BEFORE HHJ LUCRAFT QC (RECORDER OF LONDON)

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

SUBMISSIONS ON BEHALF OF THE FAMILY OF JACK MERRITT:
PREVENTION OF FUTURE DEATHS

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1. Jack's family consider that the inquest evidence revealed a number of concerns giving rise to a risk of future deaths. That was reflected in the jury's narrative findings. Some of these concerns appear to have been addressed, or are currently in the process of being addressed, through the corrective measures identified during the inquest evidence. For that reason, the focus of these submissions is on two areas where necessary remedial action does not appear to have been taken:

    a. First, in respect of the future shape of Learning Together activities and related safeguards; and

    b. Second, in respect of the approach to joint working and information sharing by MI5.

Learning Together

2. As they indicated in their submissions on conclusions, Jack's family consider that there should be a prevention of future deaths ("PFD") report directed to the University of Cambridge concerning the future shape of Learning Together activities and related safeguards. Jack's family has always maintained its support of Learning Together. Jack was deeply committed to it and would have wanted it to continue. The inquests have, however, revealed matters which give rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future.

3. Action should be taken to prevent that occurrence or continuation of such circumstances. Specifically, there should be a close analysis and review of Learning Together by the University

of Cambridge. Such an analysis might well raise complex questions. The issues which concern Jack's family touch on matters of activity design and evaluation, research methodology, and potentially difficult questions about how to protect the achievements of Learning Together whilst also safeguarding it. Jack's family advances no particular solution to most of these questions. They do not feel qualified to do so. Their concern is that the necessary conversation takes place, and is intensive. Jack's family has been surprised by the lack of evidence, from the University, that any such thinking has or is taking place. It stands in contrast to the position taken by other interested persons in the inquest, who have made significant concessions and shown a proper willingness to learn (the evidence of Sonia Flynn on behalf of the National Probation Service being the obvious example). The impression from Learning Together and the University is that both are committed to keeping Learning Together in the same form as it was at the time of Saskia's and Jack's deaths. Jack's family is concerned that if Learning Together does not learn and change, there will be moves to abolish it. That is not what Jack would have wanted.

4. The lack of evidence about learning is all the more surprising given the evidence that these matters were not thought about at the time. The evidence is that Learning Together was rolled out from HMP Grendon to HMP Whitemoor without, it seems, any relevant analysis about the new and substantial risks that were being run. There had certainly been no published evaluation at that stage (the relevant Prison Service Journal article post-dates it by nearly four years). The evidence of any other evaluation is thin.

5. For Jack's family, the circumstances creating an ongoing risk are as follows:

    a. The lack of control on those being admitted to Learning Together activities. There appears to be no interest in category exclusions, whether by conviction type, security category, or proximity to release. Dr Ludlow was clear in her evidence that Learning Together remains committed to case by case risk assessment (transcript/22 April/bottom of p.176; also p.207 and 23 April/p.3 (top)). She was also clear that that risk assessment is for prison staff colleagues.

    b. There are a number of potential issues with that. First, prison staff were only risk assessing Khan sitting in a classroom in HMP Whitemoor in circumstances where it was clear –

being part of the Learning Together mission statement – that the activities would continue outside (as to whether that is sensible, see further below).

c. Second, and in any event, responsibility for risk assessment must always be shared. Of course, that responsibility must lie first with security staff (especially given that they will have access to intelligence) but Learning Together also have a role to play. Jack's family draws particular attention to the inadequacy of the policies, and the student compact, in providing any safeguards. Yet Gina Butler's evidence was that these were part of the security arrangements (WS5053/§13). Are these documents still being used?

d. Third, individualised risk assessment inherently carries risks that something will be missed. Key information may not be shared. It may therefore be that, at least in the high security context, a category exclusion should be introduced.

e. The obvious exclusion would be around terrorism. An adjusted version of that might be terrorism plus an assessed high or very high risk of serious harm (whether via OASys or the ERG; the structured risk assessments have been shown to be critical). Jack's family would also draw attention to the particular risks associated with activities like Learning Together and someone who is assessed still to have extremist ideology. That is because:

   i. Such ideology is particularly difficult to change.
   ii. Research methodology of the kind used by Learning Together may inadvertently amplify or validate such ideology, or other distorted thinking. Jack's family has in mind the way in which Khan's distorted thinking, and false narratives, were left unchallenged, as well as the "poster boy" risk. Khan was celebrated rather than being challenged. That was the opposite of what the forensic psychologists were trying to achieve. There needs to be a conversation about that.
   iii. There also needs to be a conversation about whether the Learning Together methodology is too easy to "game". Jack's family has in mind the research interview with Khan (DC6690) where he was asked a series of questions about how his relationships with staff had improved. It was all too obvious what the interviewers were seeking, and so easy for Khan to provide it, again unchallenged. That was presumably then relied on as part of the evidence that Learning Together was succeeding.

iv. Learning Together events may represent a particularly attractive target for terrorist offenders.

v. Terrorist offenders may be particularly likely to be deceptive.

f. Again, these may be difficult issues. Jack's family is just concerned that proper thought be given. As well as the point already made about the way Learning Together was rolled out from HMP Grendon with limited if any evaluation, they note also Richard Vince's evidence that because Learning Together was classed as an external workshop (see WS5067/§82 but also accepted in his oral evidence) it was not the subject of Correctional Services Advice and Accreditation Panel checking (which is used for offending behaviour courses). Nor did it come under Ofsted. This is all, of course, in the context of one of the highest security prisons in Europe where, it may be thought, everything should be carefully evaluated.

g. Jack's family would also suggest that thought be given to restrictions around certain types of prison behaviour (in particular radicalising and/or grooming of other prisoners) and access to Learning Together. That is because of the particular risks associated with Learning Together accelerating the already plausible and articulate radicaliser. Such behaviour might be a clear counter indicator to access to Learning Together.

h. The evidence also shows real issues with contact outside prison. Jack's family notes that this appears to be contrary to the approach taken by the original provider of shared learning activities, Inside Out[1], which operates from HMP Frankland amongst other places (but Frankland is of obvious interest because like Whitemoor it is also part of the high security estate). There has been no proper explanation for how Learning Together came to take such a different approach, beyond a suggestion that "beyond the gate" working is "utterly vital to desistance"[2]. This seems to raise at least two real risks:

i. That Learning Together promises what it cannot deliver. No particular qualification is provided; there is no defined learning outcome or endpoint. Rather, there is a hope that the original "transformative" experience is somehow extended and maintained, apparently indefinitely. That raises the very real risk (particularly with terrorist

[1] See Dr Ludlow's evidence, 22 April, p.202.
[2] Dr Ludlow, 22 April, p.203.

offenders) that hopes are raised and then dashed (by offering nothing, Learning Together somehow offers everything). None of this seems to have been thought about. Learning Together assumed they could stay in contact with former students the way they did with university students. The two cohorts are obviously very different.

ii. There are also the day to day problems with policing contact and maintaining proper boundaries. Lisa Ghiggini had no understanding or experience of where to draw social or other lines with Khan. Simon Larmour did not understand that he was suddenly part of Khan's licence supervision arrangements, on public transport, and what to do or how to report should things go wrong. The evidence contained in the Learning Together emails reveals the kinds of subtle problems that can emerge: what to do when a Facebook friend request arrives, or someone turns up at a place of work. All those with experience in this area know that these relationships are very hard to police, with difficult tensions between a desire to help and a need to safeguard. Jenny Fogarty said that when she was a course convener for Learning Together in a partnership between London South Bank University and HMP Pentonville, and later HMP Brixton, she kept all of her students at arms length, would not agree to meet them informally or help them organise themselves or sort out travel arrangements, and had never met any of her prison based Learning Together students at all after their release. Inside Out seems to have decided that post-release contact cannot reliably be done. Hence their "no contact" rule. There is force in that. There needs to be a serious conversation about all this.

6. Again, these issues may not be straightforward. They require thought. However it seems to Jack's family that not only was that thought not given, or fully given, when Learning Together was rolled out to HMP Whitemoor, or at any time prior to November 2019, but it is not clear that it has been given since.

7. Jack's family would also add this. None of the above applies to other rehabilitative or educational activities in prisons or the community. None of those have given rise to risks of the kind seen here. Nor, the family understands, has Inside Out suffered anything like what was seen here (despite having been in operation for 20 years). There seems instead to have been something particularly risky about the combination of the Learning Together "transformative" experience, which quickly won over the likes of William Styles as well as

Steve Machin on the wing; the reach of the organisation and the correspondingly high profile of its events; and terrorism. Guards were dropped; the clear message from the risk assessment tools were ignored. The early impressions of Learning Together were seductive. The problem is that some seductions, thankfully very rarely, are abusive.

MI5

8. Jack's family consider that the inquest revealed an overarching concern that MI5 did not approach its involvement with MAPPA in an appropriate way. In short, the evidence revealed inadequacies in MI5's approach to joint working and information sharing with other agencies; MI5's focus was on gathering information from other agencies, rather than assisting the risk management process in which those agencies were engaged. In what was, explicitly, a multi-agency forum focused on protecting the public from a high-risk individual, MI5's approach was to:

   a. Listen but not contribute; described as MI5 being in "receiving mode" by Witness A in her evidence[3];

   b. Rarely to offer any substantive input – including their informed judgments and assessments on Khan's mindset, apparent compliance and risk – in order to assist the overall risk management of Khan. The only occasion on which such input was given was in relation to the proposed construction/dumper truck course in July and August 2019, and, significantly, that input resulted in MAPPA adopting the course sought by MI5 and, in effect, reversing the position that would otherwise have been taken; and

   c. Not to take the necessary steps to ensure that the content and validity/reliability of relevant intelligence on Khan was shared with those making decisions on how to manage Khan's risk.

9. These concerns were reflected in the jury's narrative findings. In Question 4 of the jury questionnaire, the jury answered "yes" to the question, "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?" MI5 were

[3] Witness A, 13 May, p.27 line 15.

the lead agency responsible for the monitoring and investigation of Khan. The omission or failure identified by the jury was therefore an omission or failure by MI5.

10. The jury went on to add that there was a "Missed opportunity for those with expertise and experience to give guidance." Given the evidence heard at the inquests, and the bullet points included in respect of Question 4, the jury indicated through that finding that there was a missed opportunity by MI5 to give guidance to MAPPA. In effect, the failing by MI5 was in its approach to joint working; it failed to share relevant information.

11. In answering as they did, the jury found that this failing by MI5 probably contributed to Saskia's and Jack's deaths. The significance of that finding for the purposes of a possible PFD report will be readily apparent to the learned Coroner; it means that the jury considered that a failing by MI5 gave rise to a risk of death in Saskia and Jack's cases, and, on the evidence, materially contributed to their deaths.

12. The Court of Appeal decision in *R (Lewis) v HM Coroner for the Mid and North Division of Shropshire* [2010] 1 WLR 1836 makes clear that a jury's factual findings may be a relevant foundation for a PFD report: see §27. The Chief Coroner's Guidance on conclusions[4] makes the same point (§50), as does the Chief Coroner's guidance on PFD reports[5] (§44). As the learned Coroner will know well, it is not necessary for a particular concern to have been causally relevant in the inquest in question for it to be the subject of a PFD report: see the facts of *Lewis*, the Chief Coroner's guidance on PFD reports (§19), the Rule 43 Report of Hallett LJ following the London Bombings Inquests[6] (§161), and the learned Coroner's own PFD report in the London Bridge and Borough Market Attack Inquests (§§22(c) and 24(c)). But where a matter of concern has been identified as causally relevant to the deaths that is likely to make careful consideration of a PFD report particularly important. That is the case here.

13. Jack's family consider that the concern over MI5's conduct identified in the evidence, and reflected in the jury's findings, is ongoing and has not been remedied: the one paragraph on learning points identified internally by MI5 in Witness A's statement (WS5052/§146) does not address this concern; and Witness A's oral evidence similarly did not suggest that remedial

[4] Guidance No.17, "Conclusions: Short-Form and Narrative".
[5] Revised Guidance No.5, "Reports to Prevent Future Deaths".
[6] Cited at §22(c) of the learned Coroner's PFD report in the London Bridge and Borough Market Attack Inquests, dated 1 November 2019 (https://londonbridgeinquests.independent.gov.uk/wp-content/uploads/2019/11/Final-Report-on-Action-to-Prevent-Future-Deaths-Report.pdf).

action on this issue has been taken. In these circumstances, a PFD report raising this concern is appropriate and should be made.

14. The family note that this approach – with the Coroner raising concerns and drawing attention to risks where they have been revealed by the evidence, rather than prescribing particular solutions – is the approach that the learned Coroner adopted in his PFD report in the London Bridge and Borough Market Attack Inquests (§25), including in respect of MI5 (for example, see §§53-54, 59, 63). As the Coroner said in that report, *"it would … be wrong for me not to register in this Report features of the evidence in these Inquests which suggest possible areas for improvement."* (§54). Jack's family agree. That approach is particularly appropriate in respect of MI5 because, as the learned Coroner rightly identified in his previous PFD report, there is a known risk of future deaths from terrorist attacks, including Islamic State-inspired attacks carried out using low sophistication methodologies (§§49-50).

15. Jack's family consider that the evidence in these inquests does suggest a possible area for improvement by MI5 in respect of its approach to joint working and information sharing with other agencies. That is for the reasons set out above.

16. That in itself is sufficient to engage the Coroner's PFD duty. But that duty is fortified further here because of a pre-existing concern that MI5's approach to joint working and information sharing, outside the MAPPA context, has involved deficiencies. That concern has been raised by:

    a. Parliament's Intelligence and Security Committee ("ISC"). The ISC report into the 7 July 2005 attacks[7] indicated that more needed to be done to improve the way that MI5 and Special Branches (then responsible for CT policing) come together in a combined and coherent way to tackle the 'home-grown' threat (§§131-138). The ISC's report on the intelligence relating to the murder of Fusilier Lee Rigby[8], on 22 May 2013, identified a concern over insufficient coordination between MI5 and police investigations in the context of possible disruptive measures (§§129-140 and §M at p.51) and a lack of MI5 co-ordination with the police when determining whether to refer an individual to Prevent

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/224690/isc_terrorist_attacks_7july_report.pdf

[8] https://isc.independent.gov.uk/wp-content/uploads/2021/01/20141125_ISC_Woolwich_Reportwebsite.pdf

(§§212-213). In its report on the 2017 terror attacks – "The 2017 Attacks: What needs to change?"[9] – the ISC stressed that more work could be done in promoting communication and co-ordination between the MI5 and CTP teams working on an investigation and expressed concern that *"previously identified problems around information sharing have still not been addressed"* (pp.53-58, §§129-139). In the executive summary of its 2017 report, the ISC said (pp.2-4, emphasis added):

> Previous ISC Reports – including the Woolwich Report and the original 7/7 Report – have raised concerns as to how well MI5 and CTP work together. Last year's attacks revealed that there were still problems around the sharing of MI5 information with CTP, and the involvement of CTP in MI5 decision making. We recognise that improvements have been made, but this is an area that requires continuous improvement: we would highlight the need to address cultural differences and incompatible IT systems in particular.
> …
> As can be seen from the points we have highlighted here, it has been striking how some of the issues which arose in relation to the 7/7 attacks and the killing of Fusilier Lee Rigby have also been seen as having been a factor in the 2017 attacks. We have previously made recommendations in these areas, yet they do not appear to have been acted on. This has been recognised by those we have spoken to during the course of this review.

This reflects the findings made at §§U and W (pp.57-58) of the report (emphasis added):

> U. The Committee has raised concerns about the need for improved joint working between MI5 and CTP for over ten years. Improvements have been made but we note that this is an area that requires continuous improvement.
> …
> W. The Committee welcomes the number of initiatives focused on improving the flow of information between MI5 and CTP; however, it is important that this results in real, practical change. The Committee expects a report on how this is working and what tangible benefits have been seen in six months' time.

b. Lord Anderson, in his assessment of the MI5 and police's internal reviews following the 2017 attacks[10], described *"a new commitment by MI5 to allow knowledge derived from intelligence to be shared more widely beyond intelligence circles. This should enable, for example, neighbourhood policing and other agencies to make judgements with a better knowledge of the national security risk, and to implement appropriate local action."* (§3.41). Lord Anderson identified the importance of that

[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/776162/HC1694_The2017Attacks_WhatNeedsToChange.pdf

[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664682/Attacks_in_London_and_Manchester_Open_Report.pdf

commitment, observing that it marked a *"significant cultural change"* (§5.4(a)). However, importantly, he also noted that the lasting impact of that commitment, and others, would depend on effective implementation (§5.4). Jack's family are concerned that MI5's commitment was not reflected in MI5's conduct in this case; it appears that the significant cultural change and effective implementation that Lord Anderson spoke of have not yet occurred. Further action is now required. As Lord Anderson said at the end of his assessment, in this area, *"even marginal improvements are capable of paying dividends"* (§5.28).

c. The learned Coroner in his PFD report in the London Bridge and Borough Market Attack Inquests, while generally impressed with the level of co-operation between MI5 and CTP, considered that it was *"evident that there is room for improvement in this regard. On a number of occasions during his evidence, Witness M [the CTP witness] accepted that he had been unaware of information which was in the hands of MI5."* (§73). The learned Coroner noted that the review following the 2017 terror attacks highlighted the need for closer co-working in some respects.

17. The evidence in these inquests, and the jury's findings, indicate that this long-standing concern over MI5's approach to joint working and information sharing remains live. There remains room for improvement, particularly in the MAPPA environment, which has not been the subject of previous reports and inquests and in which MI5 will be increasingly involved given the growing number of TACT offenders being released into the community in years to come. The risks will increase as those numbers grow. The importance of MI5 getting their approach right, informed by independent learning from these inquests, is vital. This issue should therefore be raised with MI5 now.

18. Doing so will, to use the words of the learned Coroner's previous PFD report, *"encourage continued efforts to develop and improve co-working arrangements"* (§74). That is what Jack's family seek. It is a goal that they hope MI5, as a self-professed learning organisation, will embrace.

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