BEFORE HIS HONOUR JUDGE MARK LUCRAFT QC

IN THE MATTER OF THE INQUESTS ARISING FROM
THE FISHMONGER'S HALL AND LONDON BRIDGE TERROR ATTACK

REPLY SUBMISSIONS OF
THE FAMILY OF MISS SASKIA JONES
ON MATTERS FOR REGULATION 28 REPORT

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1. The family of Saskia Jones have considered the submissions of the various organisations made in relation to the contents of a Prevention of Further Deaths Report pursuant to Regulation 28. We do not intend to repeat our submissions dated 29 June 2021 here (as it would not assist the Coroner to do so. We provide cross-reference below to that document in the format {§x}). These submissions intend to provide a brief response to the submissions received. Where a specific point is not explicitly addressed, that does not indicate agreement; rather, it indicates that the family maintains the stance set out in its original submissions.

2. To avoid any duplication for the Coroner the family has only addressed those sections of the responses that are directed at the recommendations invited by the family of Saskia Jones, and not those responses directed at the recommendations invited by the family of Jack Merritt. The text of the Recommendations has been reduced in some instances here to save space, given they are set out fully at the indicated paragraphs of our earlier submissions.

Secretary of State for the Home Department ("SSHD") and the Secretary of State for Justice ("SSJ")

Recommendation 1: that the prison estate and facilities, and processes be reviewed and assessed against the needs for fulfilment of the policy of de-radicalisation and risk reduction that dispersal is designed to achieve. {§7-§8}

3. Within paragraphs 14 to 16 of the SSHD/SSJ submissions it is suggested that the Prevention of Future Deaths medium is not the appropriate mechanism to explore the compatibility of the current physical prison estate with the adopted policy for dispersing and separating extremist offenders from one another. The family do not agree. The inquest heard evidence of the effect of allowing mixing of such offenders and the perpetuation or sharing of extremist ideology (including in gang operation). Indeed it is clear from the PFD submissions that the extremist population has tripled in size over the past 7 years, and (a) there would be a need for clarity as to the prison services' objective in place, if, as the SSHD/SSJ state, there are said to be arguments for a different approach than that which is current – and longstanding policy; (b) it can at its height only be asserted that it is "likely" that "the matters raised" may be considered by Jonathan Hall QC's report into Terrorism in Prisons[1]; and (c) the Exhibit 1 document detailing the Counter Terrorism Step Up Programme refers to an aim to consider how to make more effective use of separation centres (which is only one small aspect of the issue, and used for a tiny minority not for general anti-extremist accommodation) but the lists of what has been achieved and of next steps offer no reference to considering the need for any investment or alteration in the

[1] And this is a highly questionable proposition in any event given that Mr Hall QC has set out his interests as follows (at https://terrorismlegislationreviewer.independent.gov.uk/wp-content/uploads/2021/01/Terrorism-in-Prisons-Announcement.pdf):
"I have decided to review the subject of terrorism in the prison estate in England and Wales as part of my independent annual review of the Terrorism Acts.
How terrorism is detected, policed, disrupted and prosecuted when it occurs within the prison estate is relevant to the overall effectiveness of terrorism legislation.
I am particularly interested in:
A. Acts within the prison estate which amount to criminal offences such as encouraging (including glorifying) terrorism, or disseminating terrorist publications.
B. The status and influence of convicted terrorist prisoners within the prison estate, and whether there is any connection to prison gangs (Muslim and Right Wing).
C. Responsibilities for ensuring that admissible evidence of terrorist offences or terrorism related activity in prison is secured.
There is already a large existing literature of official reports, academic studies, and media coverage on radicalisation and extremism in prisons. My focus is on terrorism".

prison estate itself. There is good sense to a recommendation that the prison estate and its facility or capacity to fulfil the objective of preventing extremist spread and reinforcement of ideology whilst inside prison be subject to a review by the bodies able to allocate resources to its better ability to protect from extremist offending by prisoners or by former prisoners after release.

Recommendation 2: (i) Prisons should be advised of the potential for ongoing contact between LT and the offender post-release, and security sifting should be carried out with the possibility of post-release contact in mind. (ii) In any case where an educational project, such as LT, proposes to maintain contact with a prisoner being released on licence, HMPPS should conduct a risk assessment to assess the suitability of ongoing contact in principle (carried out with input from the prison security department, and documented and recorded). {§9-§10}

4. The family of Saskia Jones notes the risk assessment procedures referred to at the SSHD/SSJ's submissions at paragraphs 17 to 29. The family welcomes but notes the limitations and specific functions of the Risk of Serious Harm Guidance published in July 2020 to inform OASys assessments; and the digital Refer and Monitor Service launched in June 2021 (which does not extend to community engagement in education, but rather to referral services). However these are general approaches to risk management for multifarious purposes, and the submissions received do not offer any confidence that such could (nor indeed have been intended to) adequately meet the problems identified during the inquest that are specific to the danger to life arising from ongoing contact between prisoners and educational projects in the community (exemplified by Learning Together). Indeed we note from SSHD/SSJ paragraphs 10 to 12 that a working group is intended that could be more relevant in its remit to this matter of concern. The family observe however that the proposal to convene a working group to look at the issues in general is not equivalent to having implemented the proposed Recommendation to address the matter of concern. Whilst the working group is to be welcomed, the learning from this inquest would be properly communicated by R2. We also reiterate the principles at {§6} concerning the need to avoid deflection invited because some consideration or partial step shall be given to a topic without concrete action fully addressing any concerns having been implemented already.

Recommendation 3: LT to work with HMPPS to devise a structured information sharing system to share intelligence and other risk-related information on prisoners working with LT (or other organisations) in the community. {§11-§12}

5. This recommendation is addressed in the SSHD/SSJ's submissions at paragraphs 30 to 31. Again, the family welcome the news that a working group has been set up to consider the interaction between HMPPS and educational partners. However no detailed guidance on information sharing exists that would suggest that intelligence, which is credible, that an offender was planning an attack would be information shared with a community event organiser. Given the consequences exposed in this inquest, the family consider that it is essential there is an appropriate structured information sharing system for this interaction with bodies like LT, without which human error by an Offender Manager will remain more likely as they seek to obtain opportunities for their supervisee. This is not to be misunderstood; it is accepted that not all intelligence can be shared. It is an expectation that the lesson from this inquest is better systems and guidance are needed to ensure important risk information (including intelligence) is shared with external event organisers.

Recommendation 4: that consideration is given to ensuring that only qualified psychologists undertake ERG22+ assessments/alternatively, that there is a formal, documented involvement of psychologists in such assessments. {§13-§14}
and
Recommendation 5: That it be made a clear stipulation and requirement in the management of TACT offenders in the community that any ERG22+ be completed by an appropriate person not otherwise involved in the management and supervision of the TACT offender. {§15-§16}

6. These recommendations are addressed in the SSHD/SSJ's submissions at paragraphs 32 to 35. The family welcome the news that the specific allocated Offender Manager (i.e. Mr Skelton in Khan's case) shall no longer conduct ERG22+ assessments for the person they are managing (and acknowledge this is relevant to Recommendation 5). However the family remain concerned that the expertise for a thorough and comprehensive ERG22+ assessment requires a trained psychologist. The short training delivered for the ERG22+ itself had been undertaken by Mr Skelton, with the input and oversight of the CTPO Mr Johal who had also been trained in the same way. This was self-evidently not enough to

provide (a) the necessary skills for a thorough and adequate assessment; and (b) the comparable time for completion of this work amongst the other roles of the Probation officers – and there is no reason to consider that CTPOs have the equivalent time to undertake the assessment that a professional psychologist would allocate. The family consider R4 should be recommended for the permanent structure yet to be developed by the Counter-Terrorism Assessment and Rehabilitation Centre.

Recommendation 6: Clear guidance should be issued to probation to the effect that risk re-categorisation should not be decided in isolation from the OASys process, but should only ever follow the completion of that process. Consideration should be given to any further training required for probation staff to ensure that any alteration of risk level is properly undertaken and is reported to MAPPA so that any concerns may be discussed. {§17-§18}

7. The SSHD/SSJ's submissions are set out at paragraphs 36 to 39. The family note that there is new guidance in relation to risk of serious harm assessment[2] and welcome emphasis on the importance of actuarial risk assessment tools [p4] and recognition that good risk assessment is evidence based [p5]. However the passages to which attention is drawn ('Forming and recording a rationale for the risk and protective factors identified'; p19) in fact go to the *recording* of a decision to reduce risk, rather than make it clear that a *decision* to reduce risk should only properly *follow* the conclusion of a risk assessment using the OASys assessment tool. In the guidance on cross-over between exercise of judgment and the actuarial tools [p23-p26] it is not made plain the analysis and reaching of a conclusion must be undertaken first by the path of completing the assessment using the vital OASys system to undertake that. A professional judgment should be exercised considering the results, rather than adopted as a starting point, with the assessment completed to meet the assessor's private free-standing opinion. In short, the concern is that rather than use the available tool to arrive at an evidence-based, properly considered assessment, it is used as a means to merely record a prior decision to reduce risk level, as Mr Skelton and Mr Bromley did (though they also went on to fail to record the decision in an OASys). The concern remains that the quality of guidance or training for probation staff has not ensured by unambiguous instruction that the cart does not go before the horse in formally assessing any reduction of risk.

[2] https://www.gov.uk/government/publications/hmpps-risk-of-serious-harm-guidance-2020

8. The SSHD/SSJ submissions do not explain any steps envisaged to ensure that MAPPA is always informed of any alteration of risk assessment by an OM (and his senior line manager), which of course did not happen in this case.

Recommendation 7: That steps be taken (by guidance or training) to ensure Offender Managers, on each occasion that a decision is required to grant permission to depart from licence conditions, make a clear and sufficient record of the decision and the reasons for doing so. {§19-§20}

9. The SSHD/SSJ (at paragraph 40) acknowledge that there is yet to be any explicit requirement in any applicable guidance that requires a decision to temporarily suspend a licence condition, or sanction an exception to it, be recorded. The Risk of Serious Harm Guidance (July 2020) mentions the positive openness and ability to review reasons if decisions are recorded (including licence condition removal/addition) [p41] but it does not mention (a) any obligation to do so, rather than benefit to doing so; and (b) temporary one-off suspension of the effect of a licence condition that has been placed on the licence – i.e. the exercise of the power of the OM to consent to specific acts otherwise precluded by the licence. The failure to require an open recording of a decision the OM took to allow a prospective relaxation of a prohibition caused confusion and unaccountability in the management of Khan and reporting to MAPPA and discussions thereupon. The present proposal that there be a Compliance and Engagement on Licence Guidance (due August 2021) that should address the requirement to make a clear and sufficient record of any decision to grant permission to depart from licence conditions would represent an overdue provision. In light of the fact no suitable draft or final guidance has been seen it remains appropriate that this important matter of concern be highlighted in the report to that its remedy be assured.

10. The family welcome the proposal (at paragraph 41) that changes to licence conditions should be agreed with MAPPA, or its Chair, though it is unclear if this would apply also to OM permissions that temporarily suspend a condition.

Recommendation 8: That guidance and training to Offender Managers emphasise the need to remain vigilant and to review any decision to allow a relaxation of licence

conditions to enable a TACT offender to attend any (public) event shortly before and at the time of the event to ensure all relevant risk factors are given full consideration at the time that the event is to occur (and thus the risk to crystallise at such an event). {§21-§22}

11. The family welcome the fact that new guidance due in October 2021 will apparently address this concern (explained in the SSHD/SSJ's submissions at paragraph 42). However the action has not yet been taken and the guidance not yet set out or supplied. It is a matter for the Coroner whether he considers that this concern has been addressed such that it should, in all the circumstances (and considering the relevant guidance, to which the family's submissions at {6} and fn.5. referred), no longer feature in the PFD report, or whether its important need should be highlighted within the report given that it has still yet to be implemented or actioned.

Recommendation 9: Ensure that legislative and practical provision is made to enable effective polygraph use in the management of TACT offenders {§23-§24}

12. This recommendation is addressed in the SSHD/SSJ's submissions at paragraph 43. The family welcome the news that the SSHD/SSJ are implementing the legislation that came into force on 29 June 2021, and consider that this concern has been addressed.

Recommendation 10: That guidance and training be reviewed to ensure that Offender Managers of TACT offenders are reminded or made aware of the need to remain vigilant against deceptive compliance or manipulation and adopt appropriate strategies and systems of testing compliance with the licence conditions. {§25-§26}

13. This recommendation is addressed in the SSHD/SSJ's submissions at paragraphs 44 to 45. The family welcomes the news of the training in relation to potential manipulation by TACT offenders that took place in March 2021, and the apparent introduction of Core groups. The family hopes that this training will form a regular part of training of those dealing with TACT offenders. The family are unable to comment on the sufficiency or otherwise of the guidance referred to, set against the concerns revealed in this inquest (to some of which our submissions at {25} referred) which has not been supplied.

Recommendation 11: Consideration should be given to establishing a detailed review to identify what further steps can be taken in order to maximise the chances of TACT offenders who seek to rehabilitate being able to obtain employment. {§27-§28}

14. The family note the difficulties in assisting TACT offenders who (unlike Khan) may have been genuine in seeking to rehabilitate in obtaining employment, to which the SSHD/SSJ's submissions at paragraph 46 refer, and indeed as the inquest heard. However, the family would reiterate the desirability of a detailed review. Reference to the NSD Reducing Re-offending Strategy is unsupported by any content or documentation. Questions remain to be addressed: how will employment opportunities for TACT offenders be increased? and whether, for example, consideration has been given to creating public employment as a risk reduction approach? Which partner agencies are or should be involved in addressing this?

Recommendation 12: There be investigation and consideration of the means of communication and recording of mentoring need, and priority allocations, between CT Probation and managing Probation officers to ensure a system is in operation that is clear and avoids any such miscommunication or error. {§29-§30}

15. This recommendation is addressed in the SSHD/SSJ's submissions at paragraphs 47 to 48. The family note the changes made since 2019, and welcome those changes. These indicate extra resources are in place; though they do not explain the manner of recording the status (need or otherwise, priority or otherwise) of individuals under supervision who may need a mentor to be allocated, and thus how a future miscommunication could be avoided with a clarity of shared record between the Joint Extremism Unit and Home Office and the CT Probation Lead.

Recommendation 13: (i) Procedures at APs should be reviewed and improved to ensure that individuals' management plans are being adhered to, particularly in relation to drug testing. (ii) Consideration should be given to implementing or increasing drug testing of TACT offenders in the community under supervision when living independently. {§31-§32}

16. This recommendation is addressed in the SSHD/SSJ's submissions at paragraphs 49 to 50. The family note that work is ongoing to increase drug testing for those residing in Approved Premises, and welcome this news. The family do reiterate its concerns that procedures should be reviewed in order to ensure that the management plans are actually being adhered to, and the drug testing is being conducted as required.

17. In relation to testing in the community, the family reiterates its concerns. Whilst it is said that the Probation National Security Division "will consider" extending testing "where there is evidence of drug use or increased risk" and "will consider testing prior to approved attendance at events" this does not provide the reassurance that the lesson has been learnt or necessary step taken in response to the missed opportunity to have exposed Khan's non-compliance with the licence, and that same mistake could evidently occur again.

Recommendation 14: (i) MAPPA processes should be urgently reviewed to ensure that it is clear to all attendees at a meeting, and to those attending subsequent meetings, what approvals for departure from the licence restrictions have been agreed and approved by MAPPA; and what or whether risk assessments have been undertaken in relation to such events or activities. (ii) The process for varying licence conditions should be formalised, including the need to record rationale and show specific and positive approval from MAPPA. **{§33-§34}**

18. The SSHD/SSJ's submissions at paragraphs 51 to 52 do not provide an answer to the concern at 14(i), so the issue is what will come from the review of the MAPPA meeting template document referred to at paragraph 53. Unless and until a greater clarity is achieved this matter of concern remains. Attendees need to be able to see clearly what has or has not been risk assessed or approved at MAPPA previously, or during a meeting.

19. In respect to 14(ii), the SHHD/SSJ at paragraphs 54 to 58 address the recording of variation by the OM, and the antecedent question so far as MAPPA panels are concerned as to whether or not an issue is raised with them. However the matter of concern is the confusion in the MAPPA panel itself as to what has or has not been approved by it, if raised with it for approval by the OM. The concern remains that presently nothing has changed to prevent a future MAPPA panel convening unsure as to what approval or

assessment of an activity requiring an OM permission and temporary suspension of a licence prohibition has been undertaken at any previous panel meeting.

Recommendation 15: (i) That it be made a specific requirement that before relaxation of a licence prohibition the OM undertake an appropriate risk assessment of the specific proposed event or activity and steps which should be taken to mitigate risk (ii) That consideration be given to specific training for those probation and police officers involved in managing TACT offenders to enable guarding against feigned engagement and averting the risk of manipulation and deceptive compliance. (iii) Risk management training, and guidance, for probation staff and CT police should be reviewed to establish whether it sufficiently covers ways to manage risk by implementing measures short of rejecting requests, particularly in relation to the management of TACT offenders. {§35-§36}

20. In their submissions at paragraph 59 the SSHD/SSJ state that this recommendation is previously addressed. Regarding 15(ii) and training to combat 'deceptive compliance', the SSHD/SSJ position appears to cross-over with Recommendation 10 above. However for 15(i) and (iii) the matter of concern here is that allowing a step in relaxation of a risk prevention condition of the licence was treated by many of the probation and police involved in this case as an 'all or nothing' decision, which did not require any consideration of risk mitigation options once a decision had been taken to permit attendance at the event by Khan. That approach is dangerous and wrong. With respect, we are unable to identify where or how this particular, and important, concern has been met (or said to be met).

Recommendation 16: (i) A reliable means of distribution of minutes of MAPPA meetings to all participating and attending organisations and individuals; (ii) a review of the format of the Minutes for MAPPA meetings to identify the best means to ensure that key intelligence and risk factors remain in the iterative document each month {§37-§38}.

And

Recommendation 17: That the format of MAPPA minutes which remain in circulation and consideration at meetings as management occurs should contain a list of the factors identified to be relevant by the ERG22+ assessment so that these remain front and centre in the mind of the MAPPA panel and attendees. {§39-§40}

21. These recommendations are addressed in the SSHD/SSJ submissions at paragraphs 60 to 64. Regarding R16(i), it is not clear from the same how it was that in this case many of the attending individuals confirmed that they had not had access to previous meeting MAPPA Minutes until arrival at a meeting in person. It is possible that the concern lies with the receiving organisations ensuring recording of minutes received, or ViSOR access, or lies with the MAPPA arrangements for disseminating to past meeting attendees not seeming to include forthcoming meeting attendees as persons to be emailed minutes ahead of the next meeting.

22. The family note and welcome the news that the National MAPPA Team are conducting a review of the MAPPA document set, but the matters of concern 16(ii) and 17 are ones that ought to be recorded by the PFD and must be addressed in due course by such review. The SSHD/SSJ paragraph 63 refers to guidance that does not address the iterative process and ensuring vital content is not lost over time. So, for example in Khan's case the intelligence that he was going to return to his old ways[3] was not retained in the MAPPA B minutes after 5 December 2018, so would not be seen by subsequent attendees; and the ERG22+ factors relevant to his risk was not included after 26 June 2018[4]. It is important that the National MAPPA Team be given a clear indication of the failings of the Minutes record in this case – the concerns for preventing future recurrence – so that the right changes are made.

Recommendation 18: Jonathan Hall QC's recommendation to concentrate decision-making in a core group. {§41-§42}

23. The SSHD/SSJ indicate, at paragraph 65, that the recommendation has been accepted and implemented. The family therefore accept that this concern has potentially been addressed, provided that the understanding as to when it is "necessary" to have a Core group consisting of those who have security clearance is that it is necessary whenever there exists intelligence about the individual that should be known to the persons making decisions, including an OM and Part 4 managing CT police, to aid them in taking the correctly

[3] MAPPA B document DC6409/6
[4] MAPPA B document DC6406/6

cautious approach to management of the risk. This is not entirely clear, and it is noted that more detailed processes and procedures for Core Groups remain to be provided.

Recommendation 21: (i) A review be conducted of the computer systems in use for information sharing to ensure that the police and probation and prison staff who require specific access to terminals, and specific database systems, to contribute effectively to the appropriate sharing of intelligence are enabled to do so. (ii) A review to ensure that there is (where appropriate) streamlining of the use of IT systems so that these are correctly used for common sharing of intelligence between different organisations as appropriate, and with appropriate access for all relevant personnel. (iii) A review to identify the correct location of a sterile corridor between overt and covert investigations and management, so that there is the correct line drawn for the sharing of intelligence to those who require it for decision-making to manage risk. {§48-§49}

24. The SSHD/SSJ's submissions at paragraphs 66 to 67 refer. The family note the introduction of the new Multi-Agency Public Protection System ("MAPPS"), which may (once its detail is known) have the potential to address concerns over inadequacy of information sharing, but note it also adds one further system to the panoply already in place which seemed to be some part of the problem in that not all relevant individuals in relevant partner agencies were able to access relevant information, whether that be MAPPA Minutes, subject profiles, ERG22+, intelligence reports, mentor reports or contact logs, due to limited authorisations or agency-sharing or terminals. Further and alternately there remains to be seen what national approach should be taken to best practice for the sterile corridor. This inquest exposed a difference between the Part 4 management that in the case of West Midlands Police allowed the line manager of the Part 4 nominal managing police officer to have access to intelligence, but in the Staffordshire management of Khan did not allow such knowledge within the Part 4 managing team at all, so the corridor was placed entirely outside of the team managing Khan.

Recommendation 22: (i) That procedures be reviewed to identify the appropriate speed with which JOT meetings should convene. (ii) That procedures for handling and responding to requests for BSU involvement be reviewed to identify if they remain

appropriate or can be improved with a view to informing CT police of the consideration, reasoning or criteria applied to processing such a request. {§50-§51}

25. This recommendation is addressed in the SSHD/SSJ's submissions at paragraphs 68 to 69. Whilst the facility to convene an urgent JOT meeting is noted, it is not plain that such distinction or option is explained to CT Police; nor whether 12 days is to be considered appropriate lag in any case without express urgency request or has been reviewed with a view to establishing if that is a reasonably safe approach for convening JOTs requested by CT Police, and which can be by telephone/video-conference/in person. There is no explanation of the procedure inter-agency between CT Police and Security Service for responding to requests for a BSU assessment. The family appreciate the sensitivities to being given full information as to this, but are concerned to ensure that where such an issue arises there is clarity between CT Police and the Security Service, and the opportunity for dialogue about the potential value of the assessment and the criteria to be considered.

Recommendation 27: Whenever a TACT offender is to be permitted to attend at a venue or event where the public are present the Probation and Police officers responsible for the risk management of the offender ought to make contact with the organisation concerned to discuss and ascertain the specific security measures in place for the event and venue, and offer appropriate advice and guidance to strengthen the same where appropriate, and to assist in the safety of those working at or attending the event to which the offender is to be permitted to attend. {§60-§61}

26. This recommendation is addressed in the SSHD/SSJ's submissions at paragraphs 70 to 71. The family appreciates that probation officers are not the appropriate people to advise as to security measures. However, the family considers that, it is insufficient to rely on a general provision, indeed an apparent onus on a venue, to seek out CTSA advice. To the contrary it must be a concern that in cases involving TACT offenders – known to the managing agencies – there could and should be a system of mandatory referral by probation or CT police so that either the CT Police, or Home Office Counter Terrorism Security Advisors (or any other appropriate terrorist risk advisor) shall consult with and provide an event coordinator with appropriate advice as to security measures before the TACT offender attends.

West Midlands Police ("WMP")

Recommendation 15: …(ii) That consideration be given to specific training for those probation and police officers involved in managing TACT offenders to enable guarding against feigned engagement and averting the risk of manipulation and deceptive compliance. (iii) Risk management training, and guidance, for probation staff and CT police should be reviewed to establish whether it sufficiently covers ways to manage risk by implementing measures short of rejecting requests, particularly in relation to the management of TACT offenders. {§35-§36}

27. WMP's submissions (in the letter from ACC Ward) refer at paragraphs 4 to 14. There is since June 2021 a training for management of CT nominals (paragraph 5). It is not stated however whether this training is being given to all existing and not only new staff responsible for management of CT nominals; nor if it specifically addresses the concern exposed at the inquest over false compliance and manipulation of supervising officers. In relation to necessary training or guidance so that risk mitigation measures are considered it is noted that (at [11]) states that these measures can be and when necessary are deployed. That does not answer the question as to training or guidance – merely confirms that they can be (and on occasions are). It is to be welcomed that WMP now "frequently" engage with the venue and organisers of events to put in place a structured plan to manage the visit, but it is not explained on what basis or in what circumstances this is or is seen to be a requirement. It appears that CT Nominal Capability risk assessments are to be actively developed by Project SEMPER in light of post-attack reviews (at [13]). The family welcome such a development but would suggest they would benefit also from taking into account the matters of concern arising from the inquest that it is appropriate to reflect in recommendations of steps that would prevent future deaths.

28. For the record, contrary to [14], it is submitted that the police could have a power to search where a reasonable suspicion arises because of the circumstances prevailing, such as a trip to a high-profile public event, and a TACT offender has refused a voluntary search of his bag or thick coat. It does not matter that there could be some other reason for refusal; what matters is that an officer could subjectively form a reasonable suspicion over the content of the bag for example, and that this is objectively based suspicion, and so could

exercise the power in s.43 of the Terrorism Act 2000 (or s.1(3) of the Police and Criminal Evidence Act 1984). Nonetheless, the family note that the suggestion in fn.4 to paragraph 14 of the submissions of WMP raise a matter that perhaps ought to be considered by the SSHD/SSJ for probation to include in licence conditions; and therefore may suggest a further appropriate Recommendation. However that would necessarily go farther than reasonable suspicion, which we submit would have been plainly established in Khan's case and any future like circumstance.

Recommendation 19: That police management of TACT offenders should only be undertaken by adequately trained and supported CT specialists and not Prevent officers. {§43-§44}

29. WMP's submissions (at paragraphs 15 to 17) confirm that Prevent is no longer used for CT nominal management in Staffordshire or West Midlands. The learned Coroner may be concerned that this lesson has been implemented nationally. No assurance has been received from the Home Office (or National Police Chiefs Council) directly or in any evidence supplied by WMP that would ensure never again anywhere in the country would this mistake be replicated in selecting those with appropriate skills, training and systems in place for management of Part 4 nominals. However the family note the Metropolitan Police Service ("MPS") submissions have referred to the recommendations in relation to management of TACT offenders. The MPS refer to Project Semper and the overhaul of the system of nominal management since 2019. The family notes this appears to assure that no Prevent officers would now be used nationally (or certainly wherever Project Semper is in effect): MPS at paragraphs 15-17.

Recommendation 20: The quality, frequency and purpose of visits by police should be actively discussed and specific approval obtained from MAPPA before the frequency of visits is reduced, to ensure that those managing TACT offenders have a complete picture of the support structure in place, and risk can be accurately assessed. {§46-§47}

30. This recommendation is addressed in the WMP's submissions at paragraphs 18 to 20. The family accept that each CT nominal will have different bespoke requirements, but the periodic nature of MAPPA meetings would not prevent MAPPA from setting down a *minimum* number of visits until its next meeting, which could only be reduced by either

approval or at least by notice to MAPPA. This would both ensure a certain baseline in the number of visits is observed but also ensure those considering the information being fed in to MAPPA from Part 4 management understand the frequency and nature of visits being carried out to obtain information relevant to risk. Not only senior leadership (in the police) but the MAPPA panel need to know the picture. The family would welcome the possibility mooted by the WMP that the frequency of visits could be a standing agenda item for MAPPA meetings. Recommendation 20 has not yet been addressed, and this issue remains a matter of concern.

Recommendation 21: [Set out already above] [i.e. concerning the computer systems in use for information sharing between different organisations, and the correct location of a sterile corridor between overt and covert investigations and management] {§48-§49}

31. WMP's submissions (at paragraphs 21 to 23) contend that the systems in place are fit for purpose, and that the case of Mr Khan was an individual rather than a systemic failing. The family do not agree that the existing system is adequate, and R21 followed evidence at the inquest that there were issues generally experienced over access to some systems by some probation or police officers, including what was or was not entered to ViSOR and to computer access terminals. In relation to the sterile corridor, the submissions of WMP (at [22]) address specific intelligence, not the systemic point: Team 7 had a senior officer managing the CT nominal who was in the loop with intelligence, even if the CT nominal manager officer him or herself would not be sighted on the same intelligence. (For completeness, contrary to [23], the family understand there was not a confusion but a failure of WMP CT Police to share intelligence it had received with MAPPA, although it may be debated whether that is a systemic or operational failing).

Recommendation 22: [Set out already above] [i.e. concerning procedure for JOT meetings convening; and for handling and responding to CT police requests for BSU involvement] {§50-§51}

32. The family primarily rely upon the submissions already made concerning R22. However WMP submissions at paragraph 24 suggest that the JOT was requested on 6 November 2019 with no urgency and was "a routine meeting arising due to a handover in police

staff…". However as was covered in the oral evidence of DS Stephenson the request for a JOT followed his request of the same date to increase Prevent visits [email DC7443/133] and explanation to DC Mills he did so due to Khan's self-isolation and spending more time at home [DC7443/135]. DS Stephenson asked for a JOT to re-evaluate matters going forward, to understand Khan's behaviour, plans, and support network he had with probation. He also made a telephone call at 11am that day, 6 November 2019, to Mi5 and updated them with the concerns over Khan isolating, having no job, not socialising, not attending the Mosque, not seeking employment, receiving less frequent Prevent visits, and with limited information from probation. JOT processes should be considered to ensure (as noted earlier herein) that a delay of 12 days is really an appropriate lag time. The aim is to prevent avoidable future deaths of course by recognising the possible impact of delay (such as occurred in this case).

Recommendation 27: [Set out already above] [i.e. when a TACT offender is permitted to attend at a venue or event where the public are present contact with the organisation concerned to discuss and ascertain the specific security measures in place and offer appropriate advice and guidance. {§60-§61}

33. This recommendation is referred to at paragraphs 25 to 27 of the WMP's submissions. The WMP submit that the term 'venue' or 'event' is too broad to render practical the implementation of this recommendation. The words "specifically approved venue or event" could be substituted – but in any event it is plain that the reference is to an out-of-the-ordinary event for which the TACT offender will need to seek approval from the probation service (and may therefore be considered to hold a greater element of risk due to the make-up of attendees, the location and so forth, and reflects the reason that the licence would otherwise have prevented the attendance).

University of Cambridge ("UoC")

34. The family's Recommendations include (in shortened form):

Recommendation 23: That Learning Together and Cambridge University implement a requirement that a risk assessment be produced for the organisation of any event/activity where convicted offenders will be in attendance; and should engage

with the prison, probation and police authorities as appropriate to ensure that there is a full understanding of the risks and to take advice upon security. {§52-§53}

Recommendation 24: LT to inform venue owners and providers of staff at events whenever convicted offenders are invited to attend LT events, and to provide full details of risk profiles and matters relevant to potential risk relevant to security measures. {§54-§55}

Recommendation 25: That UoC carefully reviews the evidence revealed at the inquest, and (i) whether or not the programme should continue; and if it is to continue (ii) whether changes to its current leadership and/or leadership structure are required so as to ensure safety for all participants and staff. {§56-§57}

35. The family welcomes the fact that Learning Together remains suspended. Their preference would be that LT does not resume or continue. However if it does it seems to the family vital that it does not continue to be under the stewardship of the directors Ruth Armstrong and Amy Ludlow. Their evidenced refusal to address past behaviours, seeming ideological inability to take an objective perspective to the risks both before but even in the aftermath of the attack, the disregard of instructions from those in higher authority (such as requiring completion of Prevent training), and the arrogance displayed in evidence at the inquest, renders them unsuitable for leadership roles within LT even were someone else were positioned above them within the organisational structure to oversee matters. A recommendation that a new Chief Executive be appointed to LT was already apparently successfully defeated or diverted by the pair of directors working within the University's structures, and diluted to the proposal for a line manager to be identified, and that work of a Transition Board is to be supported by and "work closely with" these two directors (paragraph 16). The current directors have also managed to remain in control of discussions with the MoJ's Head of Prisoner Outcomes (paragraph 25).

36. The family continue to regard it as important that the PFD make recommendations and record matters of concern regarding the operation of LT in the respects reflected by the proposed Recommendations. That shall focus the mind, and provide the benefit of the inquest's revelations in an accessible form to any review body (such as the Transition Board or the Council of the University). Despite several completed internal reviews (the UoC has

completed the Reflection Group Report, the Advisory Body's Report and the Strategic Advisors' Report) there remains no certainty or draft proposal as to how, if it is to continue, changes will be made to LT. In particular the resistance of the two directors to proposed oversight which has already been seen (with no interim Chief Executive able to be appointed to LT since the March 2020 Reflection Group Report; nor Executive Director since the Strategic Advisors' Report), and the absence of any firm proposals from the UoC, mean that the matters of concern clearly remain. There has also still to be any proper identification of the relevant health and safety training for risk management in the work LT has been doing (paragraph 22). A current pause, and an unknown future structure, provide no assurances that remove the risk of future deaths.

Staffordshire Police

37. Staffordshire Police set out their general responses to Recommendations 19, 20 and 21. The family reiterates its comments made above in respect to these Recommendations and WMP, which also answer the suggestions made by Staffordshire (and notably, its reference, at [6], to national level policing developments adds nothing to the evidence of ACC Ward).

Fishmongers' Company

Recommendation 26: The specific risks to health and safety identified in the operation of the Company's activities should be addressed with some urgency when identified, and sufficient personnel or resources be made available to ensure that actions are taken to address such risks in a prompt and timely manner in future. {§58-§59}

38. The Fishmongers' Company sets out, by way of response to the family's recommendations, an outline of measures taken since the 2019 attack. There is no suggestion of any greater alacrity, or new personnel or staff role, now in place to ensure prompt remedying of any security and safety concerns as soon as they are recognised (such as having been reported to the Company by independent consultants by a Risk Register, which, as an example, the particular risk seen in this case was (contrary to para. 3(c) of the FC's submissions): albeit non-specific about where the lone attacker originated the R6 risk was for terror inside, and identified lack of documented response procedures and raised the option to screen guests

for example: DC5012/6). Despite the many changes to the actual security, the Company's method of working through sequentially with the gaps of meetings of its governing bodies the risks to health and safety causes delay that is a matter of concern.

D. Emergency Response

Recommendation 28: Assess and revise policy and procedure in relation to communications between emergency workers on the scene of a major incident, in order to minimise any delay in access to casualties by medical teams. {§62-§64}

Recommendation 29: Assess and revise guidance (or training) in relation to the steps to be taken when using a modified triage system in a major incident, including information to be obtained by the medical responder at the scene. {§65-§69}

London Air Ambulance (Barts NHS Health Trust) ("LAA")

39. The LAA indicates that it would have useful input and expertise to bring to any review and revision of the procedures, policies or guidance. The LAA asks that the Coroner recommend its input and involvement in any review or revision process of emergency service procedures. The family has no observation to make on these submissions.

City of London Police ("CoLP")

40. The CoLP (paragraph 9) refers to unstated matters taken from a de-brief on 7 January 2020 that are being taken forward. It is not made clear what those are, or why they would not yet have been implemented. The family acknowledge and welcome of course the intention for joint training exercises amongst the emergency services [10]. The family repeat the concerns that improvements can reasonably be sought to methods of communications at the scene between services, as Recommendation 28 refers to.

London Ambulance Service ("LAS")

41. LAS disputes that there was any issue in relation to communications on the day of the attack. The family reiterates the facts referred to at {62}-{63} of its original submissions.

42. LAS disputes that there was any issue in relation to the modified triaging system; and disputes that a list of questions for those already on the scene to answer would assist. LAS

points to reliance upon the defibrillator not advising shock, and the absence of any signs of life at the time of the triage assessment (rather than any background information being supplied; although of course questions were asked for a reason) but that begs the question – what physical checks are necessary for a sufficient triage. The family reiterates its original concern at {67} of the original submissions – i.e. that it is unclear on what basis the modified triage system allows death to be declared. In the case of Saskia Jones, it seemed to have been based purely on the length of resuscitation, rather than on lack of pulse or blockage in the airway, for example. The family maintains its recommendation for assessment of training and guidance in relation to the modified triage system, with revision as necessary, so that there is clarity and consistency amongst first responders as far as is possible.

Metropolitan Police Service ("MPS")

43. The MPS claim that there was no actual delay in this instance (which itself it not determinative of a risk arising of future deaths however); and rely on existing operating procedures. The family simply reiterate its concerns as to the apparent lack of structured communication, and considers that there could be improvements made.

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10 August 2021