SIR ADRIAN FULFORD PC
SITTING AS NOMINATED JUDGE CORONER

INQUESTS ARISING FROM THE DEATHS IN THE FORBURY GARDENS TERROR ATTACK OF 20 JUNE 2020

JAMES FURLONG
JOSEPH RITCHIE–BENNETT
DAVID WAILS

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

Addressees

1. 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 Chief Constable of Thames Valley Police
    d) Berkshire Healthcare NHS Foundation Trust ("BHFT")
    e) Midlands Partnership University NHS Foundation Trust ("MPFT")
    f) Oxford Health NHS Foundation Trust ("OHFT")
    g) NHS England

Coroner

2. I am Sir Adrian Fulford PC, and I heard these Inquests (having held office as a judge of the Court of Appeal) following nomination by the former Lord Chief Justice, Lord Burnett of Maldon, pursuant to Schedule 10 to the Coroners and Justice Act 2009 ("CJA").

Coroner's Legal Powers

3. I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

The Investigation, the Inquests and the Circumstances of the Deaths

4. The Inquests to which this Report relate concerned James Furlong, Joseph Ritchie-Bennett and David Wails who were murdered by [redacted] ("KS") on 20 June 2020 in Forbury Gardens, Reading, Berkshire.

5. The Inquests were heard at the Central Criminal Court between 15 January 2024 and 23 February 2024. I delivered my Factual Findings on 26 April 2024. These can be found at:

   https://www.judiciary.uk/wp-content/uploads/2024/04/Forbury-Gardens-Factual-Findings-for-Publication.pdf

6. The three Records of Inquest additionally can be found at:

   https://www.judiciary.uk/wp-content/uploads/2024/04/Record-of-Inquest-WAILS-D.pdf

   https://www.judiciary.uk/wp-content/uploads/2024/04/Record-of-Inquest-FURLONG-J.pdf

   https://www.judiciary.uk/wp-content/uploads/2024/04/Record-of-Inquest-RITCHIE-BENNETT-J.pdf

7. In each case the medical cause of death was a fatal stab wound. On 11 January 2021 at the Central Criminal Court KS pleaded guilty to the murders of James Furlong, Joseph Ritchie-Bennett and David Wails for which he received three

"whole life" sentences. He additionally pleaded guilty to the attempted murders of [redacted], which also occurred on 20 June 2020.

8. As set out in the Factual Findings and the Records of Inquest, the deaths were the result of a premeditated attack by KS. His intention was to take multiple lives within a short timeframe, thereafter escaping. His purpose was to advance a terrorist Islamist cause. He was not suffering from a mental disorder or mental disability which lowered his degree of culpability although he had developed post-traumatic stress disorder ("PTSD") symptomology and an emotionally unstable and antisocial personality disorder ("EUPD"), characterised by mood instability, impulsivity, irritability and aggressivity. It was accepted during the Inquests that "*working diagnoses*" of EUPD and symptoms of PTSD were reasonable.

9. In 2011, KS, following military training, fought for at least 8 months as a member of the extremist Islamist militia, Ansar al-Sharia, during the uprising against the Gaddafi regime and after its fall. During the present attacks in Forbury Gardens, he used his combat experience to target a vulnerable area on each of the three deceased (the neck or the left subclavian artery and left common carotid artery).

<u>Coroner's Concerns</u>

The Failures that Contributed to the Deaths

10. The critical context of this Report is that there were notable failures on the part of multiple bodies which both probably and possibly contributed to the three deaths. These have been explained *in extenso* in my Factual Findings. In summary form, however, there was a failure to:

    a) assess the intelligence in its entirety (there was an extensive intelligence history concerning KS's extremism and capacity for violence) and then share the intelligence appropriately; instead – certainly on occasion – limited pieces of information only were made available, which were thereby rendered potentially misleading;

    b) address the substantial consequential risks created by this lack of dissemination of the overarching intelligence picture (which included KS's extremist views and associations, military training and violent impulsivity, which were potentiated by his personality disorder);

c) provide an adequate and integrated response to the true risk posed by KS, based on a consideration of the entirety of the relevant material; and

d) offer KS adequate mental healthcare in the community and secondary mental healthcare in prison.

11. These failures principally involved the Home Office, Counter Terrorism Police South-East ("CTPSE"), HMPPS, BHFT and MPFT. There were concurrent deficiencies in the approach adopted within the **Prevent**, **Pathfinder** and **MAPPA** schemes. A common enduring error during the relevant period was the tendency to downplay or discount KS's extremist risk on account of his EUPD and symptoms of PTSD.

12. I have been assisted by detailed evidence from these organisations on changes to policies, practices, and structures as a result of reviews following the attack in Forbury Gardens and earlier terrorist-related incidents including the Fishmongers Hall attack. It is still the case that during the course of the inquest the evidence revealed matters giving rise to significant concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The failure to maintain and disseminate an adequate intelligence picture (the Secretary of State for the Home Department, the Secretary of State for Justice, the Chief Constable of Thames Valley Police)

13. Between [13] and [41] of my Factual Findings, I rehearsed the numerous occasions when it was reported (frequently by KS himself) that i) he was (certainly, in the main) motivated by an Islamist terrorist ideology, ii) he had received military training, iii) he had personally fought during a violent civil war, iv) he had a long record of violent impetuosity and v) his behaviour notably deteriorated when he was in crisis. I concluded at [40], "*the matters* […] *concerning KS's history and ideological statements were, or should have been, available to all the key state agencies who had substantive dealings with, or were responsible for, KS, particularly given the context of his serious mental health problems, his extremism and the high/very high risk he posed to the public*". Indeed, KS ought to have been assessed as posing a very high risk to others in the community in the period following his release from prison on 5 June 2020, given the totality of the intelligence picture as recorded by different bodies and agencies, which was, or should have been, available.

14. It is to be stressed in this context that during her evidence, [redacted] (the Head of Probation National Security Unit (East and South Central)) accepted she had been unaware, for instance, of KS's link to Ansar al-Sharia, his potential psychopathic tendencies, and the extent of his sometime grievances against the UK. If she had been more fully informed of these and other factors, HMPPS's view of KS's risk level could well have changed to very high risk. That could have led to him being designated a Critical Public Protection Case ("CPPC"). He may well, additionally, have been managed at MAPPA level 3. This in turn could have altered his licence conditions, the approach taken to Approved Premises and the level of contact with KS. As a CPPC MAPPA 3 case with an identified terrorist risk, his recall to prison and detention for breach of his licence conditions would have been effected within a timeframe of less than 2 hours.

15. Bearing the above factors in mind, the combination of KS's renewed use of cannabis and the extreme statements he made on 19 June 2020 (*viz*. to his brother that "*he is going to go to heaven* […] *he is going to harm himself and others. He said he was going to blow himself up* […]") should have led to his immediate recall to prison. Instead, the relevant members of the probation and police services on 19/20 June 2020 were simply unaware of the true nature of the risk that KS posed; indeed, as a consequence of this lack of knowledge, the threats made by KS were not shared with the probation service by the police. Given the speed with which recall can be effected in circumstances such as these, taking this step would probably have avoided the attack. As a separate matter, there was also a failure by CTPSE to share relevant information with MI5 – see [270-271] and [276] of my factual findings.

16. I note that steps have been taken since the attack in Forbury Gardens to rectify the intelligence and risk assessment failures identified above. The "CT Step Up Programme" was rolled out in September 2020. Its aim is to "*transform*" HMPPS's capability and capacity to manage and reduce the national security risk of those under the supervision of HMPPS and it "*covers the full spectrum of control, rehabilitation and intelligence capabilities across both prison and probation*". As part of this Programme, a "Joint Counter Terrorism Prison and Probation Hub" was created in around August 2020. Its core function is to co-ordinate "*quicker and better information and intelligence exchange between operational partners*". The National Tactical Management Command was set up within the Joint Extremism Unit ("JEXU") and is now co-ordinating the allocation of all high-risk terrorist offenders across the prison estate. The Counter Terrorism Assessment and Rehabilitation Centre ("CT-ARC") was established in response to the diverse and changing nature of terrorist offending or threat. It commenced full operations in September 2022 and has specialist staff drawn from psychology, probation, research and quality assurance backgrounds. The

National Security Division ("NSD") of the Probation Service was established in late 2020, with a specialist multi-disciplinary workforce trained to monitor and manage terrorist offenders, serious organised criminals, and CPPC offenders.

17. Assistant Chief Constable ("ACC") Metcalfe set out extensively in his statement the many and various steps taken by CTPSE to address the failures in intelligence sharing and assessing risk, to which I have made partial reference below.

18. The failure to handle the intelligence concerning KS appropriately had a notable impact on the **Prevent**, **Pathfinder** and **MAPPA** processes. In my view none of them contributed positively to the handling of KS. This was particularly the case given there was a wholesale failure to revisit and review the overall intelligence and risk assessment picture in light of newly acquired information. Indeed, each assessment took the most recent piece of intelligence as the starting point, with the risk that prior intelligence (*e.g.* the Ansar al-Sharia/Omar Brooks link) was overlooked and was not reflected in the assessment of the current threat. ACC Metcalfe expressed the clear view that when revisiting intelligence, the officer needed not just to consider the last report but the totality of the material, to check the assumptions previously made. As a consequence, ACC Metcalfe accepted that the failings in this context fell far below the standard necessary.

19. Addressing **Prevent** first, the four referrals to **Prevent** were closed, certainly in part, because of the widely accepted assessment that any risk posed by KS was based on his mental health difficulties, as opposed to an adherence to an extremist ideology. It is critical for the future that these bodies are provided with a properly considered assessment of the risk posed by the individual under consideration. There was a persistent lack of understanding of KS's sometimes inconsistent but nonetheless persistent extremist/terrorist mindset which regrettably permeated the approach to him throughout the period under review. DS ██████ accepted that if he had known the full background, such as KS's association with Ansar al-Sharia and Omar Brooks, this might have changed his assessment, leading to the conclusion that KS was vulnerable to being drawn into terrorism.

20. The evidence additionally revealed notable failures of training, supervision and selection in this important work by **Prevent**. There was some very poor work and a marked failure in supervision and support. The overall standard of **Prevent's** dealings with KS's case was not acceptable (see, for instance, [145] and [146] of my Factual Findings).

21. As set out in my Factual Findings at [145], it has been indicated that improvements have been made since 2020 in a number of areas, which have included the Home Office establishing a new joint enhanced casework team. This team is to work alongside a wide range of "*partners*", including the police, local authorities and the immigration system, and its role, *inter alia*, is to identify and manage individuals displaying early indications of extremist and radicalised behaviour or a vulnerability to such influences. It is acknowledged there is still work to be done, for instance "*around the interface between the Prevent system and the mental health system*". [redacted], the Director of Prevent, agreed that mental health should never be a reason not to make a Prevent referral. I am encouraged that these issues are seemingly being substantively addressed but it is vital that the Secretary of State for the Home Department ensures there is effective monitoring as to whether the steps that have been taken have rectified the particular deficiencies I have identified.

22. Turning next to **MAPPA,** meetings concerning KS occurred on 3 August 2018, 7 September 2018 and 4 October 2019. They were characterised by i) the failure on 3 August 2018 properly to characterise KS (he was designated as Category 3 Level 1 which does not exist), along with misconceptions about mental health provision (e.g. OHFT Pathfinder) and an absence of CMHT staff to correct those misconceptions; ii) the failure on the part of BHFT, at least from 7 September 2018, to send appropriate attendees (leading, *inter alia*, to an overly restrictive focus on PTSD, ignoring KS's personality disorder); iii) the absence of other stakeholders who could have assisted, such as representatives of immigration enforcement and CTPSE; iv) the incorrect decision on 7 September 2018 to remove KS from MAPPA (there were outstanding actions); v) a wholly deficient report sent by [redacted] (based, in turn, on comments by [redacted]) for consideration at the meeting on 4 October 2019, in which it was stated that there was no evidence to suggest that KS's crimes were rooted within terrorism or extremism; vi) a failure to obtain relevant prisons intelligence and vii) a failure to bring KS back to MAPPA before his release in 2020. It was also suggested that the main priority was addressing and stabilising his mental health issues by treating his PTSD, given this was the trigger for his violent outbursts.

23. There have been changes instituted since the attack in Forbury Gardens. By way of example, HMPPS Psychology Service Group "*support*" is now located within the Probation Service NSD with a senior forensic psychologist located in each NSD unit. NSD psychologists provide psychological consultations on cases with Specialist Probation Practitioners and Senior Operational Leads in the probation regions. NSD psychologists play a role within MAPPA meetings, in the sense of assessing risk and contributing to case plans by assisting with risk management, including release planning. As ACC Metcalfe additionally

explained in his comprehensive statement and evidence, a significant number of changes have been made by Thames Valley Police ("TVP") since these events. Simply by way of example, notification flags are now used by TVP on the Niche Record Management system to provide MAPPA with relevant information; there is now a defined process at the end of MAPPA supervision; information sharing has been improved between TVP and probation along with training for officers within CTPSE. There have been many other detailed changes which I have not set out herein, albeit I note steps have also been taken to address the fact that KS's MAPPA status was not obvious to police officers and staff, and there have been adjustments to improve the quality of investigations.

24. Notwithstanding this extensive evidence, given the extent and seriousness of the lack of adequate assistance provided to KS as regards his serious mental health difficulties, I remain concerned that a risk of future fatalities still subsists in relation to which action should be taken. **MAPPA** is the responsibility of the Prison and Probation Service and the police, and I encourage the Secretary of State for Justice and the Chief Constable of Thames Valley Police to work together to ensure that the deficiencies identified above concerning procedure, information sharing and the approach to intelligence and risk assessments have been comprehensively addressed, in light of the suggested improvements to the system. If the true position in relation to KS had been appreciated, I anticipate **MAPPA** would have been active in attempting to secure long term psychological intervention and further measures would have been in place in relation to the management of KS's risk (e.g. advanced steps in relation to recall before his release from prison in June 2020). In my view it is important that adequate monitoring is in place to ensure that the inadequacies I have identified have been rectified.

25. Finally, addressing **Pathfinder**, although KS's case was discussed at Community and Prison **Pathfinder** meetings, at no stage was he provided with any substantive assistance as a result. One feature that struck me as being of particular importance is a well-timed final review of a prisoner such as KS, sufficiently in advance of their release. As a former Pathfinder "*nominal*" (but in "*dormant review*" on the suggested basis that the risk he posed had been explored and addressed to the extent possible), KS should have been reassessed prior to his release in June 2020 but this did not happen.

26. It follows that the involvement of **Pathfinder** did little or nothing to mitigate the real risk that KS posed. Most particularly, **Pathfinder** did not assist in securing the assistance he needed for his serious psychiatric problems. As explained in summary below, the steps that have been taken since the events

in Forbury Gardens are, at least to an extent, reassuring but they tend to underscore the deficiencies that existed at the time of KS's attack.

27. At [204] of my Factual Findings I rehearsed the improvements that have been made since these attacks in Forbury Gardens. For instance, in March 2021 the Dormant Review Standard Operating Procedure was introduced. In June 2022, HMPPS and NHS England issued Guidance for healthcare staff entitled "*Increasing the Engagement of Prison Integrated Healthcare Teams in Pathfinder*". This was a result of JEXU's Review of the Mental Health Provision in the context of national security after the Forbury Gardens incident. The review identified the need to improve the engagement of healthcare teams in **Pathfinder**. In October 2022, the Pathfinder Guidance Framework Operational Delivery Guidance was issued alongside the Operational Delivery Guidance. Since 2020, certain changes have been made to assist the counterterrorism "*sector*" (particularly **Pathfinder**), with the identification and ongoing management of foreign national offenders. For instance, within Thames Valley additional training in the Pathfinder processes is now being provided. The Prison Prevent Lead for HMP Bullingdon is involved in training prison staff on the Pathfinder processes, which includes Prison Prevent Leads dealing with new intelligence concerns for an individual on dormant review, given they attend Pathfinder meetings.

28. [redacted] (the then Regional Counter-Terrorism Lead for Thames Valley) and [redacted] testified that there is a new Pathfinder IT process, including "*a single platform*", for custody and community practitioners to use. It is said that this is now much clearer in relation to non-TACT offenders who historically have posed a risk and might require a further conversation at a Prison Pathfinder meeting before release. It additionally provides alerts as to when a prisoner's release date has changed to allow planning for release to start as soon as possible. [redacted], the Head of the Security Department at HMP Bullingdon, similarly testified that processes are now in place to ensure that this always happens.

29. Notwithstanding this evidence, given the extent and seriousness of the lack of adequate assistance provided to KS as regards his serious mental health difficulties, I remain concerned that a risk of future fatalities still subsists in relation to which action should be taken. Most particularly in my view, it is critical that Community and Prison **Pathfinder** meetings are furnished with reliable and properly informed intelligence and risk assessments, and that they react appropriately to the information provided. **Pathfinder** is a Prison and Probation Service led, multi-agency process. It is, therefore, the responsibility of the Secretary of State for Justice. I strongly recommend that proper

monitoring takes place in this context to ensure the effectiveness of the **Pathfinder** system.

30. My overall conclusions as regards **Prevent**, **Pathfinder** and **MAPPA** were set out at [228] of my Factual Findings:

> "I am of the view that neither Prevent nor Pathfinder nor MAPPA provided any intervention of utility during the material stages of this case – when KS was in the community and when he was in prison – to address the threat he posed on account of the combination of serious mental health problems and the extremist risk that he posed, a risk that was, or should have been, well known. Indeed, the particular danger he presented was repeatedly emphasised, including that he could become a "*lone actor*", but there was no effective intervention. I agree with [redacted] that MAPPA, and, I would add, Pathfinder should have been active in securing mental health assistance in the community and in prison. The steps that have been taken subsequent to the events in Forbury Gardens in June 2020 and other terrorist-related events are perhaps a measure of the substantive acknowledgement of the failings in this regard. [redacted] recognised the prison and probation services were working as separate entities in this context – the system was "*under-resourced* (and) *non-integrated*". The difficulties included the fact that the community offender manager (*e.g.* [redacted]) had no direct access to the prison MIRs, albeit some of this information might reach her indirectly. As of June 2020, there were about 90 records concerning KS on the system involving reports of his involvement with drugs, violence, weapons, extremism, bad behaviour and self-harm."

31. It is self-evident that this is a wholly unsatisfactory state of affairs, common to the three agencies.

The failure to provide KS adequate mental healthcare in the community and to provide KS adequate secondary mental healthcare in prison (the Secretary of State for Justice, Berkshire Healthcare NHS Foundation Trust and Midlands Partnership University NHS Foundation Trust)

32. In my Factual Findings, I determined that BHFT failed to provide KS adequate mental healthcare in the community and MPFT failed to provide KS adequate secondary mental healthcare in prison.

33. It is to be stressed that consistent case-management/care coordination and long-term therapy provided a real potential to reduce KS's aggressivity, impulsivity and substance abuse, along with his offending, between 2015 and

2019 (albeit the impact this would have had on his extremist beliefs is more difficult to determine). There was a real risk that on his release from prison on 5 June 2020 he would commit a violent offence, and this included the risk that he could kill someone, and I have concluded that it was at least possible that this risk could have been avoided if KS's psychological difficulties had been addressed over the long term, both in the community and in prison.

34. MPFT correctly decided in December 2016 that psychology sessions were appropriate for KS on the basis that although the recovery process could take time, if he was persistent, patient and open to trying different approaches, it would have been possible to identify the most effective treatment/skills to enable him to "*take back the control*". Whilst recognising that for a brief period in February 2017 KS wanted to concentrate on his impending release, he was never offered psychological intervention during his repeat periods in prison, partly as a result of the failure to restore him to the waiting list and partly because of an unfounded assessment that he was unwilling to cooperate.

35. At [140] of my Factual Findings, I highlighted five particular failures by BHFT Community Mental Health Team ("CMHT") that merit focus:

    i) There was a failure to recognise that the CMHT should play a treatment role in helping KS gain stabilisation, for instance by providing low level psychological assistance and coordination of the services necessary for treating his mental health and by formulating a medium to long term treatment plan. Instead, he was referred to other bodies via various suggested "*Pathways*", all of which were unable to assist. This resulted in KS being caught in a "Catch 22" dilemma (*viz.* as a result of his personality disorder and/or PTSD, he abused alcohol or drugs but this rendered him permanently ineligible for treatment).

    ii) CMHT should have communicated with the relevant agencies in clear terms as to the extent or lack of care coordination they could provide, identifying particularly the areas where there needed to be input but CMHT did not have the ability to take on the particular role.

    iii) To the extent that KS's needs were social needs, most particularly his consumption of drugs and alcohol, there was a failure by CMHT to communicate adequately with the other relevant agencies the consequential limits of the treatment the Trust could provide.

    iv) There was a wholesale failure to resolve the differences between the professionals that arose as to the approach that should be taken to KS, most vividly exemplified by the effective stand-off between [redacted]

and CMHT. It meant that there was no senior determination by a director, the Positive Risk Panel or via some other mechanism as to whether [redacted] concerns were valid and whether his recommendations should prevail.

v) The failure to accept any responsibility for KS prior to coming out of prison because he had not been on the CMHT caseload when he went into custody.

36. These were, in my view, serious failings, but BHFT has helpfully set out the manifold and substantive changes that have been implemented since these tragic events. There have been substantial changes to the Care Programme Approach and care coordination, which are now governed by the Community Mental Health Framework ("the Framework"). The Framework was published by NHS England in 2019 and its objectives are to develop new and integrated models of community mental health care. The Framework acknowledges that community mental health services needed transformational change in light of the lack of alterations to the model over 30 years. The Framework proposes moving away from the "*siloed*", "*hard-to-reach*" services towards a more integrated model. It advocates breaking down the barriers between mental health and physical health and between health, social care, voluntary, community and social enterprise organisations and local communities (something the British Red Cross suggested had been missing). It encourages primary and secondary care to deliver integrated, personalised, place-based and well-coordinated care.

37. Critically in my view, in July 2021, NHS England indicated that everyone in need of mental healthcare should be allocated a named 'key worker'. BHFT has responded by publishing a programme named "One Team". This encapsulates new ways of approaching care in order for GPs, mental health teams, local authorities, and other support organisations in the community to work more effectively together, ensuring that patients can receive the care they need in a timely way without having to navigate confusing systems. This has many elements, but it includes a named key worker.

38. In light of [redacted] evidence that the British Red Cross were not informed on a consistent basis via MAPPA meetings, or by other routes, as to vital information concerning KS – perhaps most importantly the extremist risk he posed – in my view it is critical that information sharing, to the fullest possible extent permissible, should form a part of these new ways of working. This is vital for ensuring the individual is dealt with appropriately and increases the opportunities for protecting the organisation's staff and the public.

39. The previous model of teams of mental health professionals are to be replaced by multi-agency teams with a particular focus on ensuring that information about a patient is not lost or misunderstood. I have seen the status update for "One Team" dated September 2023 and this tends to indicate that transformational change is underway. As applicable to the present case, [redacted], on behalf of BHFT, has accepted that in KS's case if the One Team approach had been in place, there would have been clearer access routes into Mental Health care and less confusion for those such as KS's Probation Officer when she attempted to refer into BHFT's services. A "*psychologically informed*" key worker, either from BHFT or a partner agency would have offered him consistent input, if he was willing to engage, and would have provided the relevant agencies with a single point of contact. The assigned key worker will in future attend MAPPA meetings, along with the "*core member*".

40. Of considerable importance given my concerns at to what happened in the present case, those described as being in "*community connector roles*" are now well placed to help and encourage those in KS's position to use, for instance, drug and alcohol services. The new approach, furthermore, to those with personality disorders provides for a flexible and more inclusive approach and is intended to capture those not yet in a position to engage in formal therapy. BHFT is committed to formulating the individual's needs early on, with the assistance of any relevant outside agencies such as, in this case, the British Red Cross and the Probation Service.

41. Significantly, when tensions emerge as to whether someone should receive the support, for instance, of secondary mental health services, there is now a layer of decision-making to resolve any conflict.

42. There is essential agreement between [redacted] on behalf of BHFT and [redacted] that the use of concepts such as "*signposting*" and "*pathways*" had become unhelpful in the ways they were used, along with the too-frequent exclusionary response: "*not for our team!*". This understanding is critical, in my view, given the difficulties organisations such as the British Red Cross observed along, no doubt, with others navigating the complex mental health system in Reading and Berkshire via the common point of entry, the CMHT, the Crisis team, Berkshire Traumatic Stress Service, the adult social care mental health team and the local GP services. The roles and responsibilities were often unclear, and it was difficult to engage with even when referrals were made.

43. In the future, I have been assured the needs of those with EUPD and symptoms of PTSD, together with a long offending history, who have previously not been open to secondary mental health care at the time of going into prison will be

assessed, and appropriate assistance will be provided in anticipation of their release.

44. These changes, along with the others I have not described, appear promising, with one particular reservation. The changes reveal an appropriate understanding of, and a focus on, all the main matters that went profoundly awry in the present case. I strongly recommend that the Trust regularly assesses whether those who pose a major risk akin to that of KS will hereafter be included rather than excluded by medium and long-term mental health services, and that, within the inevitable limits of finite resources, they will receive the appropriate support, treatment and coordinated care they need. My single main reservation is that [redacted] on behalf of the British Red Cross indicated that he had not noticed any significant change in terms of access to mental health care, particularly via care coordinators, since these changes started to be applied. This makes it all the more important that the effectiveness of these services is rigorously and regularly assessed.

45. As regards MPFT, they no longer provide secondary healthcare services in HMP Bullingdon and Huntercombe. Therefore, this Report (in this context) is directed primarily at OHFT; nonetheless it will be provided to MPFT who continue to provide services in other prison establishments. I have also directed that it is sent to NHS England so that appropriate national action in this area can be considered. [redacted], service manager for OHFT, was specifically asked to address the "*tracking*" of prisoners as they moved between prisons. It became clear during the evidence that there were wider issues with the shortage of staff in prisons to provide psychological treatment and with the processes to prioritise and track prisoners on the waiting list to ensure that they were seen (regardless of whether they transferred or not). As a result, and without criticism of her statement, [redacted] does not address the current position on the level of psychological services at HMP Bullingdon and HMP Huntercombe against the background of the previous failure by MPFT to provide these to KS at any stage whilst he was in prison. I suggest that for a prisoner demonstrating KS's risk factors, he should have been offered, within the limits of available resources, the opportunity to participate in long term psychology sessions. I request that this issue is addressed by OHFT in its response to this Report, in order to prevent future deaths.

The Failures that did not Contribute to the Deaths

46. There were other failures which did not contribute to the three deaths but which I consider had the potential to do so in the future. These have been explained *in extenso* in my Factual Findings. I have set these out in summary form below.

Immigration Status/Deportation Issues (the Secretary of State for the Home Department)

47. There were a series of failures by Home Office immigration teams in managing KS's immigration status. By way of two examples only, first, KS's visa expired on 28 September 2012, meaning that from that date he was an "*over-stayer*" and was unlawfully in this country. There was no system in place to identify this fact. Second, on 10 July 2015 the Criminal Casework Intake & Triage Team, in determining that KS did not meet the threshold for deportation, relied on guidance which was out of date by two versions. Had the correct policy been followed, deportation would have been considered on the grounds that removal was conducive to the public good (albeit this step at that point in time was infeasible).

48. As I observed in my Factual Findings, the Home Office needs to reflect with considerable care on the training requirements of the relevant staff along with the sufficiency of the systems and procedures that are in place, to ensure that correct decisions are made in this context on an accurate basis. The handling of KS's case fell, at times, far below the standard that could properly be described as acceptable. However, these failures, while serious, did not contribute towards the attack.

49. Given the multiple failures by the Home Office which [redacted] candidly accepted, various changes have been introduced:

    i) The Home Office re-introduced exit checks in April 2015. The vast majority (but not all) of passengers leaving the country on scheduled commercial international air, sea and rail routes now go through exit checks. The data collected is said to be providing the police and security services with information to help track the movements of known criminals and terrorists. With the introduction of e-gates and biometric chips in passports, the Home Office now has/will have a better audit trail now of those entering and leaving the country.

    ii) In 2018 Immigration Enforcement started development of a new workflow system to better manage and understand the cases they hold. In July 2022 a dataset of all those of interest to Immigration Enforcement was introduced called Define (the Population of Interest). This system triages cases from the Population of Interest for immigration action.

    iii) Without going into detail, since KS's application for Assisted Voluntary Return in September 2013 there have been, I am told,

significant changes to this programme which is now called the Voluntary Returns Scheme.

iv) A workflow tool now sends cases at the appropriate time to the correct team. This includes when a person becomes a failed asylum seeker, and the case is automatically routed to Returns Preparation (now National Returns Progression Command) to consider the next steps.

v) A Detention Gatekeeper was introduced in June 2016 to assess the suitability of all those referred for detention in this context, independently of those making the referral, bringing consistency and scrutiny to prevent potentially vulnerable individuals being detained.

50. On the limited evidence I have received, I am not able to assess whether these and other changes have been effective. I am told that had the issues in KS's case arisen now, his case would be assessed by National Returns Progression Command and the relevant safeguarding referrals would have been made. It is reassuring that steps are being taken, including with training and the creation of an independent casework unit, but the extent of the failures revealed in KS's case have profoundly called into question the ability of the systems then in place and the personnel operating them to handle the problem of those illegally in this country in an effective way. The Secretary of State for the Home Department should direct that the new systems are adequately monitored and evaluated to ensure that the problems that emerged in KS's case have been properly addressed.

Discontinuance of Proceedings (the Secretary of State for the Home Department)

51. On 29 May 2020, KS's impending prosecutions for being drunk and disorderly, criminal damage and assault on an emergency worker were discontinued, following a misapprehension by the Home Office that KS was soon to be deported. This was a clear failure by the Home Office as the decision was made on a plainly erroneous understanding of KS's immigration status and removability. This mistake had no impact on what occurred on 20 June 2020, but in different circumstances it could have been of real significance. Changes have been instituted, most particularly that such a request is only made to the Crown Prosecution Service when written approval has been provided by an assistant director (Grade 7). However, given the potential gravity of this error, it is my view that the Secretary of State for the Home Department should provide reassurance that systems are in place which will ensure that the right

information is before the relevant Grade 7, who in turn has received appropriate training to assess the prospects of removal in circumstances such as KS.

<u>Operation Plato and the FIM (the Chief Constable of Thames Valley Police)</u>

Operation Plato

52. The police handling of the scene in the immediate aftermath of the attack was admirable. I noted in my Factual Findings (at [318]) that both with the benefit of hindsight and based on the information available to Acting Detective Chief Inspector ("ACI") Turner at the time, it was the correct decision not to call Operation Plato. However, when Operation Plato was eventually called by Inspector Summers at 19.48 this step was unjustified given the information then available. I note that under arrangements since instituted, Operation Plato can only be declared by a Tactical Firearms Commander (who in practice is likely to be the FIM). I was struck during the evidence by the range of advantages and disadvantages in declaring Operation Plato, and it is of especial significance that this step can inhibit access by the emergency services to the scene of an incident at which individuals may be seriously injured or dying. It is of the upmost importance, therefore, that the Tactical Firearms Commanders have the appropriate skills and training to make properly informed decisions in this context, given their potential impact.

The FIM

53. I was notably troubled during the evidence by the potential for serious mistakes to have occurred because the FIM was at times, in a real sense, overwhelmed by the demands of the role. I note from the evidence that many of the problems that emerged on 20 June 2020 have been addressed for the benefit of future major incidents. Indeed, subsequent to the events in Forbury Gardens a new Contact Management Platform ("CMP") has replaced the UNIX log and this has seemingly resolved the problem of simultaneous messages being recorded by way of intersecting text. ACI ███ expressed the view that the CMP is "as good as it can (presently) get", in that there is now a more efficient display of information and the messages appear as they were sent, in the sense that the lines of text are not intermingled with other messages or information. Two assistants are now assigned to the FIM, along with a third individual who "walks the floor" to deliver messages. The number of FIMs in the force has increased from 8 to 10.

54. I am particularly concerned, however, that ACI ███ remains uncertain as to whether the new arrangements will sufficiently filter the incoming information, thereby leaving the FIM free to focus on the significant issues which require his or her attention. He considers that these new arrangements should be "stress

tested" rather than evaluating them by way of desk or paper exercises. It is my strong view that due regard should be paid by the Chief Constable to ACI [redacted] thoughtfully expressed concerns. He was an extremely impressive witness. As a consequence, I recommend that the relevant systems and the available technology are given careful scrutiny and that a rigorous and reliable process of evaluation of the new arrangements is put in place.

55. As I have set out above, these are matters for the Chief Constable of Thames Valley Police.

Action that should be taken

56. In my opinion action should be taken to prevent future deaths. I have made some observations above on areas where action may be taken. However, it is the duty of those receiving this Report to identify the action that should be taken to address the risk of future fatalities about which I have raised concern. I believe that the respective individuals and organisations have the power to take such action.

Your Response

57. You are under a duty to respond to this report within 56 days of the date of this report, namely by **15 July 2024**. I, the Judge Coroner, may extend the period.

58. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.

Copies and Publication

59. I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

a) The families of James Furlong, Joseph Ritchie-Bennett and David Wails
b) Reading Borough Council
c) South Central Ambulance Service
d) Practice Plus Group
e) Change Grow Live
f) British Red Cross
g) Reading Refugee Support Group
h) MTC Novo
i) The Crown Prosecution Service

60. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

61. I may also send a copy of your response to any other person who I believe may find it useful or of interest.

62. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest.

63. You may make representations to me, the Judge Coroner, at the time of your response, about the release or the publication of your response.

DATED:

20 May 2024

SIGNED:

Adrian Fulford