BEFORE HIS HONOUR JUDGE MARK LUCRAFT QC

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

**WRITTEN SUBMISSIONS OF
THE FAMILY OF MISS SASKIA JONES
ON MATTERS FOR REGULATION 28 REPORT
ON ACTION TO PREVENT FUTURE DEATHS**

References to the transcripts of evidence are in the form [T/DAY/PAGE/(LINE-LINES)]

1. The family of Saskia Jones supply these representations pursuant to the direction made by the Coroner at the conclusion of the jury inquest into the deaths of Saskia Jones and Jack Merritt. The purpose of these submissions is to identify for the Coroner's consideration matters that it is suggested ought to be reported to interested persons and bodies in order that appropriate action be taken to prevent other deaths in future, i.e. to inform the content of the Regulation 28 report ("the Report")[1].

2. These submissions shall focus upon (i) the matters of concern that arise from the evidence heard and received in the course of this inquest[2]; and (ii) upon which action, within the power of the various organisations, should be taken to prevent future deaths.

3. The jury has returned critical conclusions concerning matters that caused or contributed to Saskia's death. The conclusions were rendered in broad terms and leave to the Coroner the detail that may be identified as proper content for the Report. It is no longer disputed by any public authority that this inquest is intended to discharge the state's Article 2 ECHR obligations of investigation of the discharge of the positive duties owed by the public authorities. (We have provided previously our submissions as to why both systemic and operational failings are evidenced in this case[3], but given that issue is merely contextual to the present concern we do not repeat them here). We note and adopt the evidence of

[1] The report issued pursuant to the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and *The Coroners (Investigations) Regulations 2013*, regulations 28.
[2] It has been noted that "Giving rise to a concern is a relatively low threshold": Chief Coroner's Guidance No. 5 (4 November 2020) at §11(2).
[3] Written submissions on behalf of the family of Saskia Jones dated 24 May 2021, paras. 4-7 in particular.

concerning matters included within paragraphs 17 to 64 and 74 of the written submissions of CTI dated 21 May 2021.

4. At this stage we recognise and agree that the focus of concern shifts to encompass not only the contributory issues, but also the relevant further matters that were not found by the jury to be causative (or potentially causative) of the death in question[4]. The Chief Coroner's Guidance No. 5 on "Reports to Prevent Future Deaths" (revised on 4 November 2020) ("the Guidance") also observes that:
    i. "A report does not have to relate to a death in similar circumstances" [19];
    ii. "A coroner may shed light on a system failure that has regional or even national implications" [21];
    iii. A report "should be clear, brief, focused, meaningful and, wherever possible, designed to have practical effect" [4];
    iv. "Even if facts are disputed, that does not prevent the making of a report" [44].

5. We appreciate that the duty is to report upon anything revealed by the investigation giving rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and 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. We direct these submissions accordingly.

6. As is well known to the Coroner, the Guidance emphasises that it is a Coroner's duty, rather than a discretion, to make a report where a concern is identified - para.7, Schedule 5 of the Coroners and Justice Act 2009. We respectfully agree with the outline of the principles by CTI in the submissions dated 21 May 2021 at §§77-83. We would also emphasise the importance that any Report should err on the side of inclusion so that the matters are properly considered by the organisations or persons concerned. It is appropriate to avoid deflection by any assertions, should they be made, that *some* consideration or partial step has been given to date to a topic without concrete action fully addressing any concerns having been implemented. Even 'good intentions' in

[4] As emphasised by CTI in the written submissions dated 21 May 2021 [hereinafter "CTI §"] at §80(c); and expressed orally at transcript day 28 (25 May 2021) page 32 lines (7)-(10) ("identify matters of concern which could give rise to future deaths, even if those matters didn't even possibly contribute to the deaths of Jack and Saskia").

organisational terms are vulnerable to changes of personnel, miscommunication or misinterpretation, or resourcing issues, that can interrupt necessary change actually taking place. The ultimate objective to save lives in the future by improving public safety, and the benefits to future posterity and auditing, properly guide the robustness with which practical concerns are to be reported. The objective also informs the heavy onus upon an organisation to dispel and answer concerns such that the matter ought not even to feature in a Report at all. The duty upon persons concerned to take all reasonable steps to save lives is a vital and heavy duty. These observations we make are consistent with the relevant Guidance[5] and principle. Formal responses to the report shall then be required by the persons or bodies addressed (pursuant to Regulation 29; and paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009).

Matters of concern upon which action should be taken

A. Management of TACT offenders in prison

Her Majesty's Prison and Probation Service ("HMPPS")

7. Matter of concern ("MC"1): The inquest heard evidence that the policy objective remains to disperse and separate extremist offenders in order to tackle their ideological offending risks and the influence upon one another perpetuating or socially rewarding extremist risks and behaviours[6]. However, the evidence was also that there is insufficient capacity in the present prison estate to achieve dispersal and separation of extremist Islamist terrorist prisoners[7].

8. **Recommendation proposed ("R"1): that the prison estate and facilities, and processes be reviewed and assessed against the needs for fulfilment of the policy of de-radicalisation and risk reduction that dispersal is designed to achieve**.

[5] e.g. Chief Coroner's Guidance No. 5 on "Reports to Prevent Future Deaths" (revised on 4 November 2020) at §§2-5, 7.
[6] [T/20/3-7] per Mr Richard Vince, Executive Director of the Long Term and High Security Estate. (Referenced is the Acheson review DC7555; and the Intelligence and Security Committee's report 2017 DC7556; and Custodial Management Review DC7470).
[7] [T/20/6(18)-(25)]

9. MC2. A matter of concern from the evidence is the process of approving prisoners to become involved with external provider courses or activities being run within the prison. This concern is as to ensuring the accurate understanding of the provision to which the prisoner is to be approved to become involved; and in such light the accurate assessment of suitability of a particular prisoner for a particular activity or programme that is outside of those accredited programmes and courses that are assessed and approved centrally by the Ministry of Justice[8]. There is an obvious concern that the prison service ought to properly understand or regulate what unaccredited programmes are accepted into the prison, and to understand when allocating prisoners to a programme whether or not it carried a risk of community involvement and to avoid assessing the risk of an individual participating in one element but not the full extent of the programme. In particular, there is a concern that there was no clarity in this case when approving Khan to become involved with Learning Together ("LT") as to the fact that the programme might/would continue to engage with the offender after release, irrespective of his risk status at that time. The risk assessment process for admission to the LT course at HMP Whitemoor did not consider the suitability of candidates for continued working with LT after release. The process for admission to the course involved referral to the Security Department for sifting[9] and 'vetting' was carried out by head of counter-terrorism, Steve Machin[10]. There was no documenting of the decision taken or approval given for attendance at the LT course. It was apparent that Steve Machin did not know at the time of sifting that contact between prisoner applicants and LT might continue post-release and based his risk-assessment only upon whether it was safe for the prisoner to undertake the course under close in-prison supervision in the particular workshop to be used, and considering which other prisoners would be in the room too[11]. Even when he became aware of the possibility

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8 https://www.gov.uk/guidance/offending-behaviour-programmes-and-interventions

"Accredited programmes. Accreditation gives confidence that a programme:

- is designed based on the best available evidence
- is monitored to make sure it is delivered as intended
- is evaluated to show the outcomes"

9 [WS5053/3]
10 [WS5060/16]
11 [T/12/114] and [T/12/125 & 126].

of ongoing contact after release, Machin believed it would be restricted to activities like "letter-writing"[12].

10. **Recommendations (R2): (i) All prisons within which LT operate should be advised of the potential for ongoing contact between LT and the offender post-release, and security sifting should be carried out with the possibility of post-release contact in mind. (ii) In any case where an educational project, such as LT, proposes to maintain contact with a prisoner being released on licence, HMPPS should conduct a risk assessment to assess the suitability of ongoing contact in principle** (NB. See further below in relation to risk assessment of specific events if in principle there should continue to be contact in the community). **The risk assessment should be carried out with input from the prison security department, having regard to category of offence, formal risk-level, and any relevant intelligence. The assessment and decision should be documented and recorded.**

B. Management of TACT offenders in the community

Her Majesty's Prison and Probation Service

11. MC3. The concerns over the monitoring or management of involvement of an offender with an external organisation continue after release. In her inquest evidence, Learning Together's Ruth Armstrong conceded the need for an effective information sharing process between HMPPS and LT that would feed into a risk assessment process "*so that we can ask them explicitly: this is the activity that's happening on a form, this is everything that's involved, we know that that information has been communicated, and that we expect communication of any risks that are relevant, and I think we could include in that something like a check box that says "Has there been any intelligence about this person?"*[13]. She went on to state explicitly that had she been informed of the intelligence regarding Khan's intention to carry out an attack there is no way that he would have been invited to the FH event[14].

[12] [T/12/126].
[13] [T/9/107]
[14] [T/9/74 & 107]

12. **Recommendation (R3): LT to work with HMPPS to devise a structured information sharing system to share intelligence and other risk-related information on prisoners working with LT (or other organisations) in the community.** (Such information to be fed into an activity-related risk assessment that LT shall undertake – see below concerns and recommendations in that respect).

13. MC4. The inquest heard that training for a probation officer to undertake Extremism Risk Guidance, ERG22+, assessments was brief (two days[15]), and may be undertaken many years before being practised in any officer's caseload, as was the case here. The draft (which was a virtually completed version) ERG22+ undertaken by the probation officer managing Usman Khan, Mr Kenneth Skelton ("OM"), was wholly lacking in detail and depth as appropriate to such an assessment and in comparison to the detailed and thorough assessment undertaken by the psychologist Ms Ieva Cechaviciute prior to his release[16]. The inquest also heard that there was a great disparity to the amount of time that a busy OM could devote to such an assessment in comparison to the time that would be taken by a psychologist to conduct such an assessment[17]. Chief Probation Officer Sonia Flynn gave evidence that psychologists are now involved in the preparation of ERGs in five security hubs[18] but it is unclear whether a psychologist *must* be involved with every ERG involving a TACT offender, and appears to be the case that it is still probation officers, albeit 'specialist' offender managers, who may complete an ERG22+ themselves[19]. The jury's finding was that a contributing factor to the deaths of Saskia and Jack was the lack of psychological assessment post-release from prison. From the evidence heard[20] it was likely that if an updated assessment had been prepared using the skills of a psychologist that this would have called into question the positive views being formed of Usman Khan's progress and that it may have led to a more rigorous consideration of the risk attaching to the prospective visit to London.

14. **Recommendation (R4): that consideration is given to ensuring that only qualified psychologists undertake ERG22+ assessments, in light of their greater expertise and training, and often experience, in undertaking detailed psychological**

[15] [T/19/24]
[16] See CTI §20. Assessment is DC5322.
[17] See also CTI §§38-39
[18] [T/19/25/10]
[19] [T/19/25]
[20] E.g. evidence of Dr Cechaviciute [T/18/17]; [T/18/22]; [T/18/26].

assessments and risk analyses of this nature. Alternatively, that there is a formal, documented involvement of psychologists in such assessments.

15. MC5. In the event that, contrary to the above recommendation, it were indeed appropriate for a specialist trained probation officer to undertake an updating ERG22+ assessment of risk factors, the concern arises that the undertaking of such by Mr Skelton in this case was inappropriate as it blurred the lines between objective independent assessment in the ERG22+ contrasted to the role of supporting Khan through his licence rehabilitation performed by the OM (responsible for day-to-day management of the offender). The two hats ought not to be worn upon the same head. Furthermore this practice is directly contrary to the good practice adopted in the prison system where only a psychologist undertakes the ERG22+ and that psychologist must not otherwise be or have been involved with the offender in any treatment capacity or programme or psychological intervention provision.

16. **Recommendation (R5): That it be made a clear stipulation and requirement in the management of TACT offenders in the community that any ERG22+ be completed by an appropriate person not otherwise involved in the management and supervision of the TACT offender.**

17. MC6. The decision was taken by the OM Mr Skelton, with conversation with his manager Mr Philip Bromley, to downgrade Khan's risk category from very high to high risk in May 2019[21]. That decision was made in the absence of completion of the formal OASys process, in the absence of any updated ERG, and without reporting the change to MAPPA for oversight, information or discussion[22]. This is a matter of concern. It does not appear to be permissible[23] but this fact was not heeded by either probation officer. This was an important decision which could have impacted upon the thinking behind decisions in risk management of Khan by those two individuals. An OASys provides structured and guided assessment, with auditing and identification of error part of the process. The assessment processes are designed to ensure that such decisions are made on a fully informed basis,

[21] See the material referenced at CTI §24
[22] [T/17/3/5].
[23] The evidence was also that the OASys having not been completed 'locked' back to the Very High Risk level of its own accord automatically [Philip Bromley T/15/97-99; and /78-79]. However Mr Bromley [T/15/42-44] and Mr Skelton [T/16/61-62]; [T/17/3] suggested generally a reduction would be agreed with his manager first and then an assessment would be completed afterwards.

to reduce the risk of TACT offenders being subject to inadequate measures. This raises a concern over the clarity or strength of guidance to, and/or training of probation officers in relation to alteration of allocated risk level for an offender under supervision.

18. **Recommendation (R6): Clear guidance should be issued to probation to the effect that risk re-categorisation should not be decided in isolation from the OASys process, but should only ever follow the completion of that process. Consideration should be given to any further training required for probation staff to ensure that any alteration of risk level is properly undertaken and is reported to MAPPA so that any concerns may be discussed.**

19. MC7. The process of the supervising probation officer approving a permission to authorise the offender to act in a manner otherwise prohibited by his licence conditions raises concerns. The concern is addressed further below as to the engagement with MAPPA on the subject; but a further concern is that Khan's licence conditions were temporarily varied, or permission given, to facilitate his attendance at the LT event without any recording of the rationale for that decision by Mr Skelton or any detailed assessment by him of the risks that would arise.[24] Chief Probation Officer Sonia Flynn stated that it was a significant decision to relax those licence conditions, and that there should have been "some sort of one-off risk assessment" before permission was given[25]. Moreover, Mr Skelton "would have been expected to record his rationale" for giving permission[26]. The absence of clear recording or reporting of Probation decisions taken to permit conduct otherwise prohibited by the licence conditions hampers the ability of MAPPA to audit the same. Clear recording would enable MAPPA attendees at a particular meeting, and those in attendance at subsequent meetings, to be clear as to whether or not a particular permission had been debated or approved at any previous meeting.

20. **Recommendation (R7): That steps be taken (by guidance or training) in order to ensure it is made clear to Offender Managers that on each occasion that a decision is required to grant permission to depart from licence conditions there is a clear and sufficient record made of the decision to grant permission and the officer's reasons for doing so.**

[24] See the evidence cited at CTI §§41-44.
[25] [T/19/50]
[26] [T/19/50]

21. MC8. A concern arises as to the need to retain ongoing open consideration of, and the need to revisit, a decision to grant permission for attendance at an event in the light of changes to circumstances over time. In this case it appears it was envisaged permission would be given or had been given by August 2019. However that ought to have been revisited prior to 29 November 2019 given that there were deteriorating changes in circumstances, including known risk factors that Khan remained unemployed having suffered numerous rejections, had ceased gym attendance or mosque attendance, was socially isolated and, after August 2019, was not having any contact with mentors.

22. **Recommendation (R8): That guidance and training to Offender Managers emphasise the need to remain vigilant and to review any decision to allow a relaxation of licence conditions to enable a TACT offender to attend any (public) event shortly before and at the time of the event to ensure all relevant risk factors are given full consideration at the time that the event is to occur (and thus the risk to crystallise at such an event).**

23. MC9. A concern arises that those supervising Khan were manipulated or rendered unduly optimistic or somewhat complacent by his overt protestations and presentations of engagement and desire not to reoffend, whilst signs of risk increasing were not heeded. The significant concern is that they became complacent or deceived by him and accepted a generally positive view of his intentions and beliefs conveyed by him to them, and minimised or disregarded warning signs from others and intelligence contrary to that impression taken by them[27]. There was evidence that polygraph testing has been successfully used for management of sex offenders on licence since 2014[28], but it remains unclear if this is yet available for TACT offenders, though it seems to be the intention to bring this about. CPO Sonia Flynn accepted that these would be useful in assisting the understanding of the mindset of the individual under supervision.

[27] See CTI §45, §48.

[28] Per Sonia Flynn [T/19/79]; per recommendation made in the Independent Review of MAPPA by Jonathan Hall QC in May 2020 [DC6513/11] paras. 2.10-2.12 (and Annex A). In evidence in the questioning of Richard Vince at [T/19/197-199] the apparent current position remains for implementation of this as intended by the government in its letter of 20 December 2020 responding to the review was highlighted. The importance of this measure for risk management requires satisfaction that it has been or imminently is to be implemented in any legislative terms and in practical equipment and training provision.

24. **Recommendation (R9): Ensure that legislative and practical provision is made to enable effective polygraph use in the management of TACT offenders without delay.**

25. MC10. A further concern arises as to the guidance or training for probation officers to structure supervision so as to test compliance fully, and so as to be able to be placed in the best position to have difficult testing conversations with the offender and to challenge them appropriately in supervision discussion. The evidence revealed that the OM Mr Skelton had visited Khan, alone, at his home address, and had not arranged meetings to occur, at least on occasion, in the security of the probation premises, to which Khan would have needed to travel in order to comply. There were matters upon which Khan should have been challenged where he gave inconsistent accounts or told untruths, or exhibited ongoing minimisation and denial of his index offending, to understand his beliefs and thinking, and levels of honesty in supervision[29]. The concern as to the approach taken, contrasted with the need to be cautious as to any presentation of overt apparent compliance as potentially duplicitous, and the need to test the offender and ask the right questions to evaluate genuine levels of risk or risk reduction in supervision, was shared by CPO Sonia Flynn[30].

26. **Recommendation (R10): That guidance and training be reviewed to ensure that Offender Managers of TACT offenders are reminded or made aware of the need to remain vigilant against deceptive compliance or manipulation and adopt appropriate strategies and systems of testing compliance with the licence conditions, for example requiring the offender to visit the office on occasions at least, and to ask searching, probing and challenging questions in supervision regarding attitudes and beliefs, not only to monitor progress in steps such as obtaining work or pro-social activities.**

27. MC11. A concern was highlighted by the inquest that it is extremely challenging to obtain employment for TACT offenders. It was apparent that even with the assistance of Department of Work and Pensions job centre officials, both at local and more senior levels, opportunities were scarce, and even companies who work with general offenders

[29] See e.g. CTI §36(a) and (d)
[30] See CTI §36(c)

have concerns about employing TACT offenders. Whilst evidence from CPO Ms Sonia Flynn was that some centralisation of expertise and effort in employment sourcing for TACT offenders has been implemented it is not clear that this has the capability to overcome the market problems in securing gainful use of time through employment for those with TACT offending history. A job is often regarded as a protective factor in that it provides both an income and a gainful use of time, and can lead to social benefit through contact with colleagues in employment.

28. **Recommendation (R11): Consideration should be given to establishing a detailed review to identify what further steps can be taken in order to maximise the chances of TACT offenders who seek to rehabilitate being able to obtain employment.**

29. MC12. A concern arises that the systems in place for provision of practical mentors to TACT offenders may be inadequate to ensure that mentoring is timely, consistent, and made available to those who require this. Mentoring was said to offer benefit both in assisting individuals, and in monitoring and supervising individuals, as reports are provided following mentoring sessions. It was also the primary means for an offender to access the internet under supervision for purposes including searching for work. The inquest revealed the following concerns: (i) practical mentoring was delayed in its provision commencement for Khan; (ii) general contracting arrangements were carried out in such a manner as allowed for a sudden and unexpected cessation of mentoring, when good practice was always to give a notice period to the individual before support was withdrawn; (iii) there was a failure of communication as to need for mentoring to resume for Khan, with CT Probation believing none was to be rearranged, and the managing unit and OM conversely believing one would be arranged but not as a priority. Had the CT Probation who arrange mentoring been aware Khan required the same those sessions would have recommenced in mid-October[31]. Probation had not arranged for a mentor to be provided by mid-October in Khan's case because he was incorrectly removed from the mentor programme rather than treated as lower priority for one after the time The Unity Initiative contract ended.

30. **Recommendation (R12): There be investigation and consideration of the means of communication and recording of mentoring need, and priority allocations,**

[31] [T/23/196(13)-197]; and WS5062/11 [42]; per Cathryn Ellsmore

between CT Probation and managing Probation officers to ensure a system is in operation that is clear and avoids any such miscommunication or error.

31. MC13. Khan had both cocaine and heroin in in his system when he died[32]. There was no drug testing of Khan after he moved from the Approved Premises[33] into his own accommodation. As such it is unknown how often he took the drugs and precisely when, though the cocaine use was occasional between August 2019 and mid-November 2019. The fact that Khan was using such drugs means that he was not, in fact, complying with his licence conditions (cf. [DC5194/1(§5(ii)]). Had this breach been detected he might well have been recalled to prison and/or his apparent commitment to reform may have been treated with more scepticism and/or closer monitoring and supervision may have been arranged. It is of concern that a very high-risk offender could use drugs without detection, and without fear of detection. Drug use indicates involvement with criminality in accessing the drugs, and raises risks of criminal lifestyle return, or indicates growing negativity, despondency or instability of emotion or outlook. It is a factor that often contributes to increasing risk of offending more widely, as well as the illicit use of the drugs itself.

32. **Recommendation (R13): (i) Procedures at APs should be reviewed and improved to ensure that individuals' management plans are being adhered to, particularly in relation to drug testing. (ii) Consideration should be given to implementing or increasing drug testing of TACT offenders in the community under supervision when living independently.**

<u>All agencies involved in MAPPA</u>

33. MC14. The jury's findings include that two contributing factors to the deaths of Saskia and Jack were unacceptable management and lack of accountability; and serious deficiencies in the management of Khan by MAPPA. It is a matter of concern that amongst those attending the MAPPA meetings, and in particular those two meetings where the subject

[32] Vincent Cirimele (read evidence) WS0324A and WS0324B; and summing-up [T/29/73(13)-74(1)]. The examinations that he conducted suggest the occasional use of cocaine by Khan between late August and mid-November 2019. The findings also suggest exposure to heroin over the same period, but the expert could not exclude external contamination as a possible contributor for the drug being in the beard hair.

[33] According to his Approved Premises Risk and Needs Management Plan, Khan should have been subjected to drug tests every week [DC5641/5]. However the NDelius reports and drug monitoring sheets indicate that he was tested just five times (on 24.12.18, 27.12.18, 02.01.19, 09.01.19 and 15/7/19) over the eight month period that he was at the Approved Premises.

of travel to London for the Cambridge University event was raised, on 22 August[34] and 14 November 2019[35], expressed no clarity or consistency as to whether or not the decision to allow Khan to attend the event was one taken with express MAPPA approval. There was no minute of any discussion of risks that accompanied or arose from attending the event. There was general agreement that there was no such discussion. There was no minute of MAPPA approval or agreement to permission to attend being given under the licence by the OM. There is (a) no clear guidance as to what decisions needed to be the subject of specific discussion and MAPPA panel approval, and therefore decisions that require panel members to provide views on the proposed activity; (b) no clear auditing or minuting of all decisions that are identified to be such as to require a risk assessment or discussion be held by MAPPA[36]. The lack of specific guidance as to the decisions which ought generally to require MAPPA approval may have contributed to the failure of Mr Skelton (and/or PS Forsyth) to have raised the matter properly before the panel for assessment and decision. It is noted that attendees at meetings can and do vary, and representatives may lack personal recollections as to what has been already decided at any prior meeting. This absence of clarity as to the supervision and risk management decisions that required MAPPA approval or discussion contributed to a situation in which the decision whether to approve Khan's attendance at this particular LT event was never discussed[37]. The process for identifying, assessing and managing risk via MAPPA requires clarity that a decision on risk concerning a particular activity or event proposed is recorded as having been taken whenever that is the case. Assumptions were made that there had been such a discussion concerning the LT event when the record demonstrates that was not the case. In practice the decision was made by Mr Skelton, who took it that there was no objection raised at MAPPA[38]. The processes in place ought to have ensured it was understood and clear to all that MAPPA had not discussed or assessed the risks, and had not given approval as a body.

34. **Recommendation (R14): (i) MAPPA processes should be urgently reviewed to ensure that it is clear to all attendees at a meeting, and to those attending**

[34] DC6415/4-5
[35] DC6417/5
[36] E.g. CTI §64(e).
[37] The evidence is clear overall that there was no discussion of the risks of attending, whether any precautionary measures should be taken in the event that he was permitted to attend, or the question whether or not to approve attendance. See e.g. CTI §§50-51.
[38] See e.g. CTI §§56-60.

subsequent meetings, what approvals for departure from the licence restrictions have been agreed and approved by MAPPA; and what or whether risk assessments have been undertaken in relation to such events or activities. (ii) The process for varying licence conditions should be formalised, including the need to record rationale and show specific and positive approval from MAPPA.

35. MC15. The evidence of multiple MAPPA attendees, including the OM and Part 4 Notification managing officer, was that the event at Fishmongers' Hall was regarded positively and as of rehabilitation value on the basis that it was connected with Learning Together and Cambridge University. There is a concern that a lack of critical analysis of the value of the association with that organisation was actually providing, a lack of inquiry into what specifically Khan had done or was doing which was positively contributing to his rehabilitation and progression on licence, took hold amongst those supervising and managing him[39]. In fact, Khan had actually not been completing any educational work in the long period since June when he was supplied a chromebook for that purpose[40]. His contact since release had been generally limited to providing a video and interview to Learning Together for its own presentation and research purposes in March 2019, and telephone contact of a general nature. There was a proposal for a one-day course attendance in April 2020[41]. There was no appreciation or consideration at MAPPA or in licence management of the absence of engagement in positive work with Learning Together that gave structure or meaning to his day or lifestyle. This treatment of his involvement with Learning Together was distinct, for example, from the inquiring consideration of the opportunity for him to participate in, Intensive Engagement[42] or the risks of employment involving the use of a dumper-truck vehicle by a TACT offender, even if that could result in a protective employment factor being supplied. The jury found a failing that contributed to the killings to be a blind spot to Khan's unique risks due to his 'poster boy' image (referring to his involvement with the Learning Together programme). The jury also found that a contributing cause of the deaths of Saskia and Jack was the failure to complete an event specific risk assessment by any party. It is also a related matter of

[39] E.g. Forsyth saw his association with LT as positive and didn't attach any risk to Khan's visit to London as a result [T/20/154/23], same with Skelton T/16/74/2] and see Lois Gell [T/17/126/3]. Linked to this, CTI's submissions identified a lack of scepticism in the management of Khan [§36]. This is evidenced in the risk assessment conducted by Forsyth [DC 5527/3] and the ERG assessment by Skelton [DC5323].
[40] CTI §48 refers.
[41] E.g. MAPPA Minutes DC6416/4-5.
[42] MAPPA Minutes DC6416/4-5; DC6417/4. See also the examples at CTI §52 of an earlier event in March 2019, and the arrangements for the visit in June 2019 to HMP Whitemoor.

concern that several witnesses described the approach taken to attendance at the Fishmongers' Hall event as an all-or-nothing decision, and that if risk mitigation measures had been deemed appropriate then the decision would be not to allow attendance rather than to allow attendance and implement mitigation of risk steps to accompany attendance[43]. This is wholly inappropriate to risk management of a TACT offender. If it is deemed appropriate for a relaxation of licence conditions or permission thereunder to be granted so that a rehabilitation objective is met, it is of obvious importance that there be specific risk assessment and consideration of that event so that appropriate consideration is given to mitigation steps, and where appropriate those steps then be taken to minimise or control risk. This indicates a training and/or guidance and policy issue of concern for risk management of TACT offenders. Potential risk mitigation or precautionary measures for example[44] might include in relation to an event attendance:

i. Notifying the local police force to the area;
ii. Contact made with the organisation(s) staging or hosting an event to discuss or ascertain security measures to be in place, including potential to request or require bag searches or metal detector use;
iii. Accompaniment or escort of the offender to the event, including the potential for attendance of the escort at the event as well as during travel;
iv. Visit arranged for the preceding day or days to the home address to check on the offender, including identifying any raising of risk concerns apparent;
v. Arranging for an unexpected spot check by police during the journey, and ensuring such officers understand properly the empowerment to search an individual if reasonable suspicion arises from for example refusal to account for an item or allow inspection of a closed bag;
vi. Ensuring enhanced covert surveillance of the offender during a trip or event.

36. **Recommendations (R15): (i) That it be made a specific requirement that before relaxation of a licence prohibition the OM undertake an appropriate risk assessment of the specific proposed event or activity and steps which should be taken to mitigate risk (ii) That consideration be given to specific training for those probation and police officers involved in managing TACT offenders to enable**

[43] E.g. DS Marc Jeromes [T/26/56], Mr Skelton [T/16/162] and Mr Forsyth [T/20/148].
[44] See CTI §55 for references to many of these options for risk management.

guarding against feigned engagement and averting the risk of manipulation and deceptive compliance. (iii) Risk management training, and guidance, for probation staff and CT police should be reviewed to establish whether it sufficiently covers ways to manage risk by implementing measures short of rejecting requests, particularly in relation to the management of TACT offenders.

37. MC16. At MAPPA meetings the evidence demonstrated that any assumption of some familiarity with an individual case on the part of attendees was frequently unreliable as attendees varied from various organisations participating in MAPPA. Further the distribution of minutes of prior meetings ahead of meetings was unreliable and unassured (minutes of MAPPA meetings were shared to attendees only by uploading onto ViSOR, a system to which some attendees did not have access between meetings), so that these might not be seen before the subsequent meeting or in good time before that meeting. Further the minutes format did not retain for each meeting thereafter, and therefore as aide memoire or to inform ad hoc attendees, the vital intelligence indicating risk nor the risk factors identified by the ERG22+ last completed.

38. **Recommendation (R16): (i) A reliable means of distribution of minutes of MAPPA meetings to all participating and attending organisations and individuals should be identified to ensure all persons have the ability to review and reflect on the same in the interval; (ii) a review of the format of the Minutes for MAPPA meetings should identify the best means to ensure that key intelligence and risk factors remain in the iterative document each month to ensure that it is not overlooked and that it is available to attendees of subsequent meetings.**

39. MC17. There was a concern that the structure of discussion and consideration of management at the MAPPA meetings lost sight of the risk factors identified by the ERG22+ completed by Ieva Cechaviciute in April 2018, and that those participating in the MAPPA did not sufficiently heed or act upon the warning signs when these became apparent in discussions in October and November 2019[45]. Nor did MAPPA ever invite the ERG author to attend to explain UK's risk if it wished to have a greater understanding of her assessment and views of his risks, which was an option the inquest was told[46]. The

[45] See CTI §§34-35
[46] See CTI §37

risk factors were identified to MAPPA in the first meeting of 26 June 2018[47], but this is not carried forward in the subsequent meeting minutes, and is not a matter therefore necessarily available to or reminded to attendees as time goes by.

40. **Recommendation (R17): That the format of MAPPA minutes which remain in circulation and consideration at meetings as management occurs should contain a list of the factors identified to be relevant by the ERG22+ assessment so that these remain front and centre in the mind of the MAPPA panel and attendees.**

41. MC18. A number of key individuals were unaware of a piece of intelligence that reported that Khan was planning to carry out an attack[48]. It was apparent that those privy to the full intelligence information were not participating actively in MAPPA meetings, while those excluded from it were in practice those making the decisions and conducting the risk assessments. The jury's findings include that two contributing factors to the deaths of Saskia and Jack were unacceptable management and lack of accountability; and serious deficiencies in the management of Khan by MAPPA. The Independent Review conducted into the effectiveness of the multi-agency public protection arrangements in mgmt. of known terrorist offenders by Jonathan Hall QC found that the need to consider sensitive information meant that a wide range of individuals involved in MAPPA meetings without the relevant security clearance could not participate effectively. He recommended for managing terrorist cases concentration of decision-making in a core group of security-cleared professionals who would manage the offender, and to use wider meetings with "Duty to Cooperate" agencies to provide oversight[49].

42. **Recommendation (R18): Jonathan Hall QC's recommendation to concentrate decision-making in a core group of security-cleared professionals, and to use wider meetings to provide oversight, should be considered for adoption to ensure a better sharing of intelligence amongst those responsible for making decisions on the licence supervision and management of the offender.**

[47] DC6406/6
[48] See CTI §§64(d)
[49] Report at DC6513/36-37 at [5.2]-[5.3]. [T/19/85] refers.

West Midlands Police, Staffordshire Police, and the Secretary of State for the Home Department

(Appropriate also to copy the report to the National Police Chiefs Council)

43. MC19. There was (a) a lack of clarity of understanding as to the role and function of the police in the management of Khan on licence; and (b) a concern over the suitability of Prevent officers to undertake the role of Part 4 management in conjunction with the probation management of the licence. The jury's findings include that a contributing factor to the deaths of Saskia and Jack was insufficient experience and training. The Prevent team considered themselves to be inadequately trained to manage TACT offenders[50] (and differences to the work done by Team 7 in the CTU at West Midlands for example[51]). Linked to this is the lack of clarity surrounding what, precisely, the role of the Prevent team was. PS Forsyth maintained that his duties were confined to overseeing Khan's Part 4 notification requirements, and not to assess risk[52], whereas others including Mr Skelton[53] understood his role to be more active management. PS Forsyth also pointed out that Prevent were not equipped to manage the workload[54]. It is a matter of concern whether or not the Prevent police officers involved in management of Khan had sufficient training and/or guidance and/or competence to fulfil the role of public protection in the monitoring and management of him. The allocation of Khan to the Prevent officers of Staffordshire Police was in circumstances where it was known or ought to have been known that:

    i. They had received no training in the management of Part 4 offenders (there being no such training in place locally or nationally at that time);
    ii. The team brought no counter-terrorist investigative experience;
    iii. They would be the wrong side of the "sterile corridor" and not have access to the full intelligence picture. There would be no-one in the offender management team sighted of the relevant intelligence and aware of the covert investigation or its details; and,
    iv. They were to work closely with an offender manager (from NPS) who was inexperienced in the management of terrorist offenders in the community

[50] See CTI §64(b).
[51] WS5014-1 exh. MW1, and the evidence of DS Jerromes [T/26/163-171]

[52] CTI §29 refers
[53] [T/16/20(10)]
[54] [T/20/45]

and the likely practical need to contribute advice or information to matters of management well outside the strict policing of the Part 4 conditions.

44. While it is understood that Prevent no longer manage TACT offenders in the wider West Midlands region, and there is now some training being rolled out in relation to Part 4 management, it is unclear what the new system is, and whether the management of TACT offenders in all areas of the country shall in future only be undertaken by adequately trained and supported CTU specialists.

45. **Recommendation (R19): That police management of TACT offenders should only be undertaken by adequately trained and supported CT specialists and not Prevent officers.**

46. MC20. Concerns arise as to the monitoring and regularity of visits by police to Khan. Prevent visits reduced in regularity very significantly, at as time when mentoring had ceased after August 2019. However, MAPPA did not know this[55]. Even PS Forsyth was not aware of the scale of reduction in such visit frequency, believing the visits to be fortnightly[56]. There was a concerning infrequency of visits by Prevent police officers after the move to private accommodation on 24 September 2019. There was a 5-week gap between the move from the AP to private premises and the next visit on 31 October 2019. He was then visited once in the middle of November 2019. It appears that no active decision was taken to reach that level of infrequency. This is turn meant that those managing Khan at MAPPA were not aware that the withdrawal of mentor support coincided with a dramatic reduction in Prevent visits. Had they known they could or should have been more concerned by his social isolation and more alert to his risk factors[57]. The visits themselves were no more than 10 minutes long[58]. It was apparent that the experienced CT officer DS Stephenson felt that increased regularity to weekly visits was required in light of the risk factors present in November 2019[59].

[55] [T/20/189/7].
[56] [T/20/191/5]
[57] see for example Skelton [T/16/87/3-25]
[58] [T/20/185/22]
[59] DC7443/133

47. **Recommendation (R20): The quality, frequency and purpose of visits by police should be actively discussed and specific approval obtained from MAPPA before the frequency of visits is reduced, to ensure that those managing TACT offenders have a complete picture of the support structure in place, and risk can be accurately assessed.**

48. MC21. There are concerns over the sensitive information sharing between state agencies, including between MAPPA personnel including the Chair; the managing police unit; and the Offender Manager. When asked to identify whether there was any omission or failure in the sharing of information and guidance by agencies responsible for monitoring or investigation of Usman Khan which may have contributed to the deaths of Jack Merritt and Saskia Jones, the jury found that a causative factor in the deaths of Saskia and Jack was a missed opportunity for those with expertise and experience to give guidance.

49. **Recommendation (R21): (i) A review be conducted of the computer systems in use for information sharing to ensure that the police and probation and prison staff who require specific access to terminals, and specific database systems, to contribute effectively to the appropriate sharing of intelligence are enabled to do so. (ii) A review to ensure that there is (where appropriate) streamlining of the use of IT systems so that these are correctly used for common sharing of intelligence between different organisations as appropriate, and with appropriate access for all relevant personnel. (iii) A review to identify the correct location of a sterile corridor between overt and covert investigations and management, so that there is the correct line drawn for the sharing of intelligence to those who require it for decision-making to manage risk.**

50. MC22. It was apparent that there is particular joint working between CT Police and the security services where the latter has an open Priority investigation. In the course of the inquest it became apparent that (a) there was a time lapse between the request for a JOT meeting made at 11am on 6 November[60] and its occurrence on 18 November 2019; and (b) no response given, or rationale for any decision taken, in relation to a request by DS Jon Stephenson for an assessment by the Behavioural Science Unit[61]. Concern arises as to the speed with which the JOT was convened (which in this case also meant it did not

[60] DC7490-T/16
[61] [T/24/55-56]

precede the MAPPA meeting on 14 November 2019); and as to the processing of the request for a BSU assessment to assist the CT police and any other bodies in liaison with CT police in managing the risks posed by Khan.

51. **Recommendation (R22): (i) That procedures be reviewed to identify the appropriate speed with which JOT meetings should convene. (ii) That procedures for handling and responding to requests for BSU involvement be reviewed to identify if they remain appropriate or can be improved with a view to informing CT police of the consideration, reasoning or criteria applied to processing such a request.**

C. Arrangements for events at which a TACT offender shall attend

Learning Together

52. MC23. Concerns arise as to the approach taken by Learning Together in discharging its own obligations to employees and invitees to consider the risk created and inform reasonable steps to be requested or taken at an event organised by LT. LT did not carry out or cause to be carried out any risk assessment for the event; and did not take steps to satisfy itself about the security arrangements to be in place at Fishmongers' Hall. LT were the employer of Jack Merritt and others attending the event; were the organisers of the event, to which around 100 people were to attend; and were responsible for selecting the invitees, which included persons of some public profile. It is a significant concern that LT failed to conduct a risk assessment concerning the Fishmongers' Hall event; or in relation to inviting Khan to the FH event. Amy Ludlow asserted in her witness statement[62] and oral evidence[63] that she did not see it as LT's responsibility to consider the risks associated with any licenced prisoners attending LT events, deferring entirely to "criminal justice colleagues". The jury found that a contributing cause of the deaths of Saskia and Jack was the failure to complete an event specific risk assessment by any party. Those involved in organising the Learning Together event did not properly consider or inform themselves of, or assess, the risks to those attending or employed at the event, or consider appropriate security measures for the event. This absence of considerations of risk was both generally

[62] WS0205A/3-4
[63] [T/8/63]; [T/8/134]

in relation to offender attendance, or to risks specifically posed by Usman Khan as an individual or as a known TACT offender.

53. **Recommendation (R23): That Learning Together and Cambridge University implement a requirement that a risk assessment be produced for the organisation of any event/activity where convicted offenders will be in attendance. The risk assessment should consider the individual risk factors of the offender(s) concerned and any additional risk presented by the type of venue and the identity of other attendees. Risk assessment should also consider the suitability of security measures at the event venue, and should engage with the prison, probation and police authorities as appropriate to ensure that there is a full understanding of the risks and to take advice upon security.**

54. MC24. Concerns arise as to the approach taken by Learning Together in not passing on attendee information to the relevant persons at Fishmongers' Company with whom arrangements were being made for the event. The jury found that there was a lack of communication and accountability; and inadequate consideration of key guidance between parties; which contributed to the deaths of Saskia and Jack. LT said it did not consider it to be its responsibility to inform venue owners of the criminal background of any of those attending their events[64]. Learning Together were aware that Usman Khan was a TACT offender, released as a Category A prisoner at the end of 2018 (although LT chose to decline the offer from Mr Skelton of further information about Usman Khan relevant to risks he might pose in attending an event such as that held at Fishmonger's Hall). Ruth Armstrong suggested that some at Fishmongers Company were aware of the type of work that LT did and therefore there was no requirement to explicitly inform the company of who would be attending[65]. LT also did not take any steps to satisfy themselves as to what security arrangements would be in place at Fishmongers' Hall. The witnesses from Fishmongers Company gave a contrasting view, suggesting variously that they had no knowledge of Khan's background[66], had they been provided with the list of attendees they would have reviewed security[67], sought advice from the police[68] and perhaps not allowed

[64] [T/8/169-170]
[65] [T/9/122-123]
[66] [T/10/110]
[67] [WS0197A/1]; [WS0529/3]
[68] [WS0444A/6]

the event to proceed[69]. Sandra Bufano did not know there were ex-offenders or a TACT offender in attendance[70]. Jeffrey Stevelman likewise did not know there were offenders attending[71]. Commodore Williamson said the FC did not have knowledge of Usman Khan as a convicted terrorist, or of high-risk offenders attending[72]. Without specific knowledge that LT could have passed on to the organisers security measures that could be taken were not taken.

55. **Recommendation (R24): LT to inform venue owners and providers of staff at events whenever convicted offenders are invited to attend LT events, and to provide full details of risk profiles and matters relevant to potential risk and so enable proper consideration to be given to event security. Basic anonymised information of the offenders' criminal history to be provided where it is relevant to potential risk.**

56. MC25. A concern arose as to the approach of Learning Together to learning from the lessons of the events that led to the deaths on 29 November 2019 at Fishmongers' Hall. [NB This is a significant concern of the family of Saskia. They would wish that Cambridge University carefully consider whether it could and would be appropriate to continue with the Learning Together programme at all, and if it is, whether this should remain run and lead by the present directors Amy Ludlow and Ruth Armstrong]. In attempting to validate the programme and demonstrate its apparent achievements, there appeared to be significant willingness on the part of the directors to accept at face value any self-report of positive response. The evidence of both directors gives rise to the serious concern that neither were willing to address past methods and attitudes that are vital to understanding objectively the risks associated with community or student involvement with individuals convicted of serious criminal offences (of violence, as well as terrorist offending). On the day of the killings there was an express concern over controlling the narrative in the media. There was a jarring reaction to the attack that indicated an attempt to mitigate the atrocity (an understanding of Khan's "desire to die (which makes absolute sense in the abject lack of much hope and good in his life)" and "It was a 'fuck it ' moment of the highest order from a man who tried so hard but there was no positive future for him. None"[73]). An offer

[69] [T/6/144]
[70] [T/5/39-40]
[71] [T/6/133-134]
[72] [T/10/76-78]; [T/10/88-91]; [T/10/99-100].
[73] [T/9/137-140]

from Usman Khan's OM to provide details of his risk factors was rejected[74]. It was heard that there was reluctance to undertake Prevent training on the grounds of "conscientious objection" by Ruth Armstrong[75]. There is a concern that an ideological mindset towards treating prisoners as any other student participant pervaded not only the attitude prior to the tragic events, but has adamantly persisted since. An attitude that fails to question this approach risks prevention of appropriate safeguarding of the public and students. The inquest further heard that there was a problem with the proposal to appoint an interim chief executive to Learning Together[76].

57. **Recommendation (R25): That Cambridge University carefully reviews the evidence revealed at the inquest, and (i) whether or not the programme should continue; and if it is to continue (ii) whether changes to its current leadership and/or leadership structure are required so as to ensure safety for all participants and staff.**

Fishmongers' Company

58. MC26. A matter of concern is the time being taken to address the risks identified by the Risk Register. Commodore Williamson accepted that at least two months prior[77] to the attack the risk register identified, as 'R6[78]', a threat of a breach of security and terror attack inside the premises, with a high risk rating. It had also identified the options to increase visible security presence and the screening of guests at selected events, for example. The evidence was that this was being addressed only in respect to one or two items each meeting cycle, so that it would take many months and even years to address all risks that had been reported by the independent consultants' review. The consequence of that approach was that no practical steps had been taken at that time to address that 'R6' risk as it was yet to be addressed in the annual cycle. Commodore Williamson said there was much going on, but he hoped that this might have been something looked at in detail by January 2020, and actions would then have been taken. He said the Company had just not got around to dealing with this by the end of November 2019. (It was also a concern that the Company did not risk assess the event, but it has explained how it has now

[74] [T/9/125-130]
[75] [T/9/112-116]
[76] [T/9/142(12)-146(9)]
[77] [T/10/118-122]
[78] *DC5009/6; and at /2 '*Terror — lone wolf attack at Fish Hall targeting the property and users (e.g. a knife attack)."

implemented such a process and policy for event approval and assessment which reflects the need for consideration of the risk to visitors and staff from its activities).

59. **Recommendation (R26): The specific risks to health and safety identified in the operation of the Company's activities should be addressed with some urgency when identified, and sufficient personnel or resources be made available to ensure that actions are taken to address such risks in a prompt and timely manner in future.**

    <u>All agencies involved in MAAPA</u>

60. MC27. The MAPPA agencies were all made aware of the fact that Khan would be attending at a central London location[79], involving two conditions of his licence being relaxed for the purpose. Each organisation was also aware of some intelligence that he intended to return to old ways (and some were aware he also was said to be planning an attack upon his release from prison); and aware of the facts that, by November 2019, 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. The jury found there to have been an 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 in the missed opportunity for those with expertise and experience to give guidance. Despite this knowledge and expertise and experience there was no implementation of risk mitigation or precautionary measure taken, including any of:

    i. Notifying the local police force(s) in London;
    ii. Contact made with the organisation(s) staging or hosting the event to discuss or ascertain security measures to be in place, including potential to request or require bag searches or metal detector use;
    iii. Accompaniment or escort of Khan to the event, including the potential for attendance of the escort at the event as well as during travel;
    iv. Visit arranged for the preceding day or days to the home address to check on Khan, including identifying any raising of risk concerns apparent;

[79] See CTI §47

v. Arranging for an unexpected spot check by police during the journey, and ensuring such officers understand properly the empowerment to search an individual if reasonable suspicion arises from for example refusal to account for an item or allow inspection of a closed bag;
vi. Ensuring enhanced covert surveillance of the offender during a trip or event.

61. **Recommendation (R27): Whenever a TACT offender is to be permitted to attend at a venue or event where the public are present the Probation and Police officers responsible for the risk management of the offender ought to make contact with the organisation concerned to discuss and ascertain the specific security measures in place for the event and venue, and offer appropriate advice and guidance to strengthen the same where appropriate, and to assist in the safety of those working at or attending the event to which the offender is to be permitted to attend.**

D. Emergency Response

London Ambulance Service, Barts Health NHS Trust, City of London Police and the Metropolitan Police Service

62. MC28. A matter of concern that arises from the evidence is the apparent lack of structured communication between the first responders on the scene. For example, at 14:09 Operation PLATO was declared[80]. This was communicated to paramedic Nicholas Eve via officers on the ground who had heard the information[81]. There does not appear to have been a structured system to ensure that decisions as to the safety at the scene were communicated to the medical first responders immediately.

63. At 14:11, the Armed Response Vehicle officers communicated with each other that Usman Khan appeared to be dead[82]. At 14:18, the officers were discussing the need to declare the area a warm zone[83]. At 14:19:08, it appears that Inspector Watkins radio-ed PS Settle asking him to declare the area a warm zone, due to critical casualties. That was affirmed by PS

[80] Police Helicopter footage at AV0016
[81] Evidence of Nicholas Eve
[82] Transcript of TC92 Bodyworn Video at DC6496
[83] Operation Bemadem Timeline at DC6192

Settle at 14:19:25[84]. The picture that is painted is therefore a rather disjointed one, whereby those charged with monitoring Usman Khan were discussing the categorisation of the area, but were not communicating that to the first responders at the Hall until they were asked to do so approximately eight minutes later. It may be that structured systems and guidance in relation to communication between responders at all areas of a major incident could help minimise potential delay to emergency medical treatment in situations such as this.

64. **Recommendation (R28): Assess and revise policy and procedure in relation to communications between emergency workers on the scene of a major incident, in order to minimise any delay in access to casualties by medical teams.**

65. MC29. The LAS Marauding Terrorist Attack Standard Operating Procedure indicates that a simplified triage procedure should be used in a warm zone: i.e. 'dead' or 'alive'[85]. This appears to be the system that Nicholas Eve was using on the scene at the time, as he was assigning the appropriate tags to the casualties, and further decisions were then taken to remove those who were alive from the scene.

66. In this incident, Nicholas Eve checked Saskia Jones' injury and asked those present how long resuscitation had been going on for. The answers were slightly varied: at first, the officers told him that resuscitation had been ongoing for 5 to 10 minutes, but then Adam Roberts indicated that there had been resuscitation attempts for longer than that. Nicholas Eve cannot be seen on video footage checking Ms Jones' airways or her pulse.

67. It is unclear whether the simplified triage procedure allows decisions to be made purely on one sign of life – i.e. breathing. In addition, Nicholas Eve accepted in evidence that he was unaware that Ms Jones' chest had been seen to rise and fall before he arrived, although he added that this would not have affected his assessment.

68. In order to ensure clarity in relation to the simplified triage system, as well as consistency of approach, we would suggest that detailed guidance and training be provided to medical responders as to a) the circumstances in which a simplified triage system is to be preferred over the usual system; and b) the precise steps to be taken to determine whether the patient is alive or not (e.g. taking a pulse, examining an airway, attempting resuscitation

[84] *Supra* at footnote 79
[85] DC6173 at page 45

themselves) and the taking of information from third-parties on scene. The steps to be taken may well include a 'checklist' of questions to be asked of those on the scene, remembering that such persons may well often be lay witnesses suffering the trauma of the events, whose recollections or accounts may not be entirely accurate even if they share the desire to assist an injured person.

69. **Recommendation (R29): Assess and revise guidance (or training) in relation to the steps to be taken when using a modified triage system in a major incident, including information to be obtained by the medical responder at the scene.**

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RAMYA NAGESH

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29 June 2021