INQUESTS ARISING FROM THE DEATHS
IN THE FISHMONGERS' HALL TERROR ATTACK

REGULATION 28 REPORT ON ACTION TO PREVENT FUTURE DEATHS

Addressees

This Report is addressed to the following:

(a) The Secretary of State for the Home Department;
(b) The Secretary of State for Justice;
(c) The Secretary of State for Education;
(d) The Director-General of the Security Service;
(e) The Chief Executive of the Office for Students;
(f) The Chief Executive Officer of the College of Policing;
(g) The Chief Constable of West Midlands Police;
(h) The Chief Constable of Staffordshire Police;
(i) The Vice-Chancellor of the University of Cambridge; and
(j) The Directors of Learning Together CIC.

Coroner

1. I am the Recorder of London. The Recorder of London is the lead judge at the Central Criminal Court (the Old Bailey) and the most senior Circuit Judge in England & Wales. I heard these Inquests in the capacity of a Judge nominated by the Lord Chief Justice pursuant to Schedule 10 to the Coroners and Justice Act 2009 ("CJA"). When I received that nomination, I was also the Chief Coroner of England and Wales, but my appointment to that post ended on 23 December 2020 before the conclusion of the Inquests.

2. My official address is The Old Bailey, London EC4M 7EH. However, responses to this report should be sent to the solicitor to the Inquests; Sinead Lester, at BDB Pitmans LLP, One Bartholomew Close, London EC1A 7BL.

Coroner's Legal Powers

3. I make this Report on Action to Prevent Future Deaths under paragraph 7 of Schedule 5 to the CJA and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 ("the Regulations").

Investigation and Inquests

4. The Inquests to which this Report relates include those of the two young people who were fatally injured in the terror attack which took place at Fishmongers' Hall on 29 November 2019; Saskia Jones and Jack Merritt. They also include the Inquest of the attacker, Usman Khan, who was fatally shot by firearms officers on the same date.

5. After my nomination to hear the Inquests, I held Pre-Inquest Review hearings on 16 October 2020, 12 February 2021 and 25 March 2021. I held a hearing of the Inquests of the victims of the attack with a jury from 12 April 2021, which ended on 28 May 2021. Immediately afterwards, I held a hearing of the Inquest of the attacker, also with a jury, from 28 May 2021 until 10 June 2021.

6. In the Inquests of the victims of the attack, the jury determined that each had been unlawfully killed and in each case provided a supplementary narrative conclusion by means of answers to a questionnaire. Attached to this Report are copies of the Determinations sheets for the two victims.

7. In the Inquest of the attacker, the jury returned a conclusion of lawful killing and added a further narrative conclusion. Attached to this Report is a copy of the Determinations sheet for the attacker.

8. Further details concerning the Inquests, including transcripts of the hearings and copies of relevant rulings, can be found on the Inquests website:

    - https://fishmongershallinquests.independent.gov.uk/

Circumstances of the Deaths

9. A very full factual summary may be found in the transcript of my summing-up on 26-27 May 2021, which appears on the Inquests website. The following paragraphs of this Report provide a short summary to assist in consideration of the matters of concern raised below.

Usman Khan: Background

10. Usman Khan was 28 years old at the time of the attack. He had had a history of involvement in events of violence as a teenager. In 2010 (when he was aged 19), he was arrested for offences of acts preparatory to terrorism and was remanded in custody. He pleaded guilty to a number of charges and was sentenced in early 2012, the basis of his plea being that he had sought to set up a militant training camp in Kashmir from which in future attacks might be launched on the UK. He was imprisoned and served his sentence in a number of prisons between mid-2010 and December 2018.

11. While Usman Khan was in prison, intelligence reports consistently showed him to be a leading extremist figure, involved in bullying, violence, radicalising others and serious disruption. An Extremism Risk Guidelines (ERG 22+) assessment report prepared on him in April 2018 by a prison psychologist, Ieva Cechaviciute, concluded that his intent for and engagement with extremism remained strong and that there was a high risk that he would become involved in extremist activity upon release.

12. At the time of his release, Usman Khan remained a Category A (High Risk) prisoner, one of very few to be released into the community with that status. An OASys assessment by his probation officer shortly before his release concluded that he posed a "very high risk" of serious harm to the public in the community, indicating that a seriously harmful event was imminent and more likely than not to happen. Shortly before his release from prison, there were two strands of intelligence indicating that (a) he intended to return to his old ways upon release (which was interpreted as a reference to some form of terrorist offending) and (b) he intended to carry out an attack after release.

13. While he was in HMP Whitemoor, from November 2017, Usman Khan began to take courses provided by Learning Together, a prisoner educational initiative supported by

academics from the Institute of Criminology within the University of Cambridge. The initiative involved undergraduate students studying alongside prisoners within prisons. It had an alumni network which allowed former prisoners to remain involved in its activities after their release. Usman Khan proceeded to take a series of Learning Together courses over his final year in prison, and he remained in contact with Learning Together staff after his release.

14. From June 2018, Usman Khan was subject to management under statutory Multi-Agency Public Protection Arrangements ("MAPPA"). These involved meetings being held at regular intervals involving representatives of police forces, the National Probation Service ("NPS") and others with relevant responsibilities for him. Reports were made to the meetings and decisions were made with a view to mitigating the risks he posed.

15. On his release into the community, Usman Khan was subject to strict licence conditions which were overseen by an offender manager from the NPS. He was initially required to live in approved premises in Stafford (a probation hostel) and he had to wear a GPS tag. In addition, he was subject to statutory notification requirements under terrorism legislation (Part 4 of the Counter-Terrorism Act 2008), which were managed by Staffordshire PREVENT team officers. Those officers visited him at intervals and prepared general reports about him. Usman Khan also had mentors provided for him under the Home Office Desistance and Disengagement Programme ("DDP").

16. In preparation for Usman Khan's release into the community, the Security Service (MI5) and West Midlands Police opened a priority investigation into him. Staffordshire Police Special Branch provided intelligence support to this operation. The investigation carried out a range of monitoring on Usman Khan over the months that he was living in the community, but did not detect any significant suspicious activity.

17. In the months following his release into the community (early 2019), Usman Khan was apparently compliant with his licence conditions and he did not engage with old associates. He was seen regularly by his offender manager and by mentors, and he visited his family in Stoke-on-Trent. His curfew conditions were relaxed progressively. He applied for a number of jobs, but all without success.

18. Usman Khan remained in contact with the Learning Together initiative. In June 2019, he attended a Learning Together event at HMP Whitemoor, being taken there by PREVENT officers. He received a non-networked Chromebook computer for creative writing, but there was no evidence that he did any actual project work. His search for employment continued and consideration was given to him applying for a job as a dumper truck driver, but the MAPPA agencies decided that that should not be permitted because of the risk he might pose if given access to heavy vehicles.

19. In August 2019, staff from Learning Together invited Usman Khan to attend an anniversary and alumni event which was due to take place in London in November 2019. The event was arranged to take place on 29 November 2019 at Fishmongers' Hall, a livery company hall in the City of London adjacent to London Bridge. Prominent figures from the field of criminal justice were invited to attend, and a number did attend. Usman Khan was permitted to go to the event by his offender manager. The prospective event was discussed in either two or three of the MAPPA panel meetings held between August and November 2019, but it does not appear that the MAPPA agencies gave express consideration to the risks of Usman Khan attending such an event or expressly approved his attendance. It is however right to say that none objected.

20. In September 2019, Usman Khan moved from the probation hostel into a one-bedroom private flat. He continued to search for work without success, and this became more difficult when his mentoring arrangements were abruptly ceased and he no longer had the benefit of supervised access to the internet for job searches. He stopped going to the gym and appears to have spent much of his time playing video games, watching DVDs and walking around Stafford. Visits from officers of the PREVENT team became less regular. Overall, he became more socially isolated.

21. On 14 November 2019, two PREVENT team officers visited Usman Khan at the suggestion of the MAPPA agencies to take photographs of his DVDs and video games. He became upset about this, which he apparently regarded as an invasion of privacy. This reaction provoked some concern on the part of investigating officers.

22. From 20 November 2019, Usman Khan purchased a number of items which he would later use in the terrorist attack, including various items of clothing and items which he incorporated into a relatively sophisticated hoax suicide vest. Most of the items were bought on 28 November 2019, the day before the attack. It is believed that, on that day, he purchased the kitchen knives that he was to use in the attack. None of these preparations were known to the Security Service or counter-terrorism police.

Events of 29 November 2019

23. On 29 November 2019, the Learning Together event at Fishmongers' Hall took place as scheduled. It was attended by current and former university students and academics; by supporters of the organisation; and by serving and former prisoners. Saskia Jones attended as a former Cambridge criminology master's degree student who had an interest in the programme and who wanted to pursue a career as a police officer. Jack Merritt was employed by the University to work full-time for Learning Together.

24. Usman Khan travelled alone by train from Stafford to Euston station, where he was met by a staff member of Learning Together before travelling on to Fishmongers' Hall. He had with him a bag containing knives. It is believed that he had put on the hoax suicide vest under his coat while in a toilet on the train journey from Stafford to London.

25. The Learning Together event began at 11am with an opening session, followed by breakout sessions. During a break and shortly before 2pm, Usman Khan went to the toilets on the ground floor, near the entrance to the building. In a cubicle he armed himself with the knives and taped them to his wrists. Jack Merritt went into the toilets, where Usman Khan attacked him, stabbing him several times. This attack took place between 1.56pm and 1.57pm.

26. Usman Khan left the toilets. A female member of staff from the Hall was standing near the door, and he gestured to her to remain silent. He then attacked Saskia Jones, who was waiting by the cloakroom desk, stabbing her in the neck and seriously injuring her. Saskia Jones moved to the main staircase, where she collapsed. She quickly received first aid from other attendees of the event. Meanwhile, Jack Merritt left the toilets in an injured condition and made his way to the entrance hall. He was helped into the reception office near the front door. Staff there called the emergency services.

27. Usman Khan continued his attack, stabbing further people on the ground floor and inflicting further injuries. A number of those at the event fought back, using improvised weapons from the Hall (including a fire extinguisher and a narwhal tusk). After a short period of confrontation with them, Usman Khan forced his way out of the building and headed onto London Bridge. He was pursued by three attendees from the event. Once on the Bridge, they managed to force him to the floor. Along with members of the public, they kicked the knives from his grip.

28. Three officers from the City of London Police ("CoLP") were the first armed officers on scene. At 2.02pm, they approached Usman Khan together and moved others away from him. Two of them, seeing him wearing an apparent suicide vest, discharged their firearms at him. The third discharged a Taser. They then backed away from him, while they and other officers kept their weapons trained on him.

29. Over the period that followed, further firearms officers from both the CoLP and the Metropolitan Police Service ("MPS") arrived on the scene and many kept Usman Khan covered from a distance with their weapons. Further shots were fired when he made movements which caused the officers to fear that he may be about to detonate the apparent suicide vest. After some time, it became clear that he had been incapacitated. He was checked by explosive officers, who established that the vest was a convincing fake. Paramedics assessed him and found him to be dead.

30. While the firearms officers were dealing with Usman Khan on the Bridge, first aid was given to those whom he had attacked. Saskia Jones was treated at the bottom of the staircase in the Hall. Jack Merritt's first aid began in the Hall, before he was moved to the junction of Cannon Street and King William Street where he received more advanced medical care. Efforts to save Jack Merritt and Saskia Jones were unsuccessful, and each was declared deceased.

Coroner's Concerns

Preface

31. During the course of the Inquests, the evidence revealed matters giving rise to concern. In my opinion, there are risks that future deaths could occur unless action is taken to address those matters. In the circumstances, it is my statutory duty to report to appropriate persons who may be able to take remedial action. This Report addresses various topics and sets out matters of concern which are being reported to the addressees. Each matter of concern is denoted by an "MC" reference and is highlighted in bold. In each instance, those to whom the point is addressed are identified. In total there are some 22 detailed MCs set out below divided in to 5 topic areas. There is then a final section covering other topics that have been raised.

32. In preparing this Report, I have taken into account submissions from the bereaved families of what matters I should consider raising, as well as the responsive submissions from other Interested Persons and reply submissions from the families. The need to give time for those submissions and to consider them explains why this Report is being issued some months after the end of the Inquests.

33. As well as identifying and explaining matters of concern, this Report also identifies some points raised by the bereaved families which do not in my view justify inclusion in a report on prevention of future deaths ("PFD report"). It is not normal practice for coroners to include such detailed explanations of matters being raised or any account of why certain matters are not being raised. PFD reports of coroners generally are, and should continue to be, short and succinct documents produced quickly after inquests. This Report by contrast is an extensive document, as is appropriate to these exceptional Inquests (just as Hallett LJ produced a lengthy PFD report following the London Bombings Inquests, and just as I did after the London Bridge and Borough Market Terror Attack Inquests). It should not be seen as a model for inquests generally.

34. A number of the concerns raised in this Report relate to initiatives for the rehabilitation and education of prisoners and ex-prisoners. I would like to emphasise at the outset that I do not intend, by raising concerns in this way, to cause such valuable programmes to be discontinued or to make it unduly difficult to manage such programmes in future.

Evidence in the Inquests established that programmes such as Learning Together can help to move people away from offending behaviour and give them a sense of belonging to an academic community. Learning Together itself has been highly praised in official reports, and I saw some examples of offenders who have benefited greatly from its work. The education and rehabilitation of offenders are aims which I very strongly support, and they are aims which Jack Merritt and Saskia Jones also supported. We all as a society benefit from projects which further those aims. To the extent that I raise concerns about the management of programmes such as Learning Together, I do so with a view to ensuring that they are operated in a safe and intelligent manner in the future.

Legal Principles

35. Before addressing the particular topics relevant to this Report, I shall set out the applicable legal principles. In doing so, I shall largely adopt the submissions of Counsel to the Inquests, which have not been disputed by Interested Persons in their submissions. It is not normal practice for coroners to set out the law in PFD reports, but the wide public interest in this Report warrants including an explanation of the law for the benefit of the general reader.

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

> "(1) Where –
>
> (a) a senior coroner has been conducting an investigation under this Part into a person's death,
>
> (b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and
>
> (c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,
>
> the coroner must report the matter to a person who the coroner believes may have power to take such action."

37. Part 7 of the Regulations contains provisions for the making of PFD reports. Regulation 28 provides as follows:

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

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

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

38. The following principles govern the making of PFD reports:

a. The regime provides for a coroner to make a report if he or she forms the opinion that a risk of future deaths can be identified and that preventive action ought to be taken in all the circumstances. If he or she forms that opinion, it is necessary to make a report with the relevant content. That is the effect of the words "must report" in paragraph 7(1). See *R (Lewis) v Mid and North Shropshire Coroner* [2010] 1 WLR 1836 at [14]-[16] and [19].

b. The power and duty to make a report only arise where the coroner forms the opinion, based on the inquiry, that particular risks of death exist for which preventive action is required. As Silber J said in *R (Cairns) v HM Deputy Coroner for Inner West London* [2011] EWHC 2890 (Admin) at [74], the statutory expression "in the coroner's opinion, action should be taken…" reflects a discretionary judgment by the coroner.

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

d. A coroner may properly decide not to make a PFD report on an issue on the basis that he or she is not satisfied that further action is necessary. If, for example, it appears that a risk or issue has been addressed by action of some kind, or if

circumstances have changed substantially since the death in question, the coroner may reasonably say that he or she is not satisfied further action is required. Equally, a coroner may decide that there is simply insufficient material to form a view that there are particular risks of future deaths and/or that further action is required. See, for example, the approach taken by Hallett LJ to various issues in her Rule 43 Report after the London Bombings Inquests (e.g. [70] and [217]). See also *Jervis on Coroners (14th ed.)* at [13-125].

e. The purpose of death investigation in both domestic law and the law of the European Convention on Human Rights includes a concern to identify systemic failures and risks. See, for example *R (Amin) v SSHD* [2004] 1 AC 653 at [31]; *R (Sacker) v West Yorkshire Coroner* [2004] 1 WLR 796 at [11]. The domestic legal scheme deliberately confers on a professional adjudicator (the coroner) the judgment whether such risks exist and whether they need to be addressed by action: see *Lewis* (cited above) at [40]; *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182 at [38].

39. Chief Coroner's Guidance No. 5, updated in November 2020, also addresses PFD reports. As that document explains:

a. PFD reports are important, but they are ancillary to the inquest procedure and not its mainspring. See Guidance at [6] (and see, to the same effect, *Dove v HM Asst Coroner for Teesside* [2021] EWHC 2511 (Admin) at [73]).

b. "Broadly speaking reports should be intended to improve public health, welfare and safety. They should not be unduly general in their content; sweeping generalisations should be avoided. They should be clear, brief, focused, meaningful and, wherever possible, designed to have practical effect." See Guidance at [4].

c. If a report is made, it need not (and generally should not) prescribe particular action to be taken. It need not (and generally should not) apportion blame or be prejudicial (see, to the same effect, *Jervis* at [13-123]). The content of the report should be focussed and limited to the statutory remit. See Guidance at [27]-[30].

40. In summary:

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

b. The coroner must form this judgment based on information revealed by the particular coronial investigation.

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

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

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

41. Finally, it is important to note that PFD reports will often draw attention to matters of concern or to risks, rather than prescribing particular solutions. A coroner is often not qualified to propose specific action and may not be aware of all the consequences of taking such action. A coroner may be unaware of exactly what remedial action is practicable, or unaware of competing demands for resources. These considerations should not, of course, lead to paralysis in the preparation of PFD reports. A coroner may raise a concern and later be properly told that there is no perfect or practicable solution.

Topic 1: Rehabilitation and Education of Offenders and Ex-Offenders

42. It is appropriate to begin with this topic, since it was plainly a matter of interest and concern to Saskia Jones and Jack Merritt. They were two young people with strong values who were both committed to making a positive impact on their society and improving the lives of others. They both played a part in Learning Together, although it is fair to say that Jack was more deeply involved with that programme, while Saskia pursued other areas of concern to her (including in relation to victims of serious crime, in particular sexual violence).

Risk assessments and mitigating risk at events

43. An issue explored extensively in evidence was whether risk assessments should have been prepared for the Learning Together event at Fishmongers' Hall. The University of Cambridge had internal guidance (at university level) on risk assessments and risk management for travel, fieldwork and work away from Cambridge. As I understand it, that guidance would have extended to an event such as that on 29 November 2019 and would have required a formal risk assessment to be produced. However, it appeared from the evidence of the founding directors of Learning Together (Dr Amy Ludlow and Dr Ruth Armstrong) that this guidance had not been implemented at departmental level, such that it was not expected that risk assessments would be produced for such an event, or indeed for any of the prison-based courses or community events run by Learning Together.

44. The preparation of a risk assessment for a major event such as this, or indeed for courses run in environments such as prisons, is an inherently valuable exercise. It requires the organisers to apply a structured approach to considering risk and it may highlight risks which would otherwise be missed even by diligent and intelligent people.

45. It is evident that the University of Cambridge had and has a well-developed set of risk management procedures at university level, as one would expect of a university with the prestige and resources of Cambridge. However, it is a matter of significant concern that risk assessment procedures appear not to have been implemented at departmental level (the Institute of Criminology), especially in relation to courses in prisons and major set-piece events attended both by ex-offenders and by senior figures from the field of

criminal justice. Furthermore, the academics who appeared at the Inquests gave credible evidence that it is commonplace not to have structured risk assessments for academic events generally. I have no reason to believe that this was a problem limited to the University of Cambridge.

46. The witnesses from Learning Together expressed the view that, if a formal risk assessment had been undertaken for the event at Fishmongers' Hall, it would not have resulted in any different measures being taken. However, that evidence was necessarily speculative and may have been coloured by the events which followed. In my view, a proper risk assessment may well have caused some consideration to be given to discussing security measures with the Fishmongers' Company and specifically informing it of the background of some of those who would be attending (i.e. some current prisoners and former inmates convicted of very serious offences).

MC1 – Addressed to the University of Cambridge, Learning Together, the Secretary of State for Education and the Office for Students: Significant academic events and courses held outside of university premises should be subject to proper formal risk assessment, especially if they take place in environments with particular risk (such as prisons) and if they are attended by individuals who pose particular risks. It is a matter of concern that there was no such risk assessment for Learning Together events as set out above. The University of Cambridge and those responsible for guidance to UK higher education institutions should consider whether further steps can be taken to encourage the making of such risk assessments.

47. Another issue raised by the evidence in the Inquests concerned whether and how clearly the Fishmongers' Company was informed that current and recently released prisoners would be attending the event. There was evidence that representatives of the Fishmongers' Company had attended Learning Together events and had a good idea of what the initiative involved. It appears that the directors of Learning Together took the view that the Fishmongers' Company must have been aware that ex-offenders would or might be attending the event, and were not told of any concern. However, the Clerk of the Fishmongers' Company gave evidence that he would have been surprised to be told that some attending had been in prison for serious offences. All this evidence suggests to me that there were failures of communications between Learning Together and the

Fishmongers' Company. It is important that comparable failures of communication do not take place in future. Without knowing that current inmates and recently released serious offenders are to attend an event, those responsible for a venue cannot conduct their own risk assessment and, if appropriate, put risk mitigation measures in place.

48. It should be noted that, following an internal security review after the attack, a new procedure for categorisation of events was implemented by the Fishmongers' Company. Any event attended by high-risk individuals or convicted offenders would now be a category D event, for which there would be a rebuttable presumption that the event would not be permitted to take place at Fishmongers' Hall. It is of course a matter for any host organisation to adopt its own procedures, and I would not want to discourage the holding of events to which ex-offenders can be invited. However, this does show that safe procedures depend upon good communications about the nature of an event and the profile of attendees.

MC2 – Addressed to the University of Cambridge, Learning Together, the Secretary of State for Education and the Office for Students: It is a matter of concern that a major event could be held by a University at a livery company hall in London without clear communication of the fact that it would be attended by serving and recently released serious offenders. Consideration should be given to guidance requiring higher education institutions to inform host venues of high-risk features of events, including for instance the attendance of such persons.

Risk assessments and mitigating risk in relation to offenders

49. The concern expressed above relates to the risk of a violent or other criminal act occurring at an event. However, the evidence also indicated a more subtle and long-term type of risk which can arise when young undergraduate students are involved in a programme alongside those convicted of serious offences. As the head of counter-terrorism at HMP Whitemoor acknowledged, some such people can be manipulative and predatory.

50. The Learning Together programme started at HMP Grendon in 2015 and was soon afterwards rolled out to HMP Warren Hill. HMP Grendon is a category D prison with a therapeutic community and some democratic involvement by which the prisoners contribute to the running of the prison to an extent. HMP Warren Hill is a category C

prison. In late 2016 and early 2017, Learning Together began its work at HMP Whitemoor, a Category A high security prison in Cambridgeshire. The directors of Learning Together were aware that HMP Whitemoor housed many terrorism offenders and others serving long sentences for other very serious and violent crimes.

51. It was clear from the evidence that proper measures were put in place by HM Prison and Probation Service ("HMPPS") to keep the visiting students physically safe while they were inside HMP Whitemoor. However, there were other risks of having young people associating closely with these offenders, and it does not appear that those involved in Learning Together gave focussed consideration to those risks. Such risks became more acute in the context of the substantial alumni and community element of the Learning Together programme.

52. A potential measure which many witnesses were invited by counsel to consider during the Inquests would be a regime whereby offenders who have committed certain categories of offence (such as terrorism offences and/or certain other serious offences) might not be permitted to take part in Learning Together courses. However, I appreciate that there may be real value in keeping such courses open to a wide range of offenders. One possible approach suggested during the hearing was for such a regime of "category exclusions" to be put in place temporarily, pending further research or safeguarding measures being pursued.

MC3 – Addressed to Learning Together and the University of Cambridge: It is a matter of concern that focussed consideration was not given to the risks of serious offenders being placed in close and continuing contact with young students. Consideration should now be given to such risks and targeted means of mitigating them.

53. In order for Learning Together to operate safely in future and to make proper assessments of the risks posed by offenders, it is important that its staff should be able to access information about the risk profiles of offenders joining courses. The same point would apply to other comparable higher education providers working in prisons. This may be a difficult issue, as there are likely to be limits to the information which HMPPS could provide to an organisation such as Learning Together. However, it should be possible to supply some information about offending history and a basic risk profile. In this case, it

is troubling that those responsible for Learning Together had no knowledge that Usman Khan was regarded by the prison authorities as a dangerous, radicalising figure in the prison community.

MC4 – Addressed to the Secretary of State for Justice: It is a matter of concern that Learning Together could operate courses in prisons in the way it did without being given information about the risk profiles of offenders joining courses. Consideration should be given to whether further procedures can be put in place to ensure or at least encourage some such information to be shared with higher education providers working in prisons.

54. The concerns expressed above relate specifically to the process by which a prisoner might be accepted onto a programme run in a prison by a higher education provider such as Learning Together. However, the facts of this case gave rise to a distinct concern as to whether such programmes ought to maintain contact with serious offenders after their release into the community and, if so, subject to what safeguards. The prison authorities cannot, of course, manage the risks involved in these alumni or community programmes.

55. Such programmes should not be ruled out entirely, since re-integrating ex-offenders into the community is a laudable aim. However, it is important to recognise that not all ex-offenders are alike. Many prisoners on their release will be well rehabilitated and ready to contribute as productive members of society, whereas others will re-offend and may pose a serious threat to those placed in contact with them.

56. If providers of higher education are to have alumni or community programmes which maintain contact with offenders after their release from prison, such programmes should be the subject of careful risk management. This might in practice involve the organisation having procedures governing what types of offenders might be involved in such a programme; how contact might be maintained and supervised; and what types of events might be arranged. Learning Together did not have such procedures governing its alumni programme.

MC5 – Addressed to the Secretary of State for Justice, the Secretary of State for Education, the Office for Students, the University of Cambridge and Learning Together: Consideration should be given to whether further measures of risk

assessment and management can be introduced for any higher education programmes running in prisons which involve continued contact with offenders after their release into the community.

57. Some of the submissions made on behalf of the bereaved families have addressed the future of Learning Together itself as an educational initiative. It would not be appropriate in a report such as this to advocate the winding-up of an initiative for the education of offenders, especially one such as Learning Together which has evidently done a great deal of good.

58. The representatives of the families have submitted that the directors of Learning Together did not, in their evidence to the Inquests, show sufficient concern to learn from this experience and specifically to reconsider possible weaknesses in their procedures for assessing and managing risk. It is not the function of this report to comment on particular individuals, either by criticising or defending them. Nevertheless, I would encourage those with relevant responsibilities within the University of Cambridge and the Learning Together programme to reflect on the contents of this Report and more generally on the lessons they may be able to learn from this tragic case. Usman Khan was a very dangerous man, who was recognised as such by the prison and probation authorities and by the police. However, as the jury found, many of those who dealt with him were unaware of the risk he posed or even chose not to consider it, preferring to accept his self-presentation as a reformed individual.

Topic 2: National Probation Service (NPS) and MAPPA risk assessment and management

59. The matters of concern set out above, insofar as they are addressed to the Secretary of State for Justice, concern the management of risk by the prison service in the context of higher education programmes. This next section of this Report addresses matters which concern the work of the NPS.

Extremism Risk Guidelines

60. As already observed, Usman Khan was the subject of an ERG 22+ assessment while in prison in early 2018. That assessment was carried out by a forensic psychologist, as was the norm for such assessments in the prison environment, and it clearly demonstrated Usman Khan as presenting a very serious threat of extremist offending. The report from that assessment illustrates that the ERG 22+ tool can be a useful one in assessing the risk posed by extremist offenders. I am aware that ERG reports prepared in relation to Sudesh Amman, who committed the terror attack on Streatham Hill in February 2020, were similarly thorough and prescient.

61. After Usman Khan's release, his NPS offender manager was tasked with the preparation of a revised ERG assessment, with assistance from a specialist counter-terrorism probation officer ("CTPO"). At the time, it was standard practice for any such assessment of an offender in the community to be carried out by a probation officer with relevant training in the assessment tool. In this case, the assessment was carried out in mid- to late 2019 and a draft report, which was almost in final form, had been prepared just before the attack. It is striking that this assessment was much less detailed and analytical than that prepared by the forensic psychologist in early 2018 and that it presented a very optimistic picture of Usman Khan, suggesting that his risk be markedly down-graded.

62. It would be unfair to criticise the offender manager for the weaknesses apparent from that draft report. He was a conscientious probation officer, but had very little experience of dealing with terrorist offenders and did not have the professional background in psychological assessment which aspects of the assessment tool appear to require. The CTPO was similarly lacking in practical experience.

63. Some important observations were made by two of the witnesses:

a. First, Sonia Flynn, the Chief Probation Officer, accepted that it is beneficial for an ERG 22+ assessment to be prepared by a forensic psychologist, as opposed to a probation officer. Since the attack at Fishmongers' Hall, the NPS has introduced the support of psychologists in the community to assist in the preparation of such assessments, with the reports themselves being written by CTPOs. Furthermore, a rule has since been introduced that it should not be the probation officer who acts as a person's offender manager who completes the assessment.

b. Secondly, Ms Cechaviciute, the forensic psychologist who conducted the assessment of Usman Khan in 2018, gave evidence that in principle it would be helpful for a MAPPA panel to hear from a person in her position summarising findings from the assessment. Although professional guidelines for the completion of an ERG assessment specified that such an assessment could be completed by "a fully qualified professional who has experience of working in forensic settings for example, a registered forensic psychologist/clinical psychologist or an experienced probation officer", the evidence of Ms Cechaviciute was that in completing her assessment she relied upon training which probation officers do not receive.

MC6 – Addressed to the Secretary of State for Justice: Notwithstanding the measures which the NPS has put in place since the attack, there remains cause for concern that ERG 22+ assessment reports may be prepared by a CTPO without the direct involvement of a forensic psychologist. Consideration might usefully be given to (a) requiring that every such report be completed by a forensic psychologist or (b) requiring that every such report on an offender in the community is either prepared by, or subject to detailed critical review by, a forensic psychologist.

MC7 – Addressed to the Secretary of State for Justice: It is a matter for concern that MAPPA panels managing even the most serious offenders may not have the benefit of hearing directly from a forensic psychologist who has prepared an ERG report shortly prior to the offender's release. Consideration should be given to introducing procedures or guidance to require or encourage the attendance of such a psychologist at appropriate MAPPA panel meetings.

OASys assessments

64. OASys is a tool for structured risk assessment of offenders both in prison and in the community. It involves the completion of a lengthy report form by a probation officer based on evidence from a range of sources. The risk of serious harm posed by the offender to various categories of person (including the general public) is expressed in a series of risk gradings.

65. As noted above, before Usman Khan's release from prison, an OASys assessment was carried out in August 2018. The conclusion of this assessment was that Usman Khan posed a "very high" risk of serious harm to the general public. No updated OASys assessment was prepared in the year following his release. The evidence was that the responsible probation officers decided to have an ERG assessment performed first in order to inform the updated OASys assessment, and that (as noted above) the ERG assessment report was just being completed at the time of the attack.

66. On 15 May 2019, Usman Khan's offender manager, in discussions with his line manager, determined that the risk of serious harm rating for Usman Khan should be reduced to "high". This was recorded in very brief terms on the NPS Delius Notes system. The decision appears to have been reached in quite an informal manner and no detailed rationale was recorded anywhere.

67. An OASys assessment is a designed to allow the assessor to reach conclusions as to an individual's likelihood of re-offending, using a structured risk assessment tool. The risk rating arrived at by this assessment tool is used by the MAPPA agencies in formulating their risk management plan. The OASys risk rating for an offender should not be changed without an offender manager conducting a full re-assessment, using the structured form, so that any change is made in a careful and informed manner. Otherwise, there is a real chance that changes will take place without proper critical thinking. Although it appears that the MAPPA agencies in this case continued to proceed on the basis that Usman Khan's risk rating was "very high", the facts give rise to a concern that an OASys risk rating may be changed without proper use of the assessment tool.

68. The Secretary of State for Justice has stated in submissions that there is new Risk of Serious Harm Assessment Guidance (published in July 2020) which stresses the need for

clear and recorded decision-making. However, it is not clear to me that it would be impossible in future for an offender's risk rating to be changed in an informal manner as happened in this case.

MC8 – Addressed to the Secretary of State for Justice: The facts of this case give rise to concern that an OASys risk rating for an offender may be changed without the offender manager completing the full assessment exercise (using the structured form) and that the change may be recorded without proper rationale. Given the importance placed on the risk ratings in management of dangerous offenders, this requires specific consideration.

Management of offenders' licence conditions

69. Offenders such as Usman Khan are often subject to licence conditions which preclude them from doing certain things or going to certain places without approval of their NPS offender managers. The evidence in this case gave rise to concern that such approvals may be given without clearly reasoned decision-making and clear lines of accountability.

70. The most significant example in these Inquests concerned the approval of Usman Khan's attendance at the Learning Together event at Fishmongers' Hall on 29 November 2019. He was subject to licence conditions which precluded him from (a) attending a railway station or (b) attending a gathering without the prior approval of his offender manager. While the offender manager was responsible for granting such approvals, the evidence was that he would follow any instructions or guidance given by the MAPPA panel.

71. In this instance, the probation officer granted permission for Usman Khan to attend the event. However, there was no formal record of his decision or the reasoning behind it. While there were records of the event having been brought to the attention of the MAPPA panel in August 2019 and again in November 2019, there is no record of it having been the subject of detailed discussion and certainly no record of the attendees having considered the risks or benefits of him attending the event. By contrast, there are substantial records of their having considered the risks and benefits of other potential activities, such as Usman Khan participating in the dumper truck course. More worrying still, there were conflicts in the evidence as to whether or not the MAPPA panel had

endorsed the decision by the probation officer to grant permission for Usman Khan's attendance at the event.

72. This was a decision to permit a terrorist offender, who was still regarded as posing a high or very high risk of serious harm to the general public, to use the rail network unaccompanied and to attend a major event at an iconic location in central London. It was an important decision which should have been the subject of specific discussion at the MAPPA meetings, with proper consideration of the risks and potential benefits. The decision to grant permission should have been recorded with a full rationale (on the Delius system, in the MAPPA minutes or in both those records). It should have been clear from the records whether the decision had been taken by the probation officer alone or with express consideration and approval by the MAPPA panel.

73. The Chief Probation Officer said that she would have expected to see the licence condition permissions, including permission to attend the event, recorded on Delius or elsewhere. It was a significant step, and she expected probation officers to record their rationale in such cases. However, it would not be fair to lay the blame on the offender manager, when in fact there appears to have been a collective failure by the MAPPA participants to give any thought to the risks arising from the prospective visit to London. In this regard, it should be noted that the jury found "serious deficiencies in the management of Khan by MAPPA" and a "blind spot to Khan's unique risks".

74. If there had been a requirement for the decision permitting Usman Khan to attend the event in London to be properly recorded, then it would have been possible for the jury and me to see and consider a contemporaneous account of the reasoning behind that decision. More importantly, such a requirement would assist in ensuring that those responsible for such decisions apply their minds to the competing risks and advantages of granting approvals under licence conditions.

75. According to submissions made in advance of this Report being produced, the new Risk of Serious Harm Assessment Guidance encourages probation officers to record the rationale for key decisions, without making it mandatory. The submissions of the Secretaries of State also indicated that further guidance which was to be produced by the end of August 2021 would make recording of such key decisions mandatory.

76. NPS offender managers should not be subject to such onerous obligations of record-keeping that they are unable to perform their primary role of supervising offenders and helping to equip them for life in the community. However, where a decision is taken to grant an approval under a licence condition, the decision and the underlying reasoning should be recorded in the Delius system or an equivalent system, even if only briefly. If an offender is subject to MAPPA management, it should be clear from the record of the decision whether the offender manager has taken the decision with or without express approval from the MAPPA panel.

MC9 – Addressed to the Secretary of State for Justice: This case gives rise to concern that offender managers may take significant decisions to give approvals under licence conditions without those decisions being properly reasoned and recorded. Consideration should be given to ensuring, by means of NPS guidance, that offender managers always (a) record a rationale for giving any permission for approval, variation or relaxation in relation to licence conditions and (b) in the case of offenders subject to Level 2 or 3 MAPPA management, record whether or not the decision has been taken with express approval from the MAPPA panel.

77. As indicated above, there was conflicting evidence as to whether or not the key decision to permit Usman Khan to attend the event at Fishmongers' Hall was actually considered or approved by the MAPPA panel. Some participants in the meetings said that it had been specifically discussed, whereas others had no recollection of such specific discussion. The Chair of the MAPPA panel believed that there had been some discussion but could not recall the detail. He said that he would have expected any lengthy discussion to be minuted and he acknowledged that the minutes did not reflect detailed consideration of the decision.

78. It will not always be possible for an offender manager's decision to grant an approval in relation to a licence condition to be endorsed by the MAPPA panel. Sometimes, decisions will have to be taken without waiting for the next MAPPA panel meeting. However, there was no dispute that important decisions of this character should be placed before the MAPPA panel where that is possible. At minimum, there should be a requirement for MAPPA minutes to record any approval of a decision to grant an approval, variation or relaxation in relation to a licence condition (with brief reasons).

79. Such a requirement would also assist in achieving accountability for decisions. Either the offender manager would take a decision without reference to the MAPPA panel, in which case his or her decision and its reasons would appear in the Delius notes and he or she would bear sole responsibility for it; or the decision would be approved by the MAPPA panel, in which case the approval and its rationale would appear in the MAPPA minutes and all the MAPPA participants would bear responsibility.

MC10 – Addressed to the Secretary of State for Justice, the College of Policing, the Chief Constable of West Midlands Police and the Chief Constable of Staffordshire Police: The facts of this case give rise to concern that important decisions on approvals, variations and relaxations in relation to licence conditions may be taken without clearly reasoned discussion and decision-making in MAPPA panels. This issue could be addressed by requiring MAPPA minutes to record any discussion or decision on such a matter. In addition, for the benefit of future inquiries and reviews, consideration should be given to having digital audio recordings made of all MAPPA meetings.

80. This case also raised a more general issue concerning the approach of probation officers to granting permissions, variations and relaxations in relation to licence conditions. Usman Khan's probation officer saw Learning Together as having a very positive influence on him. He thought that it was an important aspect of rehabilitation and personal development, although he was unaware that Usman Khan was not doing any actual work with Learning Together and had only sporadic contact with the organisation.

81. Meanwhile, the probation officer and the MAPPA panel appear not to have considered the attendance at the London event from a risk perspective. Some participants sought to justify this approach by saying that Usman Khan could have travelled around the country without special permission and that it was impossible to risk-assess his every move. However, there is a reason why terrorist offenders are often subject to licence conditions requiring approval for them to use major public transport networks and/or to attend major events. These conditions exist to allow for proper risk management, and it is important that decisions in relation to them should be taken with some specific consideration of the risks entailed.

MC11 – Addressed to the Secretary of State for Justice: This case gives cause for concern that an offender manager and/or MAPPA panel participants could approve a permission, variation or relaxation in relation to a licence condition without directly addressing the potential risks involved. Consideration should be given to whether there can be further guidance to ensure that the risks as well as the potential benefits of such decisions are carefully examined.

Specific matters relating to the management of terrorist offenders in the community

82. In addition to the concerns raised above about the procedures followed by probation officers and in MAPPA meetings, it is appropriate to raise a specific issue about substantive decision-making. Ms Cechaviciute gave evidence that, when assessing the risk of an individual engaging in extremist activity, it is important to consider whether the person's self-presentation is deceptive. It is apparent from her own assessment report that rigorous assessment often involves considering the offender's accounts on subjects such as the conduct and events which led to arrest and his/her behaviour in prison, and comparing those accounts to objective evidence.

83. In the case of Usman Khan, there are numerous examples of him being dishonest to his probation officers, especially when speaking about his offending behaviour and his time in prison. For instance, when speaking about his offending, he claimed on many occasions to have been intending to set up a mosque or a genuine religious school, and on another occasion that he had only intended to have weapons there for self-defence. These statements were squarely at odds with the express basis of his guilty pleas. When speaking about his time in prison, he claimed to have stood up to and challenged extremists, when in fact he had remained a leading radicalising influence in the various prisons. The offender manager attached very little weight to these apparent instances of dishonesty, while the CTPO involved in the case suggested in his evidence that they were unimportant.

84. The facts of this case show the value of being alert to instances of significant dishonesty in self-presentation by terrorist offenders. I am aware that similar instances of dishonesty were seen in the case of the Streatham Hill attacker, Sudesh Amman.

MC12 – Addressed to the Secretary of State for Justice: The facts of this case give rise to concern that probation officers may give insufficient regard to instances of dishonesty in self-presentation by extremist offenders. Consideration should be given to having this aspect of assessment emphasised in training of offender managers.

85. A related concern is that too much weight may be placed by those managing an extremist offender on purely passive "compliance" (i.e. the person not actually breaching licence conditions or committing criminal offences). The risk posed by such offenders, as recognised explicitly by the prison authorities is that of "deceptive compliance".

86. The forensic psychologist who assessed Usman Khan differentiated between an absence of poor behaviour and evidence of positive behaviour. By contrast, those in the NPS responsible for managing Usman Khan and those in the PREVENT team placed much reliance on Usman Khan's self-presentation and his "compliance". This case provides a powerful example of an extremist offender remaining apparently compliant with licence conditions for a year before staging a murderous attack.

MC13 - Addressed to the Secretary of State for Justice: Based on the facts of this case, there is cause for concern that probation officers may attach excessive weight in their management of extremist offenders to "compliance" (i.e. absence of evidence of breach of licence conditions and polite behaviour). Consideration should be given to training and guidance warning offender managers about placing too much reliance on this feature.

87. As explained above, the particular decision under the spotlight in this case was that Usman Khan should be permitted to attend the event at Fishmongers' Hall alone and without any measures being taken to mitigate risk. The determinations made by the jury were critical of the procedures followed in making that decision.

88. When such a decision is to be taken whether or not to permit an extremist offender to attend an event or venue (whether for work, education or social purposes), full consideration should be given to the risks which might arise. In order to address those risks properly, probation officers and police officers involved should ordinarily obtain details of security measures in place at the venue.

89. It was submitted on behalf of the family of Saskia Jones that, when an extremist offender is permitted to attend a venue or event, those managing the offender ought to contact the hosts or organisers, so as to obtain information on security measures and, where appropriate, offer appropriate advice and guidance to strengthen those measures. The concern behind this submission is entirely reasonable, but it may be too prescriptive to require this to happen in all cases, given the wide range of situations which may arise in future. For instance, there may be cases where it would be detrimental to a covert investigation to require such communication to take place. However, it would be beneficial for the authorities to consider including in future training and guidance the point that communication about security measures with event organisers and venue hosts will often be advisable.

MC14 – Addressed to the Secretary of State for Justice, the College of Policing, the Chief Constable of West Midlands Police and the Chief Constable of Staffordshire Police: This case gives rise to concern that an extremist offender may be permitted to attend an event or venue without there having been proper communication between the probation and police officers responsible for managing the offender and the event organisers and/or venue hosts. Consideration should be given to encouraging such communications within the training and guidance given to probation officers and police responsible for managing extremist offenders.

Drug testing of offenders on licence

90. Toxicology analysis carried out on samples from the body of Usman Khan after his death demonstrated that he had used cocaine in the period relatively shortly before his death. Despite the strict licence conditions controlling him and despite the various means by which he could be monitored (including the GPS tag), he was able to obtain and use cocaine while living in Stafford without that being discovered. I am well aware how easy it can be to buy Class A drugs in many town and city centres. Nevertheless, it is a matter of concern that his use of Class A drugs could not be detected, since detection would have revealed that Usman Khan was not in fact compliant with his licence conditions and it would have provided a basis for recalling him to prison. The submissions of the Secretaries of State helpfully explain that work is being done to extend the use of random drug testing of offenders on licence while they are living in approved premises, and that steps are being taken to ensure that necessary statutory powers are available.

Consideration should also be given to whether anything can be done to facilitate such testing continuing for serious offenders after they have left approved premises (e.g. by developing licence conditions for the purpose).

MC15 – Addressed to the Secretary of State for Justice: The facts of this case give cause for concern that a terrorist offender on licence, who was subject both to strict licence conditions and to a priority investigation, could obtain and use Class A drugs without that being detected. Consideration should be given to whether further steps can be taken to facilitate random drug testing of offenders on licence (especially those who have committed serious offences), including both those living in approved premises and those living independently.

Topic 3: Desistance and Disengagement Programme

91. The DDP is a Home Office programme for the rehabilitation of individuals who have been involved in terrorism or terrorism-related activity. It also aims to reduce the risk they pose to national security. One aspect of this programme is the appointment of mentors for offenders on licence.

92. Usman Khan had a theological mentor and a practical mentor. With his practical mentor he was able to have supervised access to the internet, so that he could seek employment and rebuild his life in other ways. His allocation of a practical mentor ended abruptly, as the Secretaries of State acknowledge in their written submissions. The Secretaries of State also accept that such sudden ceasing of mentoring should be avoided if possible.

93. The sudden end to the mentoring arrangement had the effect that one of the few social connections Usman Khan had in late 2019 was broken and that it became much more difficult for him to search for work. Isolation and a failure to integrate in the community had previously been identified as particular risk factors which might lead him to re-engage in extremism. Although it is unclear whether the ending of the mentoring arrangement actually contributed to Usman Khan conceiving a desire to carry out an attack, it is obviously undesirable that such mentoring arrangements should be disrupted in this way.

94. Following the end of the mentor arrangement, there was confusion between the various state agencies over whether it was a priority for Khan to be allocated a new mentor. He was not allocated a new practical mentor before his death. The Secretaries of State acknowledge in their submissions that there was some miscommunication on this subject.

MC16 – Addressed to the Secretary of State for the Home Department: This case gives rise to concern that mentoring arrangements under the DDP could be disrupted suddenly in the case of a person whose risk of re-engaging in extremism was known to be related to social isolation. It also gives rise to concern that an offender could be suddenly deprived of the means to use the internet under supervision to search for work. Measures should be taken to prevent a recurrence of these circumstances.

Topic 4: Information Sharing between Agencies

95. A recurring theme in evidence in the Inquests, and a criticism identified by the jury determinations, concerned limitations in information-sharing between agencies responsible for managing and investigating Usman Khan. The concern arose in various contexts, including the sharing of information between overt and covert police teams; the sharing of information between the Security Service and the police; and the sharing of information between the police and NPS (in both directions). Relatedly, the evidence gave cause for concern regarding procedures for communicating and recording information and intelligence for MAPPA panel participants. This included issues about the content and dissemination of MAPPA meeting minutes.

Minutes of MAPPA meetings

96. In order that MAPPA panel meetings can be effective in managing the risks posed by offenders, it is important that all participants are appraised of relevant information and intelligence about the offender, subject to the point that some security intelligence information may not be capable of being shared with all those who may usefully participate in MAPPA meetings.

97. Although there was always detailed guidance requiring that all MAPPA panel participants should receive minutes of meetings and approve them at subsequent meetings, some participants did not in fact receive and read the minutes. It appears that some participants received minutes by secure emails and that others were expected to review minutes on the ViSOR system, but that some of the latter did not actually have access to that system.

98. A related problem was that the membership of the panel varied from meeting to meeting and some participants were not aware of the prison security intelligence information which featured in MAPPA F forms and/or minutes of earlier meetings. If Usman Khan had not committed the attack and been killed, he would have been under MAPPA supervision for a considerably longer time. There would have been further changes to the membership of the panel and further risks of loss of institutional memory.

99. The Secretaries of State point out in their submissions that current statutory MAPPA guidance provides that meeting minutes will normally be sent via secure email to those

who attended a meeting and to those who were invited but did not attend. In this respect, the current guidance seems to be very similar to that in place during 2019. Furthermore, the submissions do not make clear whether there is any means for ensuring that individuals joining an existing MAPPA panel should read in and bring themselves up to date on previous intelligence and the content of previous meetings.

100. Against that background, there remains cause for concern that the statutory guidance does not in practice ensure (a) that MAPPA meeting minutes are received and reviewed by all attendees and (b) that new members of MAPPA panels appraise themselves of the contents of previous minutes.

MC17 – Addressed to the Secretary of State for Justice, the College of Policing, the Chief Constable of West Midlands Police and the Chief Constable of Staffordshire Police: Based on the evidence in this case, there is cause for concern that effective procedures are not in place to ensure that all MAPPA meeting attendees receive meeting minutes. Consideration should be given to modifying guidance to ensure that this happens, for example by (a) providing for all MAPPA panel participants to receive minutes by secure email (rather than by having to access an online system); (b) requiring that all acknowledge safe receipt and indicate whether or not they wish to make amendments (to include provision of "nil returns"); and/or (c) requiring attendees at the start of each MAPPA meeting formally to confirm that they have read the minutes of the previous meeting or meetings as appropriate.

Information available to the MAPPA panel

101. So far as possible, those attending a MAPPA meeting should have updated information relevant to assessing the risks posed by the offender and taking decisions on managing that risk. In these Inquests, there were three particular sources of information which were not available to all MAPPA participants. First, the MAPPA F form from the prison authorities was a valuable source of information for early MAPPA meetings, but was not always available to or considered by those participating in later meetings. Secondly, not all participants were aware of the helpful conclusions of the ERG 22+ assessment report, including the list of risk factors with which it concluded. Thirdly, there was intelligence held by the Security Service and counter-terrorism police of which most participants were

ignorant (including intelligence which it seems could properly have been shared with them).

102. Ensuring that the contents of MAPPA F forms and the key conclusions of ERG assessment reports are known to all MAPPA participants should not present too great a challenge. It should be possible to circulate the most recent MAPPA F form with every subsequent set of MAPPA minutes, so that those managing an offender in the community always have access to the most recent intelligence provided by the prison authorities prior to the offender's release. As for ERG assessment reports, it would for instance be possible to add a short section to MAPPA minutes for a summary of relevant conclusions and risk factors from such reports to be set out.

103. The sharing of security intelligence information with MAPPA panels presents a greater challenge. There is a positive value in MAPPA panels being attended by some people who cannot be realistically expected to receive details of secret intelligence from a covert investigation. This includes not only the offender manager and police officers responsible for overt supervision of terrorism notification requirements but also authorities such as housing and education. Procedures therefore have to be devised for MAPPA panels, or at least some participants of such panels, to receive the information they need in a way which respects the integrity of covert investigations.

104. The approach currently taken is for counter-terrorism police to attend MAPPA meetings and to act as the conduit or "bridge" for provision of security intelligence, including from any covert investigation. A significant problem which arose in the present case was that the Senior Investigating Officer ("SIO") and Deputy SIO for the covert investigation into Usman Khan did not generally attend MAPPA meetings and were not aware what information was and was not being communicated to MAPPA participants. A senior counter-terrorist police officer from West Midlands Police did attend the MAPPA meetings and contributed to discussions, but she was not directly involved in the covert investigation into Usman Khan and so could not be expected to ensure that all relevant information was being taken into account.

105. A very unsatisfactory situation arose whereby there was a strand of intelligence received shortly prior to Usman Khan's release from prison that he intended to carry out an attack, but the MAPPA panel participants were in the main entirely ignorant of that intelligence.

A number of the witnesses acknowledged that this would have been valuable to the decision-making of the panel. The officer who was SIO of the covert investigation was under the impression that this intelligence had been communicated to the MAPPA panel, and it appears that the intelligence could have been communicated to them without compromising security interests. Every effort should be made to ensure that a situation of this kind does not occur again.

106. In my view, the best means of addressing this problem would be to require that, where an extremist offender under MAPPA management is the subject of a counter-terrorist policing investigation (with or without the involvement of the Security Service), either the SIO or the Deputy SIO should be nominated as the person responsible for ensuring that relevant information from the investigation is taken into account by the MAPPA panel. If the SIO or Deputy SIO does not actually attend MAPPA meetings, he or she should at least be provided with all minutes of MAPPA meetings, should be expected to read them and should be under an obligation to ensure that information and intelligence relevant to the management of the offender is taken into account by the MAPPA panel. Where the information or intelligence is secret, this may require the SIO or Deputy SIO to speak to a person attending the next MAPPA meeting who has the appropriate security clearance, so as to ensure that the information is taken into account even if it cannot be shared in full detail.

107. It should be stressed that the above concerns may persist even if the recommendations of the Independent Reviewer of Terrorism Legislation (discussed below) are implemented so that MAPPA decision-making in relation to terrorist offenders is concentrated in Core Groups of security-cleared professionals. If there is not an officer involved in the covert investigation with personal responsibility for ensuring that the MAPPA panel and/or the Core Group is properly informed, failures of information sharing may continue.

108. The representatives of the family of Saskia Jones have submitted that there should be general reviews to address (a) IT systems for sharing intelligence between police, probation and prison staff and (b) the imposition of the sterile corridor across which sensitive intelligence cannot pass. Those are large subjects which I am aware are under consideration by the authorities. In my view, the proper focus for a report of the present kind in this regard is to recommend that there should always be a single person who is responsible and accountable for ensuring that relevant secret intelligence is at least taken

into account by MAPPA panels. Making a single police officer from the covert investigation accountable in this way should help to address the problem of blurred lines of responsibility which was evident in this case.

MC18 - Addressed to the Secretary of State for Justice, the College of Policing, the Chief Constable of West Midlands Police and the Chief Constable of Staffordshire Police: The facts of this case give cause for concern that some members of MAPPA panels responsible for managing extremist offenders may not be aware of important information from the offender's time in prison. Consideration should be given to (a) ensuring that the latest MAPPA F form from the prison authorities should be circulated with every subsequent set of MAPPA minutes; (b) including a section in MAPPA minutes for key up-to-date intelligence; and (c) including a further section in MAPPA minutes for a summary of the key conclusions of the most recent ERG assessment (including risk factors identified).

MC19 – Addressed to the Secretary of State for Justice, the Secretary of State for the Home Department, the College of Policing, the Chief Constable of West Midlands Police and the Chief Constable of Staffordshire Police: This case gives cause for concern that counter-terrorism police may be in possession of intelligence or information which may be useful to the management of an offender by the MAPPA panel, but that such intelligence or information may not be brought to the knowledge of or taken into account by MAPPA agencies. This issue should be addressed, preferably by ensuring that a single police officer from any covert investigation (such as the SIO or Deputy SIO) is responsible and accountable for ensuring that intelligence and information is properly shared and taken into account. Consideration should also be given to how intelligence known only to the Security Service may be taken into account for the purposes of MAPPA management.

109. Building upon those two matters of concern, it is also important to ensure that, in the case of serious terrorist offenders, some individuals attend MAPPA panel meetings who have sufficient security clearance to be informed of secret intelligence.

110. In the case of a terrorist offender who is subject to MAPPA management and under active covert investigation, it is likely that the Security Service and/or counter-terrorism police

will have security sensitive information from a range of sources. These may include information from covert human intelligence sources ("CHIS"), intelligence gathered by other state (or foreign state) agencies and/or products of the monitoring and analysis of communications. These are simply generic examples, not necessarily of any relevance to this case.

111. MAPPA procedures work by bringing together a range of people who have different responsibilities but who collectively contribute to the management of the offender. As noted above, is inevitable that some attendees will not have high-level security vetting. It should also be accepted that not every participant around the table (even those with high-level clearance) will need to be aware of all intelligence relating to an offender.

112. As already observed, a significant problem in this case was that there was intelligence and information which would have been highly relevant to the management of Usman Khan by the MAPPA panel but of which most participants were ignorant. The Chair himself only had limited security clearance and was not even aware of the covert priority investigation being pursued by the Security Service and West Midlands Police.

113. In his review of MAPPA dated May 2020, the Independent Reviewer of Terrorism Legislation (Jonathan Hall QC), has made a recommendation that in such cases as this there should be a Core Group of security-cleared professionals within the MAPPA panel primarily and continuously responsible for decision-making while periodic wider meetings should provide oversight: see paragraphs 5.2 and 5.6-5.7 of his review report. The Secretaries of State in their submissions have indicated that this recommendation has been accepted and is being implemented. They make reference to the updated MAPPA Guidance at paragraph 24.31.

114. While acknowledging the rigorous analysis in Mr Hall's report, it is important that I too should put my concerns on record to assist those implementing the new Guidance. It is vital that decisions on the management of terrorist offenders should take account of relevant security intelligence information. This should in practice be by a combination of (a) a Core Group of MAPPA panel participants with security clearance being quite fully informed and (b) the broader membership of the panel being given as much relevant information (sometimes no doubt in sanitised form) as can sensibly be provided.

Wherever possible, the Chair of the MAPPA panel (or one Co-Chair) should be security cleared to a high level and should be a member of the Core Group.

MC20 - Addressed to the Secretary of State for Justice, the Secretary of State for the Home Department, the College of Policing, the Chief Constable of West Midlands Police and the Chief Constable of Staffordshire Police and the College of Policing: The facts of this case give cause for concern that security sensitive information may not be properly taken into account in decision-making by MAPPA panels concerning the management of terrorist offenders. Consideration should be given to how the new procedures can best be operated to avoid this problem recurring. This might include a requirement that, wherever possible, the MAPPA Panel Chair (or one Co-Chair) should be a member of the Core Group. It might also include a requirement for the Core Group to consider what intelligence can be supplied (perhaps in sanitised form) to the broader panel.

Topic 5: Management and monitoring of terrorist offenders by the Police and the Security Service

Co-ordination of MAPPA management with overt police management of offenders

115. As the facts of this case showed, police officers responsible for supervising statutory terrorism notification requirements in practice provide a more extensive service of overt management of an offender in the community, with the police officers concerned having regular contact with the offender. This is in principle a very good idea. ACC Ward of West Midlands Police gave evidence as to how this police discipline has been developed and professionalised over the last two years.

116. In the case of Usman Khan, the officers managing him were from the Staffordshire Police PREVENT team. They had experience of dealing with extremists in their work for the PREVENT initiative, but they had no specific training in the work of managing serious terrorist offenders in the community. The changes made since November 2019 mean that this work of offender management is now done by a dedicated and trained team within West Midlands Police Counter-Terrorism Unit.

117. A specific issue which arose in the case of Usman Khan concerned the decreasing regularity of contact with members of the PREVENT team. In the later months of 2019, visits from members of that team became sporadic. This was around the same time as Usman Khan moved out of the probation hostel and his mentoring arrangements ceased. It contributed to a pattern of increasing social isolation and decreasing levels of contact between Usman Khan and figures from the authorities responsible for him. The MAPPA panel participants were unaware of the reduced regularity of visits from the PREVENT team to see Usman Khan.

118. In a letter responding to submissions from the bereaved families, ACC Ward of West Midlands Police argues that it would be wrong for MAPPA panels to be required to approve all changes to the quality, frequency and purpose of police visits. One reason is that MAPPA panels do not meet regularly enough to approve all changes. West Midlands Police agree that the frequency and reporting from such police visits should be discussed in MAPPA meetings and that police officers responsible for managing extremist offenders should take account of the views of the MAPPA panel.

119. For the reasons given by ACC Ward, it would not be workable or desirable for police officers responsible for management of an offender to obtain MAPPA panel approval to all decisions on the regularity and type of contact with the offender. Such decisions should be left to the good judgment of those responsible, who will in future form part of a more professional service governed by national standards. However, it is right that MAPPA panels should be kept informed of the regularity and type of such police contact with the offender, as well as significant reporting from the visits.

MC21 - Addressed to the Secretary of State for Justice, the Secretary of State for the Home Department, the College of Policing, the Chief Constable of West Midlands Police and the Chief Constable of Staffordshire Police: The facts of this case give cause for concern that MAPPA panels responsible for managing terrorist offenders may be unaware of the regularity and form of contact with police officers responsible for overt offender management. Consideration should be given to providing guidance that officers with such responsibilities should report to MAPPA panels on the regularity of their meetings with offenders and take account of any recommendations by MAPPA panels.

Searching of offenders on licence

120. One of the issues raised in this case was as follows: in deciding whether or not to permit Usman Khan to attend the event at Fishmongers' Hall in November 2019, would one option have been to permit him to attend but put in place some measures to mitigate the risk he posed? The measures suggested included (a) having him accompanied by a police officer; (b) contacting the Fishmongers' Company to ensure that proper security measures were in place; and/or (c) having him met while on route (for instance at Euston Station) and having him searched for any items of concern.

121. In reality, nobody appears to have considered whether such measures were practicable or desirable, since nobody appears to have assessed Usman Khan's attendance at the event with a focus upon the risks to which it might give rise. So, while some officers gave views on whether risk mitigation measures were practical or desirable, these were inevitably the product of hindsight. The representatives of West Midlands Police argued that an officer would not have had the legal power to search Usman Khan at Euston Station simply because he refused to open his coat or bag. Others, including

representatives of the bereaved families, contended that an officer could have justified a search on the basis of reasonable suspicion of possession of a prohibited article (under section 1 of the Police and Criminal Evidence Act 1984) if Usman Khan had refused to reveal the contents of a reasonably substantial cross-body bag which he did not obviously need for the Learning Together event. A senior counter-terrorism officer from the MPS who gave evidence expressed the view that a search could lawfully have been carried out in these circumstances.

122. Whether or not the representatives of the West Midlands Police are correct in their arguments as to the power to carry out a search in these circumstances, it appears that there is significant uncertainty or disagreement between well-informed police officers as to the extent of their powers in this situation. The simplest means of resolving this difficulty would be for a specific licence condition to be implemented requiring a terrorist offender on licence to submit to a search by a police officer without the officer needing to establish reasonable suspicion or other specific legal grounds for the search. Such a requirement would be no more intrusive on personal autonomy than many of the licence conditions to which such offenders are routinely subject, such as GPS tagging, hostel residence and curfew requirements and signing-in obligations.

MC22 - Addressed to the Secretary of State for Justice and the Secretary of State for the Home Department: The facts of this case gave cause for concern that those involved in managing terrorist offenders on licence may lack a valuable means of addressing risks they pose, namely an ability to carry out a search on a precautionary basis. Consideration should be given to the introduction of a licence condition which could be imposed on terrorist offenders requiring them to submit to a search by a police officer without the officer establishing specific legal grounds for the search.

Liaison between the Police and the Security Service

123. The representatives of the family of Saskia Jones have submitted that concerns should be raised about the arrangements for scheduling Joint Operational Team ("JOT") meetings between the Security Service and counter-terrorism police teams working together on a priority operation. They suggest that there was an undue delay in arranging for one such meeting to take place. In my judgment, no such concern is justified. The evidence did

not raise any real cause for concern that JOT meetings could not be arranged reasonably promptly.

124. The representatives of the Jones family have also submitted that concerns should be raised about the procedures for responding to a request from the police that a Security Service Behavioural Science Unit ("BSU") assessment should be carried out in relation to a subject of interest. In my judgment, no such concern should be raised. On the facts of this case, there was good reason why a BSU assessment was not arranged, in that Usman Khan did not meet the criteria for an assessment. There was no evidence to suggest that there was any difficulty about arranging such assessments where they were justified.

Other topics : (1) The Prison Service – Policies for De-radicalisation

125. The submissions filed by the Jones family suggest that I recommend a broad review of policies for de-radicalisation measures within the prison estate, including policies for dispersal of terrorist offenders. In responsive submissions on behalf of the Secretaries of State, it is said that such a recommendation would give rise to very wide-ranging issues of policy and resourcing going well beyond the proper scope of a PFD report.

126. It can readily be understood why the Jones family make their submission. Usman Khan entered prison at a young age with an established extremist ideology. Over the following years, he was placed in environments where he was regularly in contact with other serious terrorist offenders. Although he was moved between prisons many times and repeatedly placed in small, controlled units, he became a prominent figure in Islamist extremist gangs. It is deeply troubling that such an offender can be turned into an extremist gang-leader rather than isolated from radicalising influences.

127. Nevertheless, and after careful consideration, I accept the submission of the Secretaries of State that this is not an appropriate subject for this Report. The topic of policies for de-radicalisation and dispersal of offenders in the prison estate gives rise to major issues of practicality and resources (e.g. the number and distribution of high-security facilities) as well as questions of principle (e.g. how often offenders should be moved, and how far from their home areas). The evidence in these Inquests does not provide a proper foundation for me to identify specific matters of concern in a targeted and practical manner.

(2) Emergency Service Response to Major Incidents

128. The representatives of the Jones family raise two matters relating to the emergency response to the attack which they submit merit inclusion in this Report. The first concerns systems for communications between emergency workers on the scene of a major incident. The second relates to the modified clinical triage system used by the London Ambulance Service ("LAS") in place at a major incident.

129. In their responses to those submissions, the LAS and the police forces involved in the emergency response point out that the emergency response was organised in an efficient manner. By the time that Fishmongers' Hall and the area immediately around it were

safe for specialist paramedic staff to enter, the appropriate unit was sent forward. Those inside the Hall received care as promptly as was possible in the circumstances. The evidence about the triage system operated does not suggest that it was managed in a way which gives rise to any risk of future deaths.

130. In my judgment, those submissions by the LAS and the police forces are well-founded. The procedures for organising the emergency response to an active marauding terrorist attack are important and they raise challenging issues. They are addressed in detail in my PFD Report concerning the London Bridge and Borough Market Terror Attack. Unlike in that case, I do not consider that the evidence about the emergency response in this case gives concern of a risk of future deaths.

(3) The Fishmongers' Company

131. In their submissions, the representatives of the Jones family suggest that this Report should raise some criticism of the Fishmongers' Company and in particular the Company's approach to addressing risks identified by a Risk Register which it commissioned. In my judgment, it would not be appropriate to raise any concern in relation to the Fishmongers' Company in this Report. It is right that the procedures of the Company for assessing events and putting in place special security measures as they stood in November 2019 left something to be desired. However, the Inquests heard evidence that the Company takes a serious approach to security risks and that substantial efforts have been made by the Company to improve its procedures since the attack took place. The revised procedures as now in place were not seriously criticised during the evidence.

Action Should be Taken

132. In my opinion, action should be taken to prevent future deaths. I believe that the various addressees of this Report have the power to take the action relevant to them (as set out above).

Your Response

133. Each addressee is under a duty to respond to this Report within 56 days of the date of this Report, namely by 29th December 2021. Allowing for the Christmas and New Year break, this date will be extended to 7th January 2022. As the coroner responsible for the Inquests, I may extend that period upon application.

134. Each response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, it must explain why no action is proposed.

Copies and Publication

135. I have sent copies of my Report to the following:

    a. all Interested Persons in the Inquests (identified in the attached list); and

    b. the Chief Coroner of England and Wales.

136. I am also under a duty to send a copy of any responses to the Chief Coroner. Addressees and others may make representations to me about the wider release or publication of any responses.

HH Judge Lucraft QC

Recorder of London
(Sitting as a Nominated Judge)
3 November 2021

Annexes

(1) Determinations sheets for the inquests of the victims of the attack.
(2) Determinations sheet for the inquest of the attacker.
(3) List of Interested Persons in the Inquests.

ANNEX 1

DETERMINATIONS SHEETS FOR THE INQUESTS OF THE VICTIMS OF THE ATTACK

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

QUESTIONNAIRE FOR JURY DETERMINATIONS
IN THE INQUEST CONCERNING THE DEATH OF
SASKIA JONES

Notes for the jury

- This questionnaire has been prepared by the Coroner after receiving submissions from Interested Persons. By answering the questions, you will give your determinations on the key factual issues in the case. All are intended to address the central question: by what means and in what circumstances did Jack Merritt and Saskia Jones come by their deaths?

- After the inquests, a completed copy of this questionnaire will form part of the Record of Inquest for each of Jack Merritt and Saskia Jones.

- For a number of the questions, you are asked for a "yes" or "no" answer, and you are then given the option to explain further in a box. You are not obliged to fill in the box. Considerations and issues are then listed which you may want to consider, although you should feel free to give your own answers (provided that you follow the legal directions in these Notes and the Coroner's summing-up).

- For some of the questions, you are first asked whether there was some error, omission or circumstance that (probably) caused or contributed to the two deaths. If you have answered "no" to that, you are then asked whether the same thing may have caused or contributed to the two deaths. If answering the second part of such a question, you will need to consider whether there is a realistic possibility that an error, omission or circumstance as described caused or contributed to the two deaths.

- You may only say that something contributed to the two deaths if you consider that it made a more than minimal contribution.

- You should only give an answer to a question if all of you agree upon the answer. If you find yourselves unable to agree on an answer to one question, you may move on to the next and return to the question later. If a time comes when the Coroner can accept any answer on which you are not all agreed, you will be told.

- In resolving factual issues, you should give your answers in accordance with the "balance of probabilities"; what is more likely than not. (However please note that if you are deciding whether something may have caused or contributed to the deaths, you should consider whether there is a realistic possibility that it did so (see note above).)

- If you choose to give further explanation in any of the boxes where you are given the option to do so, please follow these directions when writing your responses:

    a. Your responses should all be directed to answering the question by what means and in what circumstances the deaths occurred. You should not make any statement or comment which does not assist in answering that question.

    b. It might help you at each stage to consider the cause(s) of the deaths; any defects in systems and practices which contributed to the deaths; and any other factors which are relevant to the circumstances of the deaths.

    c. You should try to be brief and to the point.

    d. If you wish to write more than the space in the box permits, you may continue on a separate sheet. At the top of the sheet, you should write the number of the question and the words "Answer Continued".

    e. You should not make any comment on any circumstance, act, omission or event unless there is at least a realistic possibility that it caused or contributed to the deaths.

    f. You should not say anything to the effect that a breach of civil law has been committed or that any named person has committed a crime. Because of this legal rule, when writing any explanations, you should avoid using words and phrases such as "negligence / negligent", "breach of duty", "duty of care", "careless", "reckless", "liability", "guilt / guilty", "crime / criminal", "illegal / unlawful". This rule does not prevent you confirming in question 1 that those who died were unlawfully killed: the proposed form of words in that question avoids naming the person responsible.

    g. 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", "missed opportunity", "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.

h. If you are uncertain about what may be written, you may ask a question in writing to the Coroner during your deliberations.

Question 1: Determination on Unlawful Killing of Saskia Jones

Question	Answer
Are you satisfied that, on the balance of probabilities, Saskia Jones was unlawfully killed?	**Yes**

Important Note:

The Coroner directs that you return an answer of "yes" in response to this question in the answer section, to reflect the primary conclusion that both Saskia Jones and Jack Merritt were unlawfully killed.

This direction is given because the evidence clearly supports that primary conclusion and because it is important that the Records of Inquest record that each of them was unlawfully killed.

Question 2: Basic facts of the attack and the death of Saskia Jones

Do you agree with the following statement which is intended to summarise the basic facts of the death of Saskia Jones?

"On 29 November 2019, Saskia Jones was at an event at Fishmongers' Hall in London. The event was held for the five-year anniversary of Learning Together. Saskia had been invited to attend, having previously volunteered for Learning Together whilst she was studying at Cambridge University.

An attendee of the event, who was on licence having been convicted of an offence under the Terrorism Act 2000, armed with two knives, attacked Saskia near to the cloakroom at Fishmongers' Hall. Saskia suffered a single stab wound to her neck, and she collapsed near to the place where she was attacked. This was part of a terrorist attack. The attacker moved from that area and began attacking further attendees of the event and a member of staff at Fishmongers' Hall (when that member of staff tried to intervene). Saskia's injury was not survivable. Saskia was treated by attendees of the event, police officers and ambulance staff. She was assessed as dead at the scene by a paramedic and a doctor."

In the box below, please either write that you confirm the statement above or state in what respects you would like it to be amended.

We agree

Question 3: Management of Usman Khan in the Community

Was there any omission or failure in the management of Usman Khan (as an offender in the community) by agencies of the state which contributed to the deaths of Jack Merritt and Saskia Jones? Answer "yes" or "no" in the box opposite.	Yes
If your answer to the question above is "no", was there any omission or failure in the management of Usman Khan (as an offender in the community) by agencies of the state which may have contributed to the deaths of Jack Merritt and Saskia Jones? Answer "yes" or "no" in the box opposite.	

If you can give an explanation for your answer, please do so in the box below.

- Unacceptable management and lack of accountability.
- Serious deficiencies in the management of Khan by MAPPA.
- Insufficient experience and training.
- Blind spot to Khan's unique risks due to 'poster boy' image.
- Lack of psychological assessment post release from prison.

Please go to the next page for matters which you may wish to bear in mind when answering.

In answering Question 3, you may wish to bear in mind the following considerations and issues:

- The fact that, throughout the time from his release from prison (December 2018) to the time of the attack, Usman Khan was managed by the National Probation Service.

- The fact that, throughout that time, Usman Khan was subject to Multi-Agency Public Protection Arrangements ("MAPPA") which involved meetings attended by the

National Probation Service, counter-terrorist police, police officers responsible for supervising his Part 4 terrorism notifications and other agencies.

- The facts that Usman Khan (a) had committed a serious terrorist offence in 2010; (b) had been the subject of substantial prison intelligence to the effect that he was involved in radicalising others and violence (including when he was apparently engaging positively with staff, and including in the period before release); and (c) had been released from prison as a Category A High Risk offender, with an OASys rating of Very High Risk to the general public (informed by an ERG assessment expressing significant concerns).

- The fact that Usman Khan had complied with his licence conditions and had apparently engaged positively with those responsible for managing him in the community during 2019.

- The facts that, by November 2019, Usman Khan (a) was living away from the probation hostel; (b) remained unemployed; (c) no longer had visits from mentors; (d) had reportedly become increasingly socially isolated; and (e) had not been doing any actual educational work with Learning Together.

- Whether or not some of those responsible for the assessment and management of Usman Khan in the community were properly trained and experienced and had proper access to information (including intelligence).

- Whether or not there were deficiencies in the management of Usman Khan in the MAPPA process, having regard to (a) the Chair's level of clearance; (b) arrangements for discussions between the Chair and others on sensitive matters; (c) procedures for decision-making; and (d) procedures for circulation of minutes.

- Whether or not those responsible for the management of Usman Khan in the community took a proper approach to the assessment of the continuing risk he posed, having regard to the available risk assessment tools.

- Whether or not the decision to permit Usman Khan to attend the Learning Together event at Fishmongers' Hall on 29 November 2019 was properly considered and was a reasonable professional decision when it was made (ignoring hindsight).

- Whether or not consideration should have been given to any further measures being taken if Usman Khan was to be permitted to attend the Learning Together event at Fishmongers' Hall on 29 November 2019 (e.g. arranging an escort, having him met en route or ensuring that security measures were taken at the venue) (again, ignoring hindsight).

Question 4: Sharing of Information and Guidance regarding Usman Khan

Was there any omission or failure in the sharing of information and guidance by agencies responsible for monitoring / investigation of Usman Khan which contributed to the deaths of Jack Merritt and Saskia Jones? Answer "yes" or "no" in the box opposite.	Yes
If your answer to the question above is "no", was there any omission or failure in the sharing of information and guidance by agencies responsible for monitoring / investigation of Usman Khan which may have contributed to the deaths of Jack Merritt and Saskia Jones? Answer "yes" or "no" in the box opposite.	

If you can give an explanation for your answer, please do so in the box below.

- Missed opportunity for those with expertise and experience to give guidance.

Please go to the next page for matters which you may wish to bear in mind when answering.

In answering Question 4, you may wish to bear in mind the following considerations and issues:

- The fact that, throughout the time from his release from prison (December 2018) to the time of the attack, Usman Khan was subject to a priority investigation by the Security Service and West Midlands Police CTU (supported by Staffordshire Police Special Branch).

- The facts that Usman Khan (a) had committed a serious terrorist offence in 2010; (b) had been the subject of substantial prison intelligence to the effect that he was involved in radicalising others and violence (including when he was apparently engaging positively with staff, and including in the period before release); (c) had been the subject of intelligence in late 2018 that he had said that he intended to return to his old ways (terrorist offending) and that he intended to commit an attack after release; and (d) had been released from prison as a Category A High Risk offender, with an OASys rating of Very High Risk to the general public (informed by an ERG assessment expressing significant concerns).

- The facts that Usman Khan had complied with his licence conditions and had apparently engaged positively with those responsible for managing him in the community during 2019.

- The fact that investigation of Usman Khan during 2019 gave rise to no intelligence indicating activity of national security concern.

- The facts that, by November 2019, Usman Khan (a) was living away from the probation hostel; (b) remained unemployed; (c) no longer had visits from mentors; (d) had reportedly become increasingly socially isolated; and (e) had not been doing any actual educational work with Learning Together.

- Whether or not those responsible for the monitoring / investigation of Usman Khan shared information (including intelligence) and guidance properly with other agencies.

- Whether or not those responsible for the monitoring / investigation of Usman Khan should have raised any concerns or given any advice about him being permitted to attend the Learning Together event on 29 November 2019 (ignoring hindsight).

- Whether or not those responsible for the monitoring / investigation of Usman Khan should have given any advice proposing any further measures being taken if Usman Khan was to be permitted to attend the Learning Together event on 29 November 2019 (e.g. arranging an escort, having him met en route or ensuring security measures were taken at the venue) (again, ignoring hindsight).

Question 5: Organisation of and Security Measures for the Event at Fishmongers' Hall

Was there any omission or any deficiency in the organisation of and security measures for the event at Fishmongers' Hall which contributed to the deaths of Jack Merritt and Saskia Jones? Answer "yes" or "no" in the box opposite.	Yes
If your answer to the question above is "no", was there any omission or any deficiency in the organisation of and security measures for the event at Fishmongers' Hall which may have contributed to the deaths of Jack Merritt and Saskia Jones? Answer "yes" or "no" in the box opposite.	

If you can give an explanation for your answer, please do so in the box below.

- Lack of communication and accountability.
- Inadequate consideration of key guidance between parties.
- Serious deficiencies in the management of Khan by MAPPA.
- Failure to complete event specific risk assessment by any party.

Please go to the next page for matters which you may wish to bear in mind when answering.

In answering Question 5, you may wish to bear in mind the following considerations and issues:

- The fact that Fishmongers' Hall had a number of security measures for the event, including (a) a door requiring opening from inside (with key fob operation); (b) security staff on the door at most times; (c) limitation of entry to invited guests (who were provided on arrival with identity lanyards) and (d) CCTV at the entrance.

- The fact that Fishmongers' Hall did not own or have in place any metal detector or employ any arrangements for bags to be searched on entry.

- The fact that staff of the Fishmongers' Company (a) were aware that all attendees had been invited by the Learning Together programme, but (b) some were also aware that attendees might include ex-offenders who had committed serious criminal offences.

- The fact that the Fishmongers' Company had had a risk register since April 2019 which identified the risk of a lone actor terrorist attack as an important risk to be addressed.

- The facts that (a) Learning Together organised the event, (b) Learning Together staff at the event were employed by the University of Cambridge and (c) Learning Together were aware that Usman Khan was a terrorist offender who had been released as a Category A High Risk prisoner in late 2018.

- Whether or not those involved in organising the Learning Together event properly informed themselves of and assessed the risks of the event and made appropriate arrangements based on any risks (e.g. requesting security measures).

- Whether or not those involved in organising the Learning Together event properly informed the Fishmongers' Company of the persons or types of persons attending the event, having regard to the information they had at the time (including concerning the approval of Usman Khan's attendance at the event by his probation officer).

- Whether or not those responsible for managing and/or for investigating Usman Khan ought to have given any advice on security measures to the Learning Together organisers and/or the Fishmongers' Company.

- Whether or not the Fishmongers' Company ought to have implemented any additional security measures, based on the information it had at the time.

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

QUESTIONNAIRE FOR JURY DETERMINATIONS
IN THE INQUEST CONCERNING THE DEATH OF
JACK MERRITT

Notes for the jury

- This questionnaire has been prepared by the Coroner after receiving submissions from Interested Persons. By answering the questions, you will give your determinations on the key factual issues in the case. All are intended to address the central question: by what means and in what circumstances did Jack Merritt and Saskia Jones come by their deaths?

- After the inquests, a completed copy of this questionnaire will form part of the Record of Inquest for each of Jack Merritt and Saskia Jones.

- For a number of the questions, you are asked for a "yes" or "no" answer, and you are then given the option to explain further in a box. You are not obliged to fill in the box. Considerations and issues are then listed which you may want to consider, although you should feel free to give your own answers (provided that you follow the legal directions in these Notes and the Coroner's summing-up).

- For some of the questions, you are first asked whether there was some error, omission or circumstance that (probably) caused or contributed to the two deaths. If you have answered "no" to that, you are then asked whether the same thing may have caused or contributed to the two deaths. If answering the second part of such a question, you will need to consider whether there is a realistic possibility that an error, omission or circumstance as described caused or contributed to the two deaths.

- You may only say that something contributed to the two deaths if you consider that it made a more than minimal contribution.

- You should only give an answer to a question if all of you agree upon the answer. If you find yourselves unable to agree on an answer to one question, you may move on to the next and return to the question later. If a time comes when the Coroner can accept any answer on which you are not all agreed, you will be told.

- In resolving factual issues, you should give your answers in accordance with the "balance of probabilities"; what is more likely than not. (However please note that if you are deciding whether something may have caused or contributed to the deaths, you should consider whether there is a realistic possibility that it did so (see note above).)

- If you choose to give further explanation in any of the boxes where you are given the option to do so, please follow these directions when writing your responses:

    i. Your responses should all be directed to answering the question by what means and in what circumstances the deaths occurred. You should not make any statement or comment which does not assist in answering that question.

    j. It might help you at each stage to consider the cause(s) of the deaths; any defects in systems and practices which contributed to the deaths; and any other factors which are relevant to the circumstances of the deaths.

    k. You should try to be brief and to the point.

    l. If you wish to write more than the space in the box permits, you may continue on a separate sheet. At the top of the sheet, you should write the number of the question and the words "Answer Continued".

    m. You should not make any comment on any circumstance, act, omission or event unless there is at least a realistic possibility that it caused or contributed to the deaths.

    n. You should not say anything to the effect that a breach of civil law has been committed or that any named person has committed a crime. Because of this legal rule, when writing any explanations, you should avoid using words and phrases such as "negligence / negligent", "breach of duty", "duty of care", "careless", "reckless", "liability", "guilt / guilty", "crime / criminal", "illegal / unlawful". This rule does not prevent you confirming in question 1 that those who died were unlawfully killed: the proposed form of words in that question avoids naming the person responsible.

    o. 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", "missed opportunity", "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.

p. If you are uncertain about what may be written, you may ask a question in writing to the Coroner during your deliberations.

Question 1: Determination on Unlawful Killing of Jack Merritt

Question	**Answer**
Are you satisfied that, on the balance of probabilities, Jack Merritt was unlawfully killed?	**Yes**

Important Note:

The Coroner directs that you return an answer of "yes" in response to this question in the answer section, to reflect the primary conclusion that both Saskia Jones and Jack Merritt were unlawfully killed.

This direction is given because the evidence clearly supports that primary conclusion and because it is important that the Records of Inquest record that each of them was unlawfully killed.

Question 2: Basic facts of the attack and the death of Jack Merritt

Do you agree with the following statement, which is intended to summarise the basic facts of the death of Jack Merritt?

"On 29 November 2019, Jack Merritt was at an event at Fishmongers' Hall in London. The event was held for the five-year anniversary of Learning Together. Jack was at the event as an employee of Cambridge University, and worked for Learning Together.

An attendee of the event, who was on licence having been convicted of an offence under the Terrorism Act 2000, armed with two knives, attacked Jack in the gentlemen's toilets at Fishmongers' Hall. Jack suffered a number of injuries when stabbed. This was part of a terrorist attack. The attacker moved from the toilets and began attacking further attendees of the event and a member of staff at Fishmongers' Hall. Jack moved to a different room at Fishmongers' Hall and was later removed from the building. His injuries were not survivable. Jack was treated by members of the public, police officers, ambulance staff and HEMS doctors. He was assessed as dead at the scene by a doctor."

In the box below, please either write that you confirm the statement above or state in what respects you would like it to be amended.

We agree

Question 3: Management of Usman Khan in the Community

Was there any omission or failure in the management of Usman Khan (as an offender in the community) by agencies of the state which contributed to the deaths of Jack Merritt and Saskia Jones? Answer "yes" or "no" in the box opposite.	Yes
If your answer to the question above is "no", was there any omission or failure in the management of Usman Khan (as an offender in the community) by agencies of the state which may have contributed to the deaths of Jack Merritt and Saskia Jones? Answer "yes" or "no" in the box opposite.	

If you can give an explanation for your answer, please do so in the box below.

- Unacceptable management and lack of accountability.
- Serious deficiencies in the management of Khan by MAPPA.
- Insufficient experience and training.
- Blind spot to Khan's unique risks due to 'poster boy' image.
- Lack of psychological assessment post release from prison.

Please go to the next page for matters which you may wish to bear in mind when answering.

In answering Question 3, you may wish to bear in mind the following considerations and issues:

- The fact that, throughout the time from his release from prison (December 2018) to the time of the attack, Usman Khan was managed by the National Probation Service.

- The fact that, throughout that time, Usman Khan was subject to Multi-Agency Public Protection Arrangements ("MAPPA") which involved meetings attended by the

National Probation Service, counter-terrorist police, police officers responsible for supervising his Part 4 terrorism notifications and other agencies.

- The facts that Usman Khan (a) had committed a serious terrorist offence in 2010; (b) had been the subject of substantial prison intelligence to the effect that he was involved in radicalising others and violence (including when he was apparently engaging positively with staff, and including in the period before release); and (c) had been released from prison as a Category A High Risk offender, with an OASys rating of Very High Risk to the general public (informed by an ERG assessment expressing significant concerns).

- The fact that Usman Khan had complied with his licence conditions and had apparently engaged positively with those responsible for managing him in the community during 2019.

- The facts that, by November 2019, Usman Khan (a) was living away from the probation hostel; (b) remained unemployed; (c) no longer had visits from mentors; (d) had reportedly become increasingly socially isolated; and (e) had not been doing any actual educational work with Learning Together.

- Whether or not some of those responsible for the assessment and management of Usman Khan in the community were properly trained and experienced and had proper access to information (including intelligence).

- Whether or not there were deficiencies in the management of Usman Khan in the MAPPA process, having regard to (a) the Chair's level of clearance; (b) arrangements for discussions between the Chair and others on sensitive matters; (c) procedures for decision-making; and (d) procedures for circulation of minutes.

- Whether or not those responsible for the management of Usman Khan in the community took a proper approach to the assessment of the continuing risk he posed, having regard to the available risk assessment tools.

- Whether or not the decision to permit Usman Khan to attend the Learning Together event at Fishmongers' Hall on 29 November 2019 was properly considered and was a reasonable professional decision when it was made (ignoring hindsight).

- Whether or not consideration should have been given to any further measures being taken if Usman Khan was to be permitted to attend the Learning Together event at Fishmongers' Hall on 29 November 2019 (e.g. arranging an escort, having him met en route or ensuring that security measures were taken at the venue) (again, ignoring hindsight).

Question 4: Sharing of Information and Guidance regarding Usman Khan

Was there any omission or failure in the sharing of information and guidance by agencies responsible for monitoring / investigation of Usman Khan which contributed to the deaths of Jack Merritt and Saskia Jones? Answer "yes" or "no" in the box opposite.	Yes
If your answer to the question above is "no", was there any omission or failure in the sharing of information and guidance by agencies responsible for monitoring / investigation of Usman Khan which may have contributed to the deaths of Jack Merritt and Saskia Jones? Answer "yes" or "no" in the box opposite.	

If you can give an explanation for your answer, please do so in the box below.

- Missed opportunity for those with expertise and experience to give guidance.

Please go to the next page for matters which you may wish to bear in mind when answering.

In answering Question 4, you may wish to bear in mind the following considerations and issues:

- The fact that, throughout the time from his release from prison (December 2018) to the time of the attack, Usman Khan was subject to a priority investigation by the Security Service and West Midlands Police CTU (supported by Staffordshire Police Special Branch).

- The facts that Usman Khan (a) had committed a serious terrorist offence in 2010; (b) had been the subject of substantial prison intelligence to the effect that he was involved in radicalising others and violence (including when he was apparently engaging positively with staff, and including in the period before release); (c) had been the subject of intelligence in late 2018 that he had said that he intended to return to his old ways (terrorist offending) and that he intended to commit an attack after release; and (d) had been released from prison as a Category A High Risk offender, with an OASys rating of Very High Risk to the general public (informed by an ERG assessment expressing significant concerns).

- The facts that Usman Khan had complied with his licence conditions and had apparently engaged positively with those responsible for managing him in the community during 2019.

- The fact that investigation of Usman Khan during 2019 gave rise to no intelligence indicating activity of national security concern.

- The facts that, by November 2019, Usman Khan (a) was living away from the probation hostel; (b) remained unemployed; (c) no longer had visits from mentors; (d) had reportedly become increasingly socially isolated; and (e) had not been doing any actual educational work with Learning Together.

- Whether or not those responsible for the monitoring / investigation of Usman Khan shared information (including intelligence) and guidance properly with other agencies.

- Whether or not those responsible for the monitoring / investigation of Usman Khan should have raised any concerns or given any advice about him being permitted to attend the Learning Together event on 29 November 2019 (ignoring hindsight).

- Whether or not those responsible for the monitoring / investigation of Usman Khan should have given any advice proposing any further measures being taken if Usman Khan was to be permitted to attend the Learning Together event on 29 November 2019 (e.g. arranging an escort, having him met en route or ensuring security measures were taken at the venue) (again, ignoring hindsight).

Question 5: Organisation of and Security Measures for the Event at Fishmongers' Hall

Was there any omission or any deficiency in the organisation of and security measures for the event at Fishmongers' Hall which contributed to the deaths of Jack Merritt and Saskia Jones? Answer "yes" or "no" in the box opposite.	Yes
If your answer to the question above is "no", was there any omission or any deficiency in the organisation of and security measures for the event at Fishmongers' Hall which may have contributed to the deaths of Jack Merritt and Saskia Jones? Answer "yes" or "no" in the box opposite.	

If you can give an explanation for your answer, please do so in the box below.

- Lack of communication and accountability.
- Inadequate consideration of key guidance between parties.
- Serious deficiencies in the management of Khan by MAPPA.
- Failure to complete event specific risk assessment by any party.

Please go to the next page for matters which you may wish to bear in mind when answering.

In answering Question 5, you may wish to bear in mind the following considerations and issues:

- The fact that Fishmongers' Hall had a number of security measures for the event, including (a) a door requiring opening from inside (with key fob operation); (b) security staff on the door at most times; (c) limitation of entry to invited guests (who were provided on arrival with identity lanyards) and (d) CCTV at the entrance.

- The fact that Fishmongers' Hall did not own or have in place any metal detector or employ any arrangements for bags to be searched on entry.

- The fact that staff of the Fishmongers' Company (a) were aware that all attendees had been invited by the Learning Together programme, but (b) some were also aware that attendees might include ex-offenders who had committed serious criminal offences.

- The fact that the Fishmongers' Company had had a risk register since April 2019 which identified the risk of a lone actor terrorist attack as an important risk to be addressed.

- The facts that (a) Learning Together organised the event, (b) Learning Together staff at the event were employed by the University of Cambridge and (c) Learning Together were aware that Usman Khan was a terrorist offender who had been released as a Category A High Risk prisoner in late 2018.

- Whether or not those involved in organising the Learning Together event properly informed themselves of and assessed the risks of the event and made appropriate arrangements based on any risks (e.g. requesting security measures).

- Whether or not those involved in organising the Learning Together event properly informed the Fishmongers' Company of the persons or types of persons attending the event, having regard to the information they had at the time (including concerning the approval of Usman Khan's attendance at the event by his probation officer).

- Whether or not those responsible for managing and/or for investigating Usman Khan ought to have given any advice on security measures to the Learning Together organisers and/or the Fishmongers' Company.

- Whether or not the Fishmongers' Company ought to have implemented any additional security measures, based on the information it had at the time.

ANNEX 2

DETERMINATION SHEET FOR THE INQUEST OF THE ATTACKER

Determination Sheet

This is to set out the conclusions of the Jury as to by what means and in what circumstances Usman Khan came by his death.

Short-form Conclusion: Lawful Killing

Supplementary Narrative:

On November 29th 2019 Usman Khan carried out a planned attack on multiple people in Fishmongers' Hall armed with two knives and a very realistic looking IED around his waist. The police were called at 13:58:58 and Khan left the hall pursued by attendees. He was tackled to the ground on London Bridge.

At 14:01:59 the first armed police vehicle arrived on scene carrying three armed officers. They tried to gain control of the situation. They told the public to move away and for Khan to stay still. Khan did not comply and kept on moving. Police officer YX16 used his taser because Khan wasn't complying. Police officer YX99 heard Khan say he had a bomb and YX99 felt and saw what he perceived as a viable IED on Khan. He fired 2 shots into Khan to incapacitate him and reduce the risk to the public still in the area.

The police then moved slightly further away to try to gain ballistic cover while clearing the bridge of the public.

Further armed police arrived and sought cover as best they could whilst keeping line of sight on Khan. They positioned themselves behind police vehicles, on the other side of the bridge behind the vehicle barriers and on the steps of Fishmongers' Hall.

Between 14:03 and 14:10:27 Khan continued to move while police continued to clear the surrounding area and shouted at Khan to stay still. The police believed Khan was trying to find a trigger. At 14:10:27 Khan sat up which was interpreted by the police as a move to detonate the device.

As a result of this, officers decided to take multiple critical shots to neutralise this risk. These critical shots were supported by senior officers in the command centre. From 14:12:06 there was no discernible movement from Khan. He was declared dead at 15:07.

ANNEX 3

LIST OF INTERESTED PERSONS IN THE INQUESTS

Families
Family of Saskia Jones
Family of Jack Merritt
Family of Usman Khan
Organisations/Others
Barts Health NHS Trust
Chief Constable of British Transport Police
City of London Corporation
Commissioner of the City of London Police
Director General of the Independent Office of Police Conduct
Fishmongers' Company
London Ambulance Service
Commissioner for the Police of the Metropolis (Metropolitan Police Service)
Secretary of State for the Home Department
Secretary of State for Justice
Chief Constable of Staffordshire Police
Four officers of Staffordshire Police Prevent Team
University of Cambridge
Chief Constable of West Midlands Police