all they reasonably could to avoid or minimise the risk that Khan posed. It is strongly arguable that they did not do so:

i. The structured risk assessments were effectively put to one side, solely on the basis that Khan was complying with licence conditions, and engaging with Learning Together. The extent to which Learning Together were providing anything meaningful was not properly explored or understood by any of those managing Khan. Also, witness after witness accepted that compliance with conditions was no evidence of personal change and could be false. There was therefore no or no proper basis for putting the OASys and ERG findings to one side, particularly without having completed fresh ones.

[26] *Rabone*, §38.
[27] *Rabone* (CA), §73.

ii. Relevant risk information was not shared with MAPPA, including intelligence that Khan intended to carry out an attack following his release, and MI5's assessment that Khan's mindset had not changed and their ongoing concern that Khan's apparent compliance was designed to avoid the scrutiny of the authorities. A number of witnesses, including Khan's OM, Kenneth Skelton, were unequivocal that such information would have altered their risk assessment of Khan and corresponding decisions.

iii. There was no proper, considered assessment within MAPPA about whether Khan should be permitted to attend the Learning Together event (given Khan's identified risk and the risks involved in his attendance), and whether, if attending, he should be accompanied. There was certainly no documented one (neither in the MAPPA minutes, or in any of the personal notes taken by those in attendance). A proper, considered assessment was a critical step to take. It had been taken in respect of the Cambridge University event in March 2019, the HMP Whitemoor event in June 2019, and the dumper truck course in July and August 2019. Erroneously, no proper consideration was given to the risk of Khan's attendance at the Learning Together event in London and how such risks could be addressed.

iv. Given Khan's very high risk and the particular features of the Learning Together event, it would have been reasonable to prevent Khan's attendance or direct that he be accompanied. Neither of those steps were taken.

v. It would also been reasonable to ensure that appropriate security measures were in place either on route (such as a surprise stop) or at Fishmongers' Hall given the risk Khan posed. Again, those steps should have been taken. They were not.

vi. Taking the above individually and cumulatively, the authorities therefore did not do all they reasonably could to avoid or minimise the risk that Khan posed when attending the event on 29 November 2019.

e. It is strongly arguable that had those reasonable steps been taken, there might have been a different outcome. That is apparent as a matter of common sense. The jury is of course entitled, and must, consider all factors in the round. When asking whether something caused or contributed they may consider it in combination with other matters that they consider caused or contributed.

The systems duty

17. The relevant principles are unlikely to be in dispute:

a. Article 2 imposes on the State an obligation to put in place systems, precautions and procedures which will, to the greatest extent reasonably practicable, protect life. This includes a duty to provide adequate training, employ competent staff, maintain high professional standards, put in place suitable systems of working, and have in place systems which will detect and remedy individual failings and errors before harm is done.[28]

b. The duty therefore extends beyond the State's legislative framework. The need for proper staffing (above) makes that clear. But there must also be an adequate supporting administrative framework, proper procedures and general precautions[29], and sufficient regulations, policies and guidance.[30] The authorities indicate that the systems duty requires that practical and effective procedures are put in place at ground level.[31] As has been said in one recent case, the systems duty "*is sufficiently general to allow for more detailed requirements to come under its umbrella*".[32] A telling example of how the courts apply the duty may be found in *McGlinchey v UK* (2003) 37 EHRR 821, a general duty case concerned with the system used for monitoring heroin withdrawal in prisoners. There, there had been a system in place to monitor the prisoner, including consultations with doctors, and visits and observation by nursing staff, but the three problems identified were discrepant scales (which meant doctors relied on sight to determine weight loss); doctors not working the weekend; and not admitting her to hospital. That shows that although the duty is a general one, a court considering it may descend into some detail. Note also that *McGlinchey* was also not about arguability: a breach was found.

c. There may be a violation of the systems duty even though no risk has been identified to a specified individual.[33] That is significant here. There may be an arguable breach of the systems duty arising solely from arguable deficiencies in the State's procedures and

---

[28] *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653, §30; *Middleton*, §2; *Öneryildiz v Turkey* (2005) 41 EHRR 20, §§73, 89; *Savage*, §§30-31, 36, 45; *Kolyadenko v Russia* (2013) 56 EHRR 2, §§158-159; *Smith v Ministry of Defence* [2014] AC 52, §68; *Skelton*, §51.
[29] *Van Colle*, §31; *Savage*, §§31, 36; *Smith v MoD*, §68; *Long*, §§13, 25, 28.
[30] *R (FI) v Secretary of State for the Home Department* [2014] EWCA Civ 1272, §52; *Öneryildiz*, §89; *Stoyanovi v Bulgaria* (App. No. 42980/04), §61.
[31] *Savage*, §31; *R (Scarfe) v Governor of Woodhill Prison* [2017] EWHC 1194 (Admin), §54.
[32] *Griffiths*, §561.
[33] *Savage*, §31.

processes for managing the risk that Khan posed; it is not necessary also to show an identified risk posed to Jack.

18. Applying the principles set out above to the circumstances of Jack's death, and assuming it is necessary to determine it, the evidence discloses at least an arguable breach of the systems duty. As above, arguability is a low threshold. On that basis:

    a. Generally, there are too many potential missed opportunities for this to be a case just about individual operational failure. That is also clear from the oral evidence of Sonia Flynn, and what she accepted about (for example) the inadequacy of Mr Skeleton's draft ERG and the process which led to it. That raises issues of professional competency, not having forensic psychology support, having had the relevant training several years earlier, and being supervised/supported by others who were inexperienced (Mr Johal) and/or based in other offices (Mr Johal and Ms Gell). There are also obvious staffing issues around the numbers of probation officers, and their workload (now said to have been corrected)[34]. There are issues around record keeping and documentation (the almost complete absence of relevant entries in Delius from Mr Johal and Ms Gell). It is submitted that staffing levels, training and oversight are axiomatically systems matters, and the fact that there has been system change evidences at least an arguable systems error.

    b. Jack's family would also draw particular attention to the problem of siloing, which was explored several times in the evidence. That includes Mr Machin and others at the prison not looking at risks beyond the prison walls, MI5 focusing only on sharing intelligence but not their own concerns and judgments, and the somewhat unedifying buck-passing between Staffordshire and West Midlands police about whose responsibility it was to ensure information was shared. Those are systems problems born out of fragmentation and deficits in shared responsibility.

    c. The system and procedures for sharing relevant risk information within MAPPA is worth emphasising. It was, on the evidence, obviously deficient. Information that should have been shared was not. Information that was shared was incorrectly described (the "low graded" assessment of the "old ways" strand). There were numerous opportunities for this lack of information sharing and incorrect assessment to be remedied. That did not

[34] Sonia Flynn at T/19/25.

occur. It appears that no consideration was given to a range of measures that could have been taken to facilitate proper information sharing: securing appropriate security clearance for those who needed it; gisting or providing a form of words; holding pre-meetings. None of this took place. Multiple state agents, from a range of different state bodies, were involved in this failure of information sharing. A number of them knew that relevant information had not been shared and yet did nothing to ensure it was shared. Again, the scale and extent of this suggests that this issue was systemic and procedural, not merely a consequence of individual error.

d. MAPPA's approach to risk assessment was deficient. There was insufficient focus on Khan's existing risk assessments, the risk factors that had been identified, and whether he had demonstrated any meaningful reduction in his risk based on positive work. There was no tracking against the ERG assessment, or attempt to determine whether he had progressed in his "stages of change"[35]. Reliance was placed on an incomplete ERG that was obviously inadequate but had not been seen by anyone beyond its author, Mr Skelton, and Mr Johal. Considerable emphasis was placed on Khan's involvement in Learning Together as protective factor and an indicator of risk reduction. This was despite MAPPA having little if any understanding of what Learning Together was actually doing now Khan was in the community (very little), and still less the risks to which Khan's involvement in Learning Together gave rise.

e. MAPPA's system for decision-making was inadequate. Despite the involvement of multiple state agents from a range of different state bodies, decisions were made in a haphazard and inconsistent way. Concerns about presentational issues and media fall-out were combined with risk concerns to prevent access to the dumper truck course. Yet at almost the same time – August 2019 – no consideration was given to the risks of Khan attending the Learning Together event. That was despite the dumper truck course promising immediate tangible benefits (employment) when attendance at the Learning Together event offered no such thing. The evidence indicated that MAPPA made decisions without any structured, risk-informed approach to decision-making, and without properly informing itself so it could carry out a proper risk/benefit analysis. This too was a systemic and procedural issue, not merely a consequence of individual error or oversight.

[35] DC5322 at §8.2.2.

f. Mr Skelton, the relevant probation officer tasked with managing Khan in the community, lacked expertise and experience in dealing with TACT offenders. Mr Johal, who provided input into Mr Skelton's draft ERG, also had very limited experience of dealing with TACT cases.

g. The use of the Staffordshire Prevent team to manage Part 4 offenders, including Khan, was an inadequate and inappropriate arrangement. The evidence indicated that the Prevent officers were differently focused, lacked training on their new role, had no counter-terrorism experience, were not provided with meaningful guidance on what they were supposed to be doing and how to do it, and lacked sufficient time to carry out their Part 4 role alongside their other Prevent work. The evidence from within the team itself, and in particular the evidence from PCs Hemmings and Barker about their surprise that they were being allowed to perform this role, was striking. Given the known risks posed by Khan, assigning his community management to the Prevent team posed an unacceptable risk.

The engagement of s.5(2) CJA 2009

Determination of the central issues

19. Where the Article 2 investigative duty is engaged, an inquest that culminates in a determination of the central issues in the case is generally the means by which the investigative duty is discharged[36], i.e. through a *Middleton* inquest.

20. Section 5(2) gives statutory effect to the decision of the House of Lords in *Middleton*. Under s.5(2), where the Article 2 investigative duty is engaged in respect of a death, as is the case here, it will be *"necessary in order to avoid a breach"* of Article 2 for the inquest to include *"the purpose of ascertaining in what circumstances the deceased came by his or her death."*

21. The s.5(2) purpose of ascertaining how and in what circumstances Jack came by his death requires that the inquest's conclusion should address the central and important underlying issues in the case. This may require consideration of the disputed factual issues explored in

[36] *Middleton*, §§20, 47; *Skelton*, §62.

evidence at the inquest, the wider circumstances surrounding the death, any risks that should have been recognised and preventative steps that could have been taken, systemic defects, practices or regulatory shortcomings that contributed to the death, and the issues relevant for an assessment of the role and responsibility of State agents in the death.[37]

22. In a *Middleton* inquest, there may be a public interest in the jury being given a clear opportunity to express their findings in narrative form.[38] That is the case here. That is also consistent with the position at common law, where it has long been recognised that *"[t]he function of an inquest is to seek out and record as many of the facts concerning the death as public interest requires."*[39] In this case, the public interest is of the highest order and requires that the inquest should record the jury's conclusions on the central issues.

23. There are two further reasons which support the requirement for a determination of the central issues and favour leaving a broad range of topics to the jury in this case.

24. First, the jury's conclusions can provide a helpful, even essential basis for a report to Prevent Future Deaths.[40] It has long been recognised at common law that an inquest conclusion *"can have a significant part to play in avoiding the repetition of inappropriate conduct and encouraging beneficial change"*.[41] One way in which a narrative conclusion can achieve that is through the inclusion of factual findings on matters which will assist the Coroner in a PFD report.[42] As the Court of Appeal observed in *R (Lewis) v HM Coroner for the Mid and North Division of the County of Shropshire* [2010] 1 WLR 1836, §27:

> I see no reason to doubt the propriety of the ruling we have been shown of the City of London coroner in the case of Heather Claire Waite (3 July 2006) that *"the jury may, in addition to finding the direct or indirect causes or contributions to the death, also find facts relevant to the exercise of the coroner's power under rule 43."* This is likely to be more useful - as the House of Lords suggested in Middleton (§20) - where facts are disputed or uncertain. Indeed it may be in such cases that a finding by verdict is a desirable or even a necessary foundation of any rule 43 report [now a report to prevent future deaths].

---

[37] *Middleton*, §§14, 16-18, 20, 28, 31, 36, 45; *R (Sacker) v West Yorkshire Coroner* [2004] 1 WLR 796, §28; *Hurst*, §§28-29, 34; *R (Smith) v Secretary of State for Defence* [2011] 1 AC 1, §153; *Mammadov v Azerbaijan* (2014) 58 EHRR 18, §123; Chief Coroner's Guidance No.17 on Conclusions, §§46-47, 49.

[38] *R (P) v HM Coroner for the District of Avon* [2009] EWCA Civ 1367, §28; Chief Coroner's Guidance No.17 on Conclusions, §55.

[39] *R (Hurst) v London District Coroner* [2007] 2 AC 189, §§21-22, *Frost v HM Coroner for West Yorkshire (Eastern District)* [2019] EWHC 1100 (Admin), §29, and *R (GS) v Wiltshire and Swindon Senior Coroner* [2020] 1 WLR 4889, §62, approving the comments of Lord Lane CJ in *R v South London Coroner, ex parte Thompson* (1982) 126 SJ 625.

[40] Para 7(1) Sch 5 CJA 2009 and Regulation 28 of the Coroners (Investigations) Regulations 2013.

[41] *R v Inner South London Coroner ex p Douglas Williams* [1999] 1 All ER 344, 347-348.

[42] Chief Coroner's Guidance No.17 on Conclusions, §50.

25. In this case, where, it is respectfully submitted, there is such a clear opportunity for learning and future prevention, there are compelling reasons to allow the jury to address a broad range of matters in order to inform the Coroner's PFD duty.

26. Second, the purposes of the Article 2 investigative duty favour leaving a broad range of topics to the jury. In order to discharge the investigative duty, the purposes of Article 2 should, so far as possible, be met by the inquest. Those purposes, summarised below, will best be met by allowing a full narrative conclusion:

    a. Identifying and holding to account those responsible for the death, including state officials or authorities involved in whatever capacity in the chain of events.[43]

    b. Ensuring that the facts surrounding the death and the full circumstances are opened up to public scrutiny, culpable conduct is exposed, and suspicions as to how the death occurred are addressed.[44]

    c. Contributing to the victims' sense of catharsis and resolution.[45]

The central issues in this case

27. In light of the above, a broad approach should be taken when identifying the central issues on which the jury should be invited to comment. The issues identified at §§16 and 18 above should be considered by the jury. Jack's family agree with the issues identified by CTI in the draft jury questionnaire and the proposed structure. To those they would add the following:

Question 2

    a. Here, Jack's family would delete the word "programme" at the end of the first paragraph (and throughout). The evidence is that one of the problems in this case was that there was

[43] *Edwards v UK* (2002) 35 EHRR 19, §§69-73; *Amin*, §§20, 32.
[44] *Jordan v UK* (2003) 37 EHRR 2, §§105, 128, 143-144; *Amin*, §31; *Middleton*, §§5, 30; *Öneryildiz*, §§91, 94.
[45] *Dyer v Chief Constable of West Yorkshire* [2021] 1 WLR 1233, §§101, 121-122; *Keyu v Secretary of State for Foreign & Commonwealth Affairs* [2016] AC 1355, §§136, 157; *R (Khan) v HM Coroner for West Somerset* [2002] EWHC 302 (Admin), §17.

believed to be an LT "programme" (with all that implies in terms of a defined end point and objective) when there was not. It will be remembered that Learning Together was treated by the Ministry of Justice as an activity or intervention, like an external workshop[46]. That is why it was not the subject of Correctional Services Advice and Accreditation Panel (the means for accrediting offending behaviour programmes) or Ofsted consideration (despite being said to be educational).

Question 3

b. Jack's family considers that the ERG is of such central importance that it should be specifically mentioned in this section, perhaps as part of the third bullet point (to make it clear that the OASys is informed by the ERG: together these are *the* two key tools for risk assessing in this area) or by adding a further (fourth) bullet. In this case the ERG, when done properly by Ms Cechaviciute, and supported by Dr Al-Attar, worked. It correctly identified the relevant risk factors, and should have been the foundation for all following assessments. The jury should be given the opportunity to record that. It is submitted this is particularly important where others (notably Jonathan Hall QC) have been relatively critical of the ERG and its utility.

c. A fourth bullet might say: "That OASys was informed by an ERG assessment which identified limited acceptance of responsibility for Khan's offending; identified warning signs including lack of purpose, feelings of injustice, unemployment, boredom, a need for status, trying to adjust to new living circumstances and coping with setbacks; and considered that if Khan was changing at all this was recent, inconsistent, and subject to frequent lapses"

d. As a small point, "Category A High Risk offender" in the third bullet (and in respect of Q4 below) should perhaps be re-written as "High Risk Category A". That is how it has been referred to throughout the inquest, because "High Risk" is a subset of Category A, not the other way around.

[46] Vince WS5067/§82.

e. After what is currently the third bullet point we would propose including: "The fact that Usman Khan's behaviour in prison often sat alongside periods of apparent polite engagement with staff and with offending behaviour programmes".

f. After the fourth bullet point, we propose: "The fact that Usman Khan had lost the support of mentors from August 2019; that he had moved from Approved Premises in September 2019; and that he had been reported as being increasingly isolated and withdrawn in October and November 2019".

g. The importance of the OASys and the ERG is such that what is currently the sixth bullet might be rewritten so that it reads "took a proper approach to the assessment of the continuing risk he posed, making proper use of the available risk assessment tools".

h. A bullet point should be added along the lines of "Whether or not those responsible for the management of Usman Khan properly took steps to inform themselves about the limits of what he was doing with Learning Together and any associated benefits".

Question 4

i. Jack's family understands other IPs have a concern about the focus on "investigation". If that is an issue the reference might instead be to "monitoring, information gathering and sharing". The point is to flag to the jury that it was not just the NPS that were informing the management of Khan. That management also was, or should have been, informed by those conducting the investigation of Khan throughout the period and up to the date of the attack. No doubt this is what CTI had in mind and it is submitted they are right to do so.

j. With regard to the first bullet under question 4, Jack's family wonders whether the reference to the priority operation being led by WMCTU and Staffordshire SB is potentially misleading. The covert operation was led by MI5. The bullet could be amended so it reads: "Usman Khan was subject to a priority investigation led by the Security Service with counter-terrorism police (with West Midlands Police CTU leading on the police side and involving Staffordshire Police Special Branch)."

k. The same points concerning the importance of referencing the ERG are repeated here. The additional bullets ((c), (e) (and (f) above) should be added again here. What is currently the fourth bullet should be amended to read "took a proper approach to the assessment of the continuing risk he posed, making proper use of the available risk assessment tools".

l. Because this question is aimed at agencies beyond probation (so the police in particular) it is suggested that there be a particular reference to the Dawn Banner assessment, as contained in the subject profile and her notes to the ALM stakeholders meeting[47].

m. Importantly, it is submitted the jury should be specifically invited to record, and consider, the unchallenged evidence that there was no good reason not to share into MAPPA the attack aspiration strand of intelligence. That is a key matter, which absorbed a lot of time, and is an obvious foundation for future learning. It should be specifically set out in the questionnaire.

n. This bullet (from above) should also be added again (in some form): "Whether or not those responsible for the investigation of Usman Khan properly took steps to inform themselves about the limits of what he was doing with Learning Together and any associated benefits".

Question 5

o. There is a significant focus here on Fishmongers Hall and much less on Learning Together as the organiser of the event. In order to correct this the fifth bullet might read "Whether or not those involved in organising the Learning Together event <u>properly risk assessed and took appropriate steps</u> including inform<u>ing</u> the Fishmongers' Company of the ~~types of~~ persons attending the event". It is submitted that "types of" should be deleted because it is broader than that. The risk arose in part from the nature of Khan's offences, and the identity of some invitees.

<u>Eliciting the jury's narrative conclusion</u>

[47] DC7450/2.

28. Jack's family recognise that it is a matter for the Coroner, in the exercise of his discretion, to decide how best to elicit the jury's conclusion on the central issues.[48] With that in mind, they make some brief observations below to assist the Coroner in eliciting the jury's conclusion.

Determination of the central issues

29. Jack's family agree with CTI[49] that the jury are likely to be assisted by being told that their narrative conclusion should address the central and important underlying issues in the case, including any systemic defects, practices or regulatory shortcomings that contributed to the death and any other factors which are relevant to the circumstances of the death.[50]

30. Jack's family strongly agree with CTI[51] that in relation to all of their answers, the jury should be given the opportunity to provide an explanation for their answer(s). That is essential given the facts of this case, the evidence that has been heard, and the broad nature of the proposed questions.

Probably causative failings

31. The jury's narrative conclusion should address those acts, omissions and circumstances which, on the balance of probabilities, made a more than minimal, negligible or trivial contribution to Jack's death.[52] The narrative may include findings on the direct and indirect causes or contributions to death, and findings on those matters that were part of the broad chain of causation that led to the death.[53] It follows that an act, omission or circumstance need not be the sole, predominant or direct cause to be included in the jury's narrative. A matter may operate in combination with another matter. It is only necessary for the jury to conclude that something probably made a contribution that was more than minimal, negligible or trivial.

---

[48] *Middleton*, §36.
[49] Draft jury questionnaire v.1 (p.3, bullet point 1(b)).
[50] *Middleton*, §36.
[51] CTI submissions, §75.
[52] *Avon*, §§8, 31; *Chambers v HM Coroner for Preston and West Lancashire* [2015] EWHC 31 (Admin), §40; *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] 4 WLR 157, §41; *R (Chidlow) v HM Senior Coroner for Blackpool and Fylde* [2019] EWHC 581 (Admin), §§36-37; *R (Carole Smith) v HM Assistant Coroner for North West Wales* [2020] EWHC 781 (Admin), §§55, 62.
[53] *R (Lewis) v HM Coroner for the Mid and North Division of the County of Shropshire* [2010] 1 WLR 1836, §27; *R (Lewis) v HM Coroner for the Mid and North Division of the County of Shropshire* [2009] EWHC 661 (Admin), §§80-99, 107-108, 129, 213-214.

32. CTI cite *Tainton* and *Chidlow* for the established causation test.[54] In *Tainton*, §41 (emphasis added):

> Third, it is common ground that the threshold for causation of death is not the same thing as the standard of proof required to prove causation of death. In cases such as this, the latter is proof on the balance of probabilities. It is agreed that the threshold that must be reached for causation of death to be established, is that the event or conduct said to have caused the death must have "more than minimally, negligibly or trivially contributed to the death" (see e.g. *R. (Dawson) v. HM Coroner for East Riding and Kingston upon Hull Coroners District* [2001] Inquest LR 233, [2001] EWHC Admin 352, per Jackson J at paragraphs 65-67). Putting these two concepts together, the question is whether, on the balance of probabilities, the conduct in question more than minimally, negligibly or trivially contributed to death.

33. In *Chidlow*, §37 (emphasis added):

> It follows that the question of a causal link between the delay in the attendance of the ambulance service and death should have been left to the jury in this case if there was sufficient evidence upon which the jury could safely find that, on the balance of probabilities, such delay had more than minimally, negligibly or trivially contributed to Mr Bibby's death.

34. The appropriate direction applying the established causation test is:

> You may only say that something contributed to the two deaths if you consider that it made more than a minimal, negligible or trivial contribution to the deaths.

35. Currently, the draft jury questionnaire direction on contribution says this: *"You may only say that something contributed to the two deaths if you consider that it made a significant (rather than minimal) contribution."*[55] The reference to "significant" is not reflected in the case law and may inadvertently mislead the jury. Jack's family respectfully invite the Coroner to adopt the direction proposed in the paragraph above: it is enough to direct them that a matter needs to make a "more than a minimal, negligible or trivial contribution to the deaths".

Possibly causative failings

36. In addition to probably causative matters, the Coroner has a power to elicit the jury's conclusions on acts, omissions and circumstances that may have caused or contributed to

[54] CTI submissions, §10(e).
[55] Draft jury questionnaire v.1 (p.2, bullet point 5).

death.[56] CTI propose that the jury are asked to consider both probable and possible causation.[57] Jack's family agree. This approach has been adopted successfully in other high-profile jury inquests[58]. No doubt it works because the approach is clear and easy to understand, ensuring that the jury are able to express their conclusions fully and accurately. It is consistent with both the Article 2 investigative duty and the strong public interest engaged in these inquests.

Admitted non-causative failings

37. The Coroner has a discretion to elicit the jury's conclusions on admitted non-causative failings. In certain circumstances, that discretion may become a duty.[59] A number of failings have been admitted in this inquest: see in particular the evidence of Ms Flynn on the lack of experience, expertise and time available to Mr Skelton. It is respectfully submitted that those failings that have been admitted were in any event causative, certainly to the extent that they should be left for the jury's consideration. However, to the extent that the Coroner decides to withhold any admitted failing from the jury, it is submitted the jury should be directed to record such failings on the Record of Inquest (in Box 3).[60] That would be required here: as a matter of fairness to the family of the deceased[61]; to satisfy both the Article 2 investigative duty[62] and the public interest engaged by the circumstances of Jack's death; and in recognition of the nature and importance of the failings that have been admitted.

Appropriate judgmental language

38. In broad terms, Jack's family agree with CTI's submission on this issue.[63] The authorities indicate that: findings of fact, however robustly stated, are permitted; acts, omissions or circumstances may be characterised as "serious"; causative language such as "because" and "contributed to" can be used; there is no requirement that a narrative conclusion must be neutral or non-judgmental; and in some cases, a proper conclusion on the key factual issues

[56] *Lewis* (CA), §§28-29; *R (Lepage) v HM Assistant Deputy Coroner for Inner South London* [2012] EWHC 1485 (Admin), §47; Chief Coroner's Guidance No.17 on Conclusions, §50.
[57] CTI submissions, §§73 and 75; Draft jury questionnaire v.1 (p.2, bullet point 4).
[58] See the jury questionnaire in the Hillsborough Inquests.
[59] *Tainton*, §§69, 73-75, 79.
[60] Such an approach is consistent with *Tainton* (a jury inquest), is not prevented by the reasoning in *Carole Smith* (a non-jury inquest), and has recently been approved by HM Senior Coroner for London Inner South in the inquest touching the death of Ms Emma Day (see Ruling dated 23 May 2021, p.11).
[61] *Tainton*, §75.
[62] *Tainton*, §75.
[63] CTI submissions, §10(i).

may require critical or judgmental findings to be considered.[64] It is respectfully submitted that this is such a case.

39. The draft jury questionnaire includes helpful guidance to the jury on this issue.[65] That proposed guidance is consistent with that provided to the jury at the Hillsborough Inquests, following detailed submissions from numerous IPs.[66] Jack's family respectfully invite the Coroner to make one addition which is drawn from the authorities:

> You may use ordinary and non-technical words which express factual judgments. So, you may say that errors or mistakes were made and you may use words such as "failure", "inappropriate", "inadequate", "unsuitable", "unsatisfactory", "insufficient", "omit / omission", "unacceptable" or "lacking". Equally, you may indicate in your answer if you consider that particular errors or mistakes were not made. You may add adjectives, such as "serious" or "important", to indicate the strength of your findings. <u>You may also use words which indicate causation, such as "because" or "contributed to"</u>.

<u>PFD report</u>

40. Jack's family agree the timetable proposed by CTI at paragraph 84 of their document. They would just wish to be clear, now, that they submit a PFD report is necessary in respect of Learning Together. As already indicated, and as will be clear from their questioning of Drs Ludlow and Armstrong, and of Richard Vince, Jack's family is concerned that Learning Together rolled out their activities from HMP Grendon to HMP Whitemoor without full evaluation or appreciation of the very different risks that pertain to high security prisoners; TACT offenders; and in particular high security TACT offenders who may be about to be released.

41. There may be any number of arguments about whether and how to draw category exclusions in this area. However, Jack's family has been surprised and disappointed to see a complete absence of any such consideration in any of the Learning Together and University of Cambridge reflection documents, at least so far (no corporate statement has been submitted that such work or thought is being given). In her oral evidence Dr Ludlow said there was no principled or research basis for drawing an exclusion around offence type[67]. The problem in

---

[64] *Middleton*, §37; *R (Catherine Smith) v Assistant Deputy Coroner for Oxfordshire* [2008] EWHC 694 (Admin), §45; *Lewis* (Admin Ct), §172; *R (Cash) v HM Coroner for the County of Northamptonshire* [2007] 4 All ER 903, §§51-52; Chief Coroner's Guidance No.17 on Conclusions, §52.
[65] Draft jury questionnaire v.1 (p.3, bullet point 1(g)).
[66] Hillsborough Inquests general jury questionnaire, §8(g).
[67] T/8/207.

apparently refusing to countenance such an exclusion (or alternatively to take a different approach to post-release contact) is to risk the Learning Together project as a whole. Jack's family do not believe that is what Jack would have wanted.

42. Jack's family raise this now because they recognise that these issues are probably too far back in the causation chain to mean that Learning Together issues of this kind ought to be left to the jury. Jack's family is neutral about that. If such matters are not, however, to go to the jury they should be the subject of a PFD report. These issues are important.

NICK ARMSTRONG
Matrix
JESSE NICHOLLS
Doughty Street Chambers

24 May 2021