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

FACTUAL FINDINGS

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26 April 2024

Introduction

1. These Inquests have followed the sentencing of Khairi Saadallah on 11 January 2021. Saadallah ("KS" hereafter) had earlier pleaded guilty to the murders of James Furlong, Joseph Ritchie-Bennett and David Wails, in addition to the attempted murders of Stephen Young, Patrick Edwards and Nishit Nisudan on 20 June 2020.

2. He was sentenced by Mr Justice Sweeney, sitting in the Central Criminal Court, on the three counts of murder to terms of life imprisonment, which are to be served as whole life orders. For the three counts of attempted murder, he was sentenced to terms of 24 years' imprisonment. All these sentences are to be served concurrently.

3. At the commencement of the Inquests, I heard thoughtful, dignified and poignant descriptions of the deceased from Mr Robert Francis Ritchie (the brother of Joseph Ritchie-Bennett), Mr Gary and Mrs Janet Furlong (the parents of James Furlong) and Mrs Josephine Wails (Dr David Wails' mother) read by his brother Mr Andrew Wails. This evidence vividly demonstrated the unique contribution made by each of them to the lives of their families and friends, along with the inestimable loss to our society that has been occasioned by what occurred in Forbury Gardens on 20 June 2020.

The Approach

4. Paragraph 8(5) of Schedule 1 of the Coroners and Justice Act 2009 provides:

> "In the case of an investigation resumed under this paragraph, a determination under section 10(1)(a) may not be inconsistent with the outcome of […] the proceedings in respect of the charge (or each charge) by reason of which the investigation was suspended […]"

5. The impact of this provision, in my judgment, is that these Factual Findings should not undermine the factual basis of either the convictions or the sentences passed in the Crown Court. In paragraph 15 of the "Rulings and Directions by the Judge Coroner following the second Pre-inquest Review" on 5 June 2023, I concluded:

> "Applying a common sense and purposive interpretation of the expression "the outcome of the proceedings", it encompasses, in my view, not only the verdict of the court (whether by a jury or as a result of the accused's guilty plea) and the sentence imposed by the judge, but also, *inter alia*, the findings of fact that materially underpinned the

conviction and sentence. Undermining the factual basis of either of those decisions (*viz.* conviction and sentence) by way of an inconsistent determination by the coroner's court, would constitute a finding that was incompatible with the outcome of the criminal proceedings. Where, as here, the criminal proceedings result in a conviction rather than an acquittal, both the verdict of the court and facts materially underpinning the conviction and sentence will have been established to the criminal standard of proof by those proceedings."

6. These inquests have, therefore, proceeded on the firm basis of the findings of fact that materially underpinned the conviction and sentence. As a result, I have quoted hereafter, as appropriate, from the relevant conclusions reached by Mr Justice Sweeney.

7. Section 10(2) of the 2009 Act provides:

> "(2) A determination under subsection (1)(a) may not be framed in such a way as to appear to determine any question of—
>
> (a) criminal liability on the part of a named person, or
>
> (b) civil liability".

8. Neither these Factual Findings nor my determination within the Records of Inquest for each of the deceased will determine or appear to determine any question of criminal liability on the part of a named person. Where I refer in these Factual Findings to the criminal liability of KS, such references are all to the findings already made determinatively by Mr Justice Sweeney.

9. The next critical factor as regards the approach I have adopted is that all counsel agree that it would be appropriate to proceed on the basis that the enhanced procedural obligation under Article 2 of the European Convention on Human Rights ("ECHR") is engaged. As counsel to the Inquests have helpfully set out, Article 2, which states that, "*(e)veryone's right to life shall be protected by law*", carries two positive substantive duties for the state.

10. The first is the **<u>systems duty</u>** (sometimes referred to as the general duty), *viz.* an obligation on the part of the state to have appropriate legal regimes and administrative systems in place to provide general protection for the lives of citizens and persons in its territory. I accept there is a valid issue to be considered as to whether there has arguably been a systemic failure rather than simple negligence by an individual, and this will include any potential failure

to put in place suitable systems of working. The critical issue under this heading is whether, given the multiplicity and nature of the suggested shortcomings in the management and the treatment of KS, along with the failure properly to assess the extremist risk he posed, this went beyond a series of simple operational failures by those at ground level or their immediate supervisors. I am persuaded there has arguably been such a breach by one or more identified state agents of the systems duty and that the criminal proceedings – for the most understandable reasons – have not met the Article 2 enhanced procedural obligation.

11. The second positive substantive duty is the **operational duty**, *viz.* an obligation on the state to take operational steps to protect a specific person or persons when on notice that they are subject to a risk to life of a particularly clear and pressing kind. Critically, this duty is not limited to those individuals whose identities are known to the state authorities at the time. Instead, the duty can extend to the public at large or a particular section of the public. A real risk is one that is more than remote, and an immediate risk is one that is present and continuing. This is not to be judged with the benefit of hindsight. In the context of the present case, it would be sufficient that the deceased lost a real and substantial chance of survival as a result of the failure to take measures. Although the threshold will not be satisfied merely because of an offender's previous convictions, in this case it is arguable that the particular combination of KS's recent violent offending, his known extremist background, the failure adequately to treat his mental ill-health, the breakdown in the sharing of information as to his extremist tendencies, the inadequate assessment of the high/very high risk he posed, together with the failure to recall him for breach of his licence conditions on 19 June 2020 indicate that arguably there was a breach of this operational duty.

12. These conclusions have had a significant impact on the approach that I have taken to drafting these factual findings and my conclusions within the Record of Inquest for each of the deceased. The fact that the enhanced procedural obligation is engaged means that I must reach conclusions not just on the question of "*by what means*" each of the deceased died but as to the questions of "*by what means and in what circumstances*" the deceased came by their deaths. There have been identified a number of significant matters which, if they had been handled in a different and more appropriate way, arguably could have avoided KS "*finally settling on jihad as the solution to his turmoil*" (in the apt words of Detective Chief Superintendent (DCS) Wright) or having the opportunity to do so. The critical question, therefore, is whether these deaths could have been avoided if better and more sustainable decisions had been taken in the management of KS at key junctures?

KS's background and information concerning him, as held by the authorities

13. KS was 25 at time of the attacks. He was born in Tripoli, Libya. Mr Justice Sweeney described KS's involvement in violence in Libya during the period leading to the overthrow of Muammar Gaddafi as follows:

    > "In 2011, as a teenager in Libya, the Defendant was trained to fight and fought (for a period of at least 8 months) as a member of the extremist Islamic militia Ansar al-Sharia (which is now proscribed in this country) – doing so both during the uprising against the Gaddafi regime and after the fall of that regime."

14. The Home Office immigration records reveal that KS arrived lawfully in the United Kingdom ("UK") on 5 April 2012 with his father on a visitor's visa. His visa was annotated to state it was only valid if he was accompanying his father. The latter travelled out of the UK on 7 April 2012 and then returned on 4 September 2012. Although KS stated that he also left the UK, the Home Office does not hold any record of KS leaving or re-entering. He was in the UK on 10 September 2012 because the Reading Refugee Support Group was supporting his claim for asylum by that date. KS in due course informed the Home Office that he had returned to the UK on 3 September 2012. His visa expired on 28 September 2012, meaning that from that date he was an "*over-stayer*" and was unlawfully in this country. Jane Sutton, Director of the Foreign National Offenders Returns Command at the Home Office, accepted that it was a failure by the Home Office that there was no system then in place to highlight this fact.

15. **PFD**: This latter issue will form part of my Preventing Future Deaths ("PFD") report to the Secretary of State for the Home Department.

16. On 16 October 2012, KS attended the Asylum Intake Unit in Croydon to apply for asylum. During the interview which formed a part of this process, he provided certain details of his military service with a militia in Libya. On 9 November 2012, at his subsequent asylum-screening interview with the Home Office, KS explained he had been a member of "*Liwaa Tripoli*", which was part of "*Katibat Ansar al-Sharia*". He produced a military ID card for the "*Ansar al-Sharia Regiment*". Ansar al-Sharia was a group that had close links with the Islamic State. He indicated that between 14 February 2011 and 25 October 2011 he had been involved in the anti-Gaddafi uprising, fighting in Benghazi with a militia that came to be known as the "*17th February Martyrs Brigade*". He repeated this claim to police officers in Manchester in March 2015. He said he returned to Tripoli two days after it fell to the rebels, to be met with threats against him by members of Ansar al-Sharia.

17. At his full asylum interview on 20 November 2012, he said that if he returned to Libya "*they will kill me*". He indicated he had fought against the government, assisted the wounded and delivered weaponry to the battlefield. He denied having used weapons but images introduced in his asylum appeal and later found on his telephone, as set out at [39] below, indicate this was not true. He maintained that in 2011 he had been ordered to torture a woman on behalf of Ansar al-Sharia but had refused. I note at this stage that in 2014 the UK proscribed Ansar al-Sharia as a terrorist organisation.

18. On 9 November 2016, KS was detained for assessment and taken to a place of safety (*viz.* Prospect Park Hospital). Marnie Robinson who is employed by Berkshire Healthcare NHS Foundation Trust ("BHFT") as a Team Lead was one of the assessors. KS highlighted that he had been trained as a child soldier and had killed people. He had felt persecuted by the British population. He said that he was going to set fire to people and kill them, given he was able to make TNT explosives and he had petrol.

19. On 9 November 2016, KS described to Dr Ahmad, Consultant Psychiatrist, how he envisaged killing others and then killing himself. He graphically described chewing his victims and drinking their blood. He said he would act in this way if discharged from Prospect Park Hospital.

20. Ms Robinson was informed on 16 November 2016 that KS had threatened to "*blow up the town centre and take people with him when he dies*".

21. A Thames Valley Intelligence Report dated 6 December 2016 indicated that KS "*intends to go back to Libya to avenge his family's deaths, who he says have been killed. His brother wants him to go out there and fight with him. (KS) can become quite aggressive and suffers from mental health issues as well as possible alcohol abuse*."

22. On 20 December 2016, a Counter Terrorism Police Standard Intelligence Submission set out:

> "(KS) previously fought in Libya for Ansar-Sharia based in Tripoli. (KS) does not wish to return to Libya as he does not want to be forced into fighting. (KS) witnessed a number of unpleasant incidents including torture whilst in Libya and as a result came to Europe to escape the fighting. His father brought him to the UK in 2000. (KS's) father is a wealthy businessman and used to work for the Libyan Foreign office. His father wishes for him to return to Libya as there are concerns regarding Saadallah being involved in criminality and drugs in the UK."

23. It became known that during January 2017, whilst at His Majesty's Prison ("HMP") Bullingdon, KS had been keen to associate with Trevor Omar Brooks, a convicted terrorist and a senior member of the proscribed terrorist organisation Al-Muhajiroun ("ALM"). Brooks, having been convicted of funding and glorifying terrorism, was in custody for breaches of his parole conditions. The Prison Service entered KS on their Pathfinder programme (not to be confused with the Oxford Health NHS Foundation Trust ("OHFT") Pathfinder service (see [192] and [193] below)). As part of the Prison Pathfinder programme, His Majesty's Prison and Probation Service ("HMPPS") collate and share information and manage risk in respect of prisoners who have committed terrorist-related offences and those identified as being vulnerable to extremism. The two men were separated and placed on separate wings. This intelligence was disseminated to the Police's South-East Counter Terrorism Unit ("SECTU"), the Special Branch Police Intelligence Officer ("SBPIO") and Rebecca Langley, the Prison Prevent Lead ("PPL"). Prevent is the government led multi-agency programme that aims to stop individuals becoming terrorists. The role of Prevent is described at [141] below.

24. In a Mercury Intelligence Report ("MIR") from HMP Bullingdon dated 20 January 2017, it was reported that KS had stated he wanted to return to Libya to "*fight the people who killed his family*".

25. The following was set out in a Thames Valley Police Intelligence Report for 26 February 2018:

> "(KS) no longer wants to return to Libya to fight in the conflicts over there. He now feels that this idea was both stupid and pointless. He still supports the International Libyan Army and wants stability for his country. He wants Libya to be a safe place for everyone. He wants democracy for Libya. (KS) does not support ISIS and thinks that they are "*terrible people*" or "*terrible Muslims*". He does not agree with anything that ISIS has done and he believes that no true Muslim would, as the Koran does not preach hatred and violence towards others. He used to participate in the revolution in Libya, which was against Colonel Gaddafi. (KS) has had military training and he has been taught how to use an AK47 assault rifle and other firearms some years ago but he has forgotten a lot of what he had been taught over the years."

26. A Prison Intelligence report dated 22 March 2018 suggested that KS was planning to return to Libya and start a revolution and come back to Britain to "*blow people up*".

27. On 31 July 2018, KS showed Christopher D'Aguiar, a probation officer and KS's then offender manager, four pictures on his mobile telephone of i) KS in Army uniform when aged 15; ii) an AK47 gun; iii) a picture of KS in Army uniform holding another gun; and iv) a picture of an unknown type of gun. He said that being shot was a good way to die and that terrorist groups would make him fight for them.

28. The following is contained in a Thames Valley Intelligence Report dated 17 November 2018:

> "On the 16/11/2018 (KS) was in custody at Loddon Valley police station. He was rambling on about being desperate to go back to his home country of Libya so he can shoot people and do things that he is supposed to do to "*support his kin*". He is frustrated by the fact that the Home Office won't deport him. He has 11 previous occasions where he has assaulted police. He told us he has just finished a stint in prison for assault police and he hates England mentioning Allah and his kin. He is currently living in a B&B? Not sure which one though he gave the address of 25 Russell Street. He was behaving in a very concerning way and possibly has mental health issues. He said if he didn't get deported by Monday he would commit suicide and die and make sure someone else dies in the process. He was on the over bridge of the IDR saying he wanted to kill himself. Some of the stuff he was saying was said under his breath and inaudible."

29. This intelligence was disseminated to SECTU, SBPIO and Rebecca Langley, the PPL.

30. On 3 December 2018 it was reported that KS had stated, following an arrest when he was carrying a knife, that he hated the UK and could "*easily*" shoot Theresa May, the then British prime minister. On 4 December 2018 he indicated he did not wish to return to Libya. Of particular relevance to the issues in these Inquests, he suggested that he suffered from mental health problems and was addicted to alcohol, with the result that when in a crisis he makes statements such as these but does not do so when "*well*".

31. It was reported on 21 December 2018 by Gemma Nunn, the head of adult safeguarding for BHFT, that KS had spoken about throwing grenades and killing children. He had stated that he did not care about his own life or others. As a consequence, it was posited that he was exhibiting psychopathic tendencies with traits of a lack of both remorse and a sense of responsibility.

32. In an MIR dated 28 March 2019, KS is recorded as stating he was a member of ISIS and that he wanted to be deported to Libya in order to continue fighting for that fundamentalist group. On 29 March 2019, further prison intelligence referred back to earlier reporting from 2017 which said that KS wanted to fight in Libya in order to get killed as a martyr because suicide was against the teachings of Islam.

33. On 30 March 2019 whilst in his cell KS wrote about how he had ruined his life at the age of 15 by running away to join ISIS.

34. On 31 March 2019, KS was reported as saying said he wanted to fight in Libya in order to get killed as a martyr. On the same day, KS said he wanted to return to Libya and that he would immediately join ISIS. However, in a later MIR on 25 April 2019, KS repeated his earlier account that he had been "*forced to carry out torture (of women) for ISIS*" and had been locked up for 48 hours when he refused.

35. On occasion KS had claimed to have fought for an army called the "*Rubbies"/"Rumbles*" which it was suggested wanted to get rid of ISIS.

36. On 26 July 2019, KS admitted to Emily Perrin, a Criminal Justice Liaison and Diversion ("CJLD") Practitioner, that he was likely to attack people when he felt under threat or in a state of hyperarousal.

37. On 22 August 2019, Mr McCarthy, a counter terrorism analyst at HMP Wandsworth, wrote to Tracey Lewis from the South London and Maudsley NHS Foundation Trust setting out that KS "*is a Libyan national who claims he is an active member of ISIS and members of his family have been killed in Libya which may be where the PTSD claims come from* […]".

38. KS's ideology and beliefs were described by Mr Justice Sweeney as follows in the sentencing remarks:

> "The Defendant held extremist Islamic views whilst in Ansar al-Sharia, and continued to do so, albeit with lapses (for example in relation to drink and drugs) up to and including the events on 20 June 2020 – as illustrated by his retention of militaristic images relating to his time in Ansar al-Sharia, his interest in the radical preacher Omar Brooks in January 2017, the images that he viewed in 2017, 2018, 2019, and (using a Huawei phone) in the run up to 20 June 2020 (it being no coincidence that resultant cached images in June 2020 included "*Martyrs of Volcano*

of Rage" and the Isis flag), and the writing that was found at his address, together with what he said whilst he carried out the offences and thereafter."

39. By way of partial, *ex post facto* confirmation of these general conclusions concerning KS, a mobile telephone was seized from him during one of his arrests in 2019, which he had been attempting to have returned to him. It remained in police custody and was examined on 16 September 2020 following the events in Forbury Gardens. It contained photographs of KS holding an AK-47 assault rifle and in military uniform, along with images of other foreign fighters. There was a further photograph of the text "*revenge is obligatory*", which was set alongside an individual with bloodied knuckles. There was an image of the flag which is often associated with ISIS.

40. DCS Wright (who led the post-attack police investigation) suggested that KS could be viewed as a complex individual; he had been radicalised in Libya and he had an enduring extremist Islamist mindset; and, as set out above, he "*finally settled on jihad as the solution to his turmoil*". I agree. On the basis of all the material I have considered, it is apparent that at the time of these attacks KS adhered to the fundamentalist and apocalyptic viewpoint of Ansar al-Sharia, which predicted the "*end times*" and a war between the armies of "*Rome*" and the armies of the Muslims, prior to the return of Jesus to earth. Indeed, as Mr Justice Sweeney set out "*(a)t the Police station he admitted, on a number of occasions, that what he had done was Jihad (in the sense used by extremists) and that as a result he was going to paradise*." DCS Wright acknowledged, importantly in my view, that historically and including at the time of the present events, motivations based on extremism, on the one hand, and mental health difficulties, on the other, were viewed as being mutually exclusive. It is now accepted that they can be interrelated. The matters set out above 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.

41. On the basis of the entirety of this information, therefore, spread over a number of years and notwithstanding some contradictory statements, KS in my view should have been treated as an individual who potentially adhered to a fundamentalist and terrorist ideology and whose past experiences demonstrated his ability to act with lethal violence. He had repeatedly indicated he had a terrorist "*mindset*" along with a capacity to kill. As developed later in these Factual Findings, the overall body of intelligence about KS was not fully re-assessed in light of newly acquired information; this was

accepted, for example, by Detective Sergeant ("DS") Spiers, a Counter Terrorism Police South East (CTPSE) Counter Terrorism Field Intelligence Officer. Furthermore, it appeared that 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 link) was overlooked and was not reflected in the assessment of the current threat. Although the risk KS posed at any particular moment would need to have been carefully evaluated, this background information was crucial to making realistic assessments of his threat to the public. Assistant Chief Constable ("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 and, as a consequence, he accepted that the failings in this case, discussed in detail hereafter, fell far below the standard necessary.

42. Finally under this heading, it is convenient to observe that although some members of the first group KS attacked were gay, there is no evidence to suggest that his actions were, perhaps additionally, motivated by homophobia. Although this may well have formed a part of KS's extreme Islamic fundamentalist mindset, there is nothing credible to suggest that the deceased were selected as targets in Forbury Gardens on the basis of KS's perception of their sexuality.

<u>KS's convictions/criminality</u>

43. On 18 July 2013, KS was arrested in Reading for possession of a bladed article. He was released with "*no further action*" being taken. On 16 June 2015, now aged 20, he was convicted of a racially/religiously aggravated public order offence for which he received a 12 months' conditional discharge. On 7 July 2015, he was convicted of attempted theft, battery and shoplifting. He was sentenced to 24 weeks' detention. On 26 May 2017, he was convicted of assaulting a police officer by spitting, assaulting a detention officer, battery, and affray. He was sentenced to 20 months' imprisonment. On 30 October 2017, he was convicted of assaulting a police officer and causing unnecessary suffering to an animal (he had damaged his brother's home and attacked the police officer and his dog when they tried to subdue him). He was recalled to prison vis-à-vis his last sentence and he additionally received an immediate eight-week custodial term. On 25 March 2019, KS was convicted of assaulting an emergency worker, being drunk and disorderly and possessing a knife in a public place, for which he received a sentence, following an appeal, of six months' imprisonment, suspended for 24 months. On 19 September 2019, KS was convicted of assault (he spat at the sentencing judge on 25 March 2019). He was sentenced to 10 weeks' imprisonment. On 14 October 2019, KS was

convicted of a range of offences: i) for a racially/religiously aggravated public order offence on 16 December 2018 (spitting at a black police officer), following an appeal he received a prison sentence of one month; ii) for possession of an offensive weapon (a knife in his waistband) and for carrying an empty wine bottle during the incident on 16 December 2018, he was sentenced to 5 months' imprisonment, to be served consecutively; iii) for criminal damage to a book whilst in custody on 17 December 2018, he was sentenced, following an appeal, to one month's imprisonment to be served concurrently; iv) for affray and battery (he struck a security guard in the face and spat at another, whilst also arming himself with a broken bottle) on 16 January 2019, he was sentenced to 7 months' imprisonment, to be served consecutively; v) for assaulting an emergency worker (kicking and spitting, after he had chased two men with a baseball bat) he was sentenced following an appeal to three months' imprisonment. At the conclusion of the appellate proceedings, his total sentence was 17 months and 20 days immediate imprisonment. He was released from HMP Bullingdon on 5 June 2020.

44. A cursory review of these convictions indicates a deterioration in his behaviour from late 2018 in that, as he had in July 2013, he once again started carrying offensive weapons in public (knives on two occasions and a broken bottle). More generally, he had demonstrated a propensity to attack others.

Periods when KS was imprisoned in the UK

45. KS was in custody in the UK on the following dates and at the locations indicated:

- 23 May 2015 – 14 August 2015 – HMP Forest Bank;
- 24 November 2016 – 12 June 2017 – HMP Bullingdon;
- 12 June 2017 to 22 September 2017 – HMP Manchester;
- 1 November 2017 to 1 May 2018 – HMP Bullingdon;
- 25 March 2019 to 4 June 2019 – HMP Bullingdon;
- 8 August 2019 to 19 August 2019 – HMP Bullingdon;
- 19 August 2019 – 21 August 2019 – HMP Wandsworth;
- 21 August 2019 – 13 September 2019 – HMP Bullingdon;
- 13 September 2019 to 16 September 2019 – HMP Wandsworth;
- 16 September 2019 – 12 February 2020 – HMP Bullingdon;
- 12 February 2020 – 6 March 2020 – HMP Huntercombe; and
- 6 March 2020 – 5 June 2020 – HMP Bullingdon.

The response to KS's mental health and behavioural problems

46. The history set out in this section includes only a selection from the extensive records and evidence relating to KS's mental health. I have focussed on the events which best illuminate the issues raised in these Inquests.

47. I have already referred to BHFT in considering information that was known to the authorities about KS. Throughout the relevant period, BHFT provided specialist mental health and community health services within Berkshire. In addition to acute in-patient wards such as those at Prospect Park Hospital, BHFT provided a Mental Health Crisis Service, the Crisis Resolution and Home Treatment Team ("CRHTT" or "Crisis Team") and a Community Mental Health Team ("CMHT"), with referrals being channelled through a Common Point of Entry ("CPE"):

- The primary role of the Crisis Team was to act as an alternative to admission to a mental health unit. It was a short-term team, providing a 24/7 service, and normally providing interventions for no longer than six weeks when a patient was in crisis.

- The CMHT provided treatment in the community for those with serious mental illness including those suffering from schizophrenia, post-traumatic stress disorder ("PTSD"), clinical depression and, in appropriate cases, personality disorders. Treatment was delivered in the form of Psychological Therapy, Pharmacology and Care Coordination, dependent on individually assessed need and willingness to engage. The CMHT had a number of sub-teams including Core Teams in the North and South of the Region, a team for Psychological Therapies which would include the Berkshire Traumatic Stress Service, and a team for Emotionally Unstable Personality Disorder (EUPD) psychological treatment.

- The CPE provided a single point of access for all mental health referrals into BHFT. The service provided a screening, triage and assessment function for all adult referrals. The CPE was run by mental health professionals who carried out the initial assessment and decided whether to refer the patient to the CMHT services or to elsewhere, such as Talking Therapies. Referrals to CMHT were always considered by a CMHT multi-disciplinary team, with the potential result that a Care

Coordinator would be appointed, along with a referral to a psychologist or psychiatrist.

48. There are two further aspects I should mention. The first is how those with a personality disorder fitted into this structure of mental health services. Martin Gill from BHFT agreed in evidence that in accordance with the Guidelines issued by the National Institute for Health and Care Excellence ("NICE") (28 January 2009), individuals with a personality disorder should not be excluded from any health or social care service because of their diagnosis or because they have self-harmed. Furthermore, consideration should be given to referring a person with a borderline personality disorder to community mental health services when their levels of distress or risk to themselves or others are increasing or have not subsided despite interventions. The Guidance additionally provides that Mental Health Trusts should develop multidisciplinary specialist teams and/or services for people with personality disorders. These teams should have specific expertise in the diagnosis and management of a borderline personality disorder and should provide assessment and treatment services for people with a borderline personality disorder who have particularly complex needs and/or high levels of risk. The potential for rapid fluctuations in mood with the more serious forms of personality disorder was highlighted, along with high levels of emotional distress which can lead to repeated crises involving self-harm and impulsive aggression. There will need to be a multi-disciplinary care and risk-management plan, along with consideration, when appropriate, of psychological treatment. Mr Gill indicated that in 2018 there were no policies in place for considering referrals in this context and instead decisions were taken by clinicians at the Referral Meetings (known as Multi-Disciplinary Team Meetings ("MDTs")).

49. The second aspect is that there was a material change to the organisation of the CMHT which came into effect in October 2018. Up until that time, the CMHT was an integrated service with BHFT staff working alongside Reading Borough Council ("RBC") staff. It was at that time jointly funded by RBC and BHFT. Organised in this way RBC employed social workers formed part of the same team as BHFT's Community Psychiatric Nurses and other professionals, and they were co-located in the joint team. They all used BHFT's RiO case management system. They rarely had recourse to the RBC's case management system, Mosaic. The social workers, Occupational Therapists and CPNs came under the umbrella term "*Care Coordinators*" and a named Care Coordinator would be appointed who could be from any of the relevant disciplines. The Care Coordinator used a Care Programme Approach Tool to carry out assessments. This involved an "*holistic*" approach to health, social care, and

financial, spiritual and educational needs. On the social care side, the joint CMHT team used the criteria for assessment as set out in section 13 of the Care Act 2014. They would focus on assessing an individual's social care needs and his or her basic personal care and household activities. This would sometimes lead to the appointment of a social worker and funding for such things as accommodation in a bed and breakfast establishment if needed, for instance following discharge from Hospital (this happened in relation to KS, as humanitarian assistance, when he was ineligible for state funding due to his immigration status). In addition, I should note that some of RBC's qualified social workers like Mr Sesay had appropriate training and qualifications to do shifts as Bank Staff for BHFT's Crisis Team.

50. From 1 October 2018, following a period of consultation and planning, the joint team separated. RBC considered that it would be better able to deliver its statutory duties through a dedicated Mental Health Social Care Team that was managed by the Council rather than by BHFT, with social workers focussing on the social care needs and related interventions rather than being involved in all assessments, consideration, delivery or monitoring related to a person's broader mental health treatment needs. The RBC formed a new Mental Health Social Care Team which was staffed by two senior social workers, five mental health social workers and two unqualified staff members who supported the qualified social workers. The BHFT team continued as a CMHT ("BHFT CMHT") but now without social workers embedded in the team and funded on its own. The intention was that the two teams would still work closely together.

51. Perhaps unsurprisingly, views on this significant change to the CMHT varied. Melissa Wise, the RBC Executive Director of Communities and Adult Social Care, explained in her evidence that RBC had been concerned that it had not been meeting, or could not sufficiently evidence that it was meeting, its adult social care statutory obligations, being drawn into the wider aspects of mental health care. Hristo Stoyanchev became Deputy Team Manager in the RBC Mental Health Social Care Team in or around October 2018 (thereafter, team manager in the summer of 2019). Focussing purely on his own responsibilities, Mr Stoyanchev considered the split had been useful because it meant his team could focus on social care. He described the functioning of the two distinct organisations from the perspective of RBC. BHFT CMHT were not provided with any direct access to the RBC Mental Health Social Care Team and any referral needed to be made through the "*Adult Social Care Front Door*". The referral was screened before eligible cases were passed to the Mental Health Social Care Team for allocation. For social workers like Isheka Sesay, his role became more focussed on social work and less on mental health. The RBC team

lost the easy access they had previously had to psychiatric assistance. They ceased using the RiO system and instead now accessed RBC's case management system, Mosaic.

52. Dr Bonner, BHFT's Clinical Director for Specialist Mental Health Services testified as to how "*very positive*" it had been when the two teams were located together and were integrated. Collegiate relationships were probably lost when the split occurred, along with the opportunity to have informal conversations about cases and to seek advice, based on a wealth of experience, skills and knowledge, albeit there was now a greater focus by BHFT CMHT on mental health needs.

53. As well as losing the benefits of co-location there were some difficulties in practice, including in relation to the attendance at meetings of MAPPA ("*Multi-Agency Public Protection Arrangements*") (the role of MAPPA is described at [210] below). The memorandum of understanding between BHFT and RBC that addressed how the new arrangements were to work specified that RBC would "*... send relevant representation to MAPPA ... meetings to provide a Social Care perspective, and will share information relevant to BHFT colleagues. BHFT will attend in relation to individuals that they are working with in accordance with good practice*."

54. Against this necessarily brief outline of the Mental Health Services, I turn to the illustrative examples from the chronology of KS's mental health treatment.

55. Mr Sesay first met KS on 24 September 2016 at Prospect Park Hospital when he completed an initial psycho-social risk assessment. KS had been referred by the British Red Cross and a GP to the CPE (because of his constant low mood, poor sleep, sense of being under threat, limited social activity, poor appetite, suicidal thoughts, flashbacks, nightmares/re-experiencing traumatic events *etc*.). The referral had been accepted. Mr Sesay assessed that KS was experiencing psychotic symptoms, hyperarousal and insomnia, along with obsessive suicidal thoughts. He concluded that KS needed to see the duty doctor immediately along with receiving "*continuous CRHTT short-term support*".

56. Mr Sesay discussed KS the following day with Dr Ahmad, consultant psychiatrist, during a case discussion at CRHTT. He explained KS's reported symptoms of recurrent suicidal thoughts, depression, hearing voices, difficulty sleeping and paranoia, against the background of his traumatic life experiences in Libya and in the UK. Dr Ahmad agreed that an urgent out-patient's appointment should be arranged for a psychiatrist/medication review at Prospect Park Hospital with a view to potential intervention.

57. On 26 September 2016, a referral for KS to join the Eye Movement Desensitisation and Reprocessing ("EMDR") therapy research project was refused. This was because he did not meet the referral criteria on account of the lack of stability in his living situation and the fact that he did not have a Reading General Practitioner. Furthermore, he was deemed to be "*too complex*" for this particular therapy: the EMDR project was based on a few sessions and was not long-term intervention (which KS needed).

58. Dr Ahmad saw KS on 27 September 2016. KS reported that he had left high school at about 16 to fight in the war, for about eight months. He had traumatic memories of the war, removing bullets from friends and fellow soldiers, transporting injured soldiers with severe wounds (sometimes over hundreds of miles) to safe hospitals. KS appeared to be very traumatised whenever he reflected on those experiences. Dr Ahmad diagnosed PTSD and possible underlying dysfunctional personality traits. His psychosocial situation was "*very challenging*" and may become "*complex*" due to his court appearances and his immigration concerns. His risk to others was considered at that time to be low but could increase given his previous history of aggressive behaviour and his experience of violence in the military. He was discharged from the Crisis Team on 4 October 2016.

59. On 27/28 October 2016, KS was the subject of a voluntary admission to Prospect Park hospital (these admissions frequently occurred over the following years). He was diagnosed with paranoid psychosis (possibly cannabis induced) and PTSD "*superimposed*" by a personality disorder. KS was willing to receive treatment via medication. The risk of further deterioration was considered to be high. He was discharged on 2 November 2016.

60. On 7 November 2016, Dr Ahmad was involved in a discussion with the home treatment team vis-à-vis the allocation of a Care Coordinator prior to carrying out a "*seven-day follow up*", following his discharge on 2 November 2016. Information as to the identity of the Care Coordinator was to be given the following day (*viz.* Ms Robinson).

61. When KS saw Dr Ahmad later on 9 November 2016, the latter noted that he had just become homeless (short term B&B funding apparently having been terminated). He had been very agitated at Prospect Park and head-butted a member of staff. As already rehearsed, he graphically described how he envisaged killing others and then killing himself. He depicted chewing his victims and drinking their blood. Dr Ahmad diagnosed an underlying personality disorder with antisocial elements and he surmised that KS's behaviour was driven by his homelessness. He was not detainable under the

Mental Health Act. The risk to others was considered medium to high, and the police were to be informed.

62. There was a multi-disciplinary meeting concerning KS on 14 November 2016 (Drs Ahmad, Levy and Mohammed). The doctors discussed KS's "*maladaptive coping mechanisms*", and his long-term use of cannabis, given his mental health problems were compounded by substance misuse. They emphasised the instability with his accommodation. It was recognised that there needed to be long-term plans for KS's management. Ms Robinson's care-coordination ended on 1 November 2017 when KS's case was closed. By coincidence, on the same day KS told representatives of the British Red Cross that he had drunk large quantities of alcohol and had stopped taking his medication. He felt paranoid about everyone around him and he wanted to kill himself and harm the people who had attacked him in Manchester two years earlier.

63. A snapshot of the support that had been offered by Ms Robinson as KS's Care Coordinator during the nine months she filled this role is provided by her attendance at Reading Magistrates Court with a junior doctor on 23 November 2016 to provide an assessment of KS and to support him through the court process. When he was remanded into custody, Ms Robinson liaised with the In-Reach Team at HMP Bullingdon, the legal team at RBC, the Red Cross and KS's brother. Mr Gill agreed that following the separation of services, if resources had permitted, BHFT would have considered maintaining this coordination role.

64. KS had significant dealings with the Midlands Partnership University NHS Foundation Trust ("MPFT") whilst serving sentences of imprisonment at HMP Bullingdon and HMP Huntercombe. Importantly, MPFT provided "*secondary*" mental health and psychosocial alcohol and drug services. These included, within the Secondary Care Mental Health provision, psychological and psychiatric support (albeit psychiatrist cover was effectively subcontracted to the OHFT by way of a "*secondment arrangement*"). The mental health services followed the Stepped Care Model. Whilst KS was a prisoner, the two prisons had a single clinical psychologist (Dr Kinga Komarzynska), an expert in complex trauma whose time was shared across the two prison estates (one day at Huntercombe and three days at Bullingdon each week). Dr Komarzynska offered, *inter alia*, Dialectical Behavioural Therapy ("DBT") which is designed to treat people with a personality disorder, to improve their way of thinking about life in order to reduce the risk of them exhibiting unstable behaviours. As Dr Komarzynska testified, this was to help them cope with their emotions, to regulate themselves, to be more aware of their feelings and to cope with them in a healthier way. This was to lower the risks of self-harm, aggression and

feelings of despondency. Chandra Rudolph, a mental health nurse, indicated that those with mood disorders and trauma-related issues (such as personality disorders or complex trauma) could join the caseload.

65. Dr Komarzynska operated two extensive waiting lists respectively for Bullingdon and Huntercombe, of several months. She was only able to see three or four prisoners each day. Moreover, during the Covid-19 pandemic face to face meetings were not possible and she either spoke with prisoners via the telephone or through their cell door. She was limited to seeing one patient a day whilst the Covid restrictions were in place.

66. There was, additionally, a Drug and Alcohol Psychosocial Service at Bullingdon which worked with individuals in need of support with substance misuse problems.

67. KS first entered HMP Bullingdon on 23 November 2016. He was referred to the mental health in-reach team due his diagnosis of PTSD, and his history of prolific self-harm and attempted suicide. On 24 November 2016 he was placed on Dr Komarzynska's psychology waiting list. On 1 December 2016 Dr Daniel Whiting, a psychiatrist, prescribed KS Olanzapine and Sertraline (later changed to Mirtazapine). It is of significance that KS indicated his preparedness to engage in psychological work.

68. Throughout the period December 2016 to February 2017, KS reported that voices were instructing him to self-harm (these statements were viewed as reflecting his unstable emotional traits and the complex trauma he had experienced rather than amounting to a "*psychotic presentation*"). There were occasions when he threatened self-harm if his demands for additional medication were not met. On 6 December 2016 he met Dr Komarzynska for the first time. The note of that meeting in the medical records includes the following:

> "He looked distressed and worried. He explained that he feels "*out of control*" (as) regards to "*voices*". He said that in the past he was able to ignore them. However, he said that a couple of days ago he self-harmed because "*the voices told him to*" and feels "*scared of what he can do next*". He said that the medication does not seem to help and he felt overwhelmed by his feelings. **I have explained that soon I will be able to see him for psychology sessions.** **He said that he would like to engage in those.** We talked about how difficult it is sometimes to try different things (coping strategies/medications, *etc*.) just to find out they are not very helpful. I have explained to him that the recovery process can take some

time but reassured him that it is about being persistent, patient and open to try different things; people respond to various approaches in different ways and it is important to find the most effective treatment/skills that will allow him to "*take back the control*". […] He explained that he is hearing voices telling him to self-harm but he is trying not to act on them. […]" (my emphasis).

69. Of importance to the issues arising on these Inquests, therefore, Dr Komarzynska explained that she would soon be able to see KS for psychology sessions, with which he confirmed he wished to engage.

70. On 15 December 2016, KS was seen by Dr Whiting and he indicated he still wished to engage with Dr Komarzynska.

71. He was referred to the substance misuse team on or about 8 February 2017 because Dr Whiting was of the view that his drug-seeking behaviour may be his primary difficulty. He attended an initial meeting with the team on 6 March 2017 but failed to attend subsequent appointments.

72. KS next met Drs Komarzynska and Whiting on 22 February 2017, when they once again discussed the commencement of psychological work. Dr Komarzynska noted that KS had "*some understanding of what such work would entail, as (he) had done some (work) in the past with Freedom from Torture*." KS indicated that at this stage his main focus had become his potential release from prison. He was due in court on 28 February 2017, there was a plea hearing on 28 March 2017 and he had a trial due to start in April 2017 (albeit I note in passing that was delayed more than once). KS suggested, therefore, "*he would find it difficult to engage in potentially distressing psychology work*." It was agreed that given these circumstances it was an inappropriate time to commence such work, albeit a plan was made that depending on the outcome of the court processes this decision, as a matter of course, could be reviewed, if appropriate, in the future. In her evidence, Dr Komarzynska suggested that prisoners sometimes vacillated as to whether they wanted to start therapy. If a prisoner left the prison for more than a short period, they would be discharged from Dr Komarzynska's waiting list.

73. KS had uneventful meetings with Dr Whiting on 8 March 2017, 22 March 2017 and 4 May 2017. After the last meeting, it was planned that KS should be discharged from the mental health team following a final review. He was transferred to HMP Manchester on 12 June 2017. Ms Rudolph considered she would have told HMP Manchester that KS was interested in psychological work, but she had no record of doing so, and on 27 June 2017 he was discharged

from their mental health in-reach service. He was released from prison on 22 September 2017.

74. KS was referred to the mental health team on his return to Bullingdon on 2 November 2017. There were inaccurate indications in the medical notes for 3 and 16 November 2017 that KS was only interested in medication and not in psychological therapy. It was decided that he should be managed by way of the care planning process for prisoners identified as being at risk of suicide or self-harm known as Assessment, Care in Custody and Teamwork ("ACCT") and, as a consequence, he was not accepted on to the In-Reach Case Load. No one from the in-reach team spoke to KS to establish if he wished to engage with psychological therapy, which Ms Rudolph accepted would have been an easy and appropriate step.

75. On 31 July 2018, whilst back in the community, KS significantly injured himself between his left elbow and his left wrist. He told Mr D'Aguiar, who he saw, that he was "*not in any way OK*", given he had just been informed he had no right to be in the UK, receive benefits or have access to medical assistance. Mr D'Aguiar thought his presentation was particularly unusual and KS said his mental health was getting "*so bad*", "*worse and worse*". As already set out above at [27], KS referred to fighting in Libya. He said that being shot was a good way to die and that terrorist groups would make him fight for them. Joanna Godfrey, an experienced probation officer who had taken over as KS's offender manager, contacted CMHT to request urgent support and to explain their increasing concerns about the risk that KS might pose to himself and others. The mental health services, however, appeared reluctant to engage with KS or to offer further support outside of an appointment arranged for 13 August 2018. Despite CMHT's reluctance, it was agreed a further assessment would nonetheless be completed. Ms Godfrey had considered the possibility of recall to prison, albeit this could not occur because his licence had expired. Her consideration of this option is of significance in relation to my overall conclusions as to whether the deaths in this case were avoidable. On 1 August 2018, the Crisis Team carried out a mental health assessment. KS was not considered to pose a risk to others or to have any mental health issues.

76. Dr Ahmad also saw KS on 1 August 2018. There was no sign of thought disorder. His self-inflicted injuries appeared potentially superficial. He was frustrated at his inability to access a biometric residence card which would afford him access to housing, state benefits and in-reach medical care, such that he expressed an intention to commit suicide. Dr Ahmad recognised that KS's history revealed a significant risk to others, albeit there was no immediate indication of this. Critically, although the current risk of harm to others was

assessed as being low, this needed to be reviewed on each contact as KS "*has a significant risk history when he is unwell*".

77. On the following day, 2 August 2018, a member of the Crisis Team communicated to Mr D'Aguiar that KS did not pose any risk to others; his previous behaviour did not inform risk; KS had no mental health issues justifying hospitalisation; and he had stated he did not want to hurt anyone. Mr D'Aguiar argued that notwithstanding his present intentions, offences had occurred and individuals had been seriously hurt. The Crisis Team, nonetheless, indicated they would be unable to attend the MAPPA meeting on 3 August 2018 and they closed his case on 7 August 2018. Dr Ahmad strongly disagreed with this assessment by other members of the Crisis Team: in his view, a "*low risk*" at present did not equate to "*no risk*", and in KS's case the assessment needed to be kept under continuous review. Furthermore, he considered that they should have continued to work very closely with MAPPA. He would also have wished for a clearer explanation as to why they had assessed the risk as being "*low*".

78. I note at this stage that when KS was seen in September 2018, it took place in the lead up to the split of the CMHT which I have already described.

79. On 4 September 2018, Mr Sesay, whilst working on behalf of BHFT as a Duty Senior Mental Health Practitioner, accepted a referral from CPE for KS, due to "*the well-noted risks to the patient and others*". The referral was made by Mr D'Aguiar, who was co-working with Ms Godfrey on KS's case. He highlighted his concerns over KS's "*significant mental health deterioration*" following his recent departure from St Leonards Approved Premises. He had stopped taking his medication; he indicated he could not "*handle this anymore*"; and that he would either hurt himself or someone else. KS had threatened to set himself on fire. He had been hearing voices and believed the devil was coming for him. Mr D'Aguiar assessed there were indicators of serious harm, including to others. This was because the risk KS posed to the public was at its greatest when he was experiencing difficulties coping, was using alcohol, felt hopeless, had financial difficulties, was in a mental health crisis, had stopped taking his medication and was homeless. All of these factors were then present.

80. Mr Sesay agreed an appointment should be made for KS the following day. Mr Sesay spoke with KS's brother. KS was seen by a community mental health nurse on 6 September 2018 who proposed that a Crisis Team psychologist should review his case. However, later that day KS had been detained in Prospect Park having smashed a window in his brother's car, whilst stating he

thought someone was going to shoot him and that he was in any event going to "*commit suicide*".

81. On 12 September 2018, it was considered inappropriate by BHFT to refer KS to the Crisis Team or the Joint CMHT due to his high level of chaotic instability (including substance misuse), and as such no psychology pathway would be of benefit.

82. On 3 October 2018, KS went to see Dr Ahmad to discuss psychological treatment for PTSD (potentially, dynamic or trauma therapy). However, as explained to KS, this could not be provided by CMHT until his legal status in the UK had been regularised. He would, additionally, have needed consistently to have been willing to engage and to have been relatively stable.

83. On 5 October 2018, KS jumped out of a car travelling at 60 miles an hour into the path of an oncoming lorry which had to make an emergency manoeuvre to avoid killing him.

84. On 23 October 2018, KS saw representatives of the psychiatric team in the Emergency Department, suggesting he was "*not getting the help*" he needed. He said he posed a danger to himself and others, and he threatened suicide. He became agitated and abusive.

85. On 9 November 2018, an RBC social worker, Harry Stacey, carried out a Care Act assessment of KS which was subsequently approved. He referred to the diagnosis of PTSD and EUPD. The record included his regular nightmares relating to fighting in the Libyan civil war. He harboured suicidal and self-harm thoughts (as set out at [83]) he had attempted to jump from a moving vehicle and he had cut his arms and legs), and he was emotionally labile on account of his symptoms of EUPD. In terms of "*Desired Outcomes*" it was suggested that KS required "*mental health supported accommodation*" to help him manage his problems related to PTSD and EUPD. This would provide him with an opportunity to develop working relationships with the staff; gain a sense of security when talking about his experiences of PTSD and EUPD; and find appropriate ways to manage the distress and feelings of hopelessness he experienced (which led to acts of self-harm and thoughts of suicide). The likelihood of this approach succeeding was considered to be high, as he had engaged well with staff from Adult Social Care and had expressed a desire to receive help. Supported accommodation would enable him to develop skills in budgeting, preparing and cooking food, and maintaining personal hygiene and clean clothing. This assessment was presented to RBC's Eligibility Risk and

Review Group ("ERRG"). As it transpired, Mr Stoyanchev organised emergency B&B accommodation prior to consideration by the ERRG.

86. On or about 27 November 2018, Mr Stoyanchev was consulted about a letter from KS's solicitor raising the fact that on his previous discharge from Prospect Park Hospital, KS was meant to have been provided with a Care Coordinator but this was not implemented. His response was that care coordination is a specialist role, and a mental healthcare professional from BHFT CMHT would need to carry out an initial diagnosis and an assessment of needs which would form the basis of a care plan which would then be managed by a Care Coordinator. He stressed RBC Adult Social Care did not provide care coordination which would have had to come from BHFT CMHT. In his experience this was always provided by the health authority, not the local authority. The Care Coordinator would complete a care programme, which involves an "*holistic*" approach vis-à-vis behaviour, mental health, medication, treatment, social care factors and social care needs. They monitor the individual at least once a month, and fortnightly if he or she is in crisis.

87. On 28 November 2018, Dr Ahmad saw KS. He was in a bright mood, although this continually fluctuated. He still experienced nightmares. He denied suicidal thoughts but acknowledged he was drinking heavily. He talked about his military training. Dr Ahmad considered there was no change in his diagnosis, which was complex PTSD, with traits of antisocial and borderline personality disorder ("BPD"). Dr Ahmad added that his problems were compounded by his alcohol and substance abuse. Furthermore, he noted his impulsive and erratic behaviour; his failure to take responsibility for his behaviour; a tendency to place the "*locus of responsibility on others*"; and his expectation of "*instrumental solutions*" to his problems. In Dr Ahmad's view these were the remaining challenges to his consistent engagement with services. His problem of substance misuse was further "*challenging the management plans*".

88. Dr Ahmad's considered, bearing in mind KS's chaotic lifestyle, his multiple psychosocial needs and his requirement for ongoing support, that he would have benefited from more consistent support from CMHT. Therefore, the Crisis Team was asked to refer him to CMHT "*for care coordination*". Dr Ahmad considered that KS needed a single point of contact who could liaise with all the relevant services, to secure cooperation between them and to arrange periodic meetings. Dr Ahmad concluded that this was something CMHT could have provided. BHFT's own Care Programme Approach ("CPA") (February 2017), was introduced to provide a framework for the care of mentally ill people, requiring the health and social care authorities to work together in this context. It had four essential elements, *viz.* a systematic assessment of health

and social care needs; the formulation of an agreed care plan; the appointment of a named Care Coordinator; and a regular review of the individual to re-evaluate his or her needs and/or risks. Thereafter there would be adaptions or changes to the care plan, as necessary. This approach was applicable to all adults with complex mental health needs whenever a multidisciplinary approach was required. The Care Coordinator needed to be suitably trained to assess, plan and evaluate the individual's care needs. The CPA supports, therefore, Dr Ahmad's view that the appointment of a Care Coordinator required the involvement of CMHT, along with the other relevant bodies.

89. Dr Ahmad recognised that the implementation of a multi-disciplinary care plan would not have involved triggering "*all the treatments*" simultaneously. He accepted that in advance of psychological treatment, KS should have achieved a period of stability, including as regards drugs and alcohol. Under the "*personality disorder pathway*", CMHT had a team within the psychology department, run by experienced psychotherapists and psychologists, who were able to provide different levels of psychological intervention. Dr Ahmad was of the view that the first priority should have been trauma therapy, delivered by their specialised trauma therapy teams. Once KS had better control over his emotions as a result of their intervention, then treatment could commence, sequentially, for his PTSD and EUPD.

90. Mr Skelton KC, on behalf of the families of the deceased, suggested that KS was trapped by a "Catch 22" dilemma (*viz.* as a result of his BPD and/or PTSD he abused alcohol or drugs but this rendered him permanently ineligible for treatment). Dr Ahmad agreed it was a very difficult situation, but he did not accept that someone in KS's position would inevitably be trapped or stuck. In his view, it was critical that there was a key worker who was able to capitalise immediately on any periods of abstinence, for instance providing positive feedback and "*inculcating hope*". That, in Dr Ahmad's view, was the best way to motivate the individual in these circumstances, to strengthen their decision making, thereby taking him or her to a stage at which other services and techniques could be provided. He considered that with such assistance, KS, as someone with BPD and/or PTSD, would escape the Catch-22 dilemma.

91. On 5 December 2018, CMHT, at a Referrals Meeting, declined the referral from the Crisis Team. The reasons were the complexity of KS's "*presentation*", including his current use of alcohol and the absence of evidence that he wanted to stop; his history of erratic engagement and violence; the likely limited scope for any therapeutic engagement; and the lack of available treatment for the antisocial aspect of his personality. Given the difference that had emerged between the crisis services (Dr Ahmad, in particular) and the CMHT, the

Referrals Meeting recommended a referral to the Trust's Positive Risk Panel, which was composed of senior clinical managers, psychologists and psychiatrists. This body discussed cases for which the management plans had come to a "*dead end*" or the plan carried a very substantial risk. In effect, the Risk Panel was to be asked to consider the CMHT's refusal to provide care coordination.

92. Dr Ahmad disagreed with CMHT over their decision and he believed "***there (was) a massive risk brewing***" (my emphasis). Furthermore, he considered a concerted effort was required before a referral was made to the Trust's Positive Risk Panel, and it was in this context that the Crisis Team was requested to arrange a Professionals' meeting on 21 December 2018, inviting all the "*relevant people*" involved in his care to share their thoughts and to try to help formulate a concerted care plan. I note at this stage as a matter of concern that the Positive Risk Panel, however, never considered KS's case.

93. On 21 December 2018, Ms Nunn was advised by Dr Ahmad that the Crisis Team continued to be concerned about KS's risk to others. He stressed that KS had a military background from Libya, which was substantiated by his brother; he had discussed throwing grenades and killing children; KS considered the UK had been unjust to him (when he came out of prison he felt he was "*dumped*" in bed and breakfast accommodation, and due to his immigration status he was unable to get longer term treatment for his mental health and a back problem, and he was only able to access emergency treatments via Accident and Emergency and the Crisis Team); KS was indifferent to his own life and those of others (Dr Ahmad considered he displayed psychopathic tendencies, with traits of lack of remorse and responsibility); he blamed his drug and alcohol use on the PTSD that the UK caused by denying him access to relevant services; on 17 December 2018 he had been arrested for being in possession of a weapon; and in Dr Ahmad's view he remained chaotic in his presentation and his mental state.

94. In advance of the Professionals' meeting on 21 December 2018, Dr Dean Rutland, medical psychotherapist, on behalf of the Trust, wrote to Dr Ahmad. This email encapsulates the enduring approach of BHFT towards KS:

> "Having looked at the notes, my impression is that (KS's) most pressing difficulties are around some of his most basic needs (food, accommodation etc) and his misuse of alcohol. He seems to present as rather antisocial in terms of his personality and unfortunately this is not something we can readily treat within the Trust and certainly not whilst the aforementioned problems remain unresolved. I suspect that his

> medication will be of little benefit if he is taking it sporadically and concurrently drinking large quantities of alcohol. Unless there is clear evidence that it has been helpful, I would be inclined to consider stopping it.
>
> As such, I see little benefit to him being open to secondary mental health care services at present. IRIS [a Drug and Alcohol Service focussing on substance misuse] and Social Care would seem like more appropriate avenues of support. I believe the Criminal Justice System has also been involved and this process will have to be followed through."

95. Dr Ahmad responded that in his view KS's current level of alcohol consumption was the result of the limited and inconsistent support he had received and should not be viewed as a reason not to provide support. He noted that in the recent past at least six services have been involved with KS. It is of note in this context that Arjun Malhotra, on behalf of the British Red Cross, observed that for his organisation one of the striking features of KS's case is that they were told by statutory mental health services that he had no mental health issues and that his presentation was circumstantial due to his status as an asylum seeker, and, at times, his homelessness.

96. I pause in this narrative to observe that the British Red Cross worked intensively ("*tirelessly*", as Alex Fraser, the organisation's UK Director of Refugee Support, put it) with KS over a number of years, providing him with a high level of practical support and assistance, whilst passing on their concerns, with his knowledge, to the relevant statutory bodies. The Red Cross deserves the thanks of the public for the diligence and dedication the organisation's case workers demonstrated, notwithstanding that he was frequently an extremely difficult and demanding client.

97. Returning to the history, I turn next to the Professionals' meeting on 21 December 2018 at Prospect Park Hospital. By way of background, on 16 November 2018 KS had been arrested and detained on a bridge where he was threatening to kill himself. He assaulted a police officer. On 3 December 2018 he had been detained carrying a knife having been involved in shoplifting (he was admitted to Prospect Park Hospital). On 16 December 2018 he was arrested in possession of a butter knife, which he said he had on him for revenge having been assaulted. The purpose of the meeting was "*(t)o discuss and agree a concerted care plan for KS*". Those in attendance included Dr Ahmad (Team Consultant CRHTT), Diane Evdoka (Clinical Team Lead CRHTT), Mr Stoyanchev (Social Care Team), Alex Alewood (police officer), Ms Robinson (Team Lead CMHT), Kareen O'Conner (CMHT), Manprit Vig and Jessica

Beagent (British Red Cross) and Carolyn Gill (IRIS). Prevent and probation were not represented.

98. Dr Ahmad set out certain core information regarding KS, including his childhood trauma relating to his recruitment for seven months by the army in Libya at a young age, when he shot and killed others. He had been trained to use hand grenades and other weapons. He learnt to set bombs and to make other explosives. He became a freedom fighter, using a machine gun. A friend was killed by a sniper and he collected dead bodies. He became involved in a terrorist group. It was highlighted that KS had been in prison for assault and carrying an offensive weapon. He had been observed under the influence of alcohol. There was a risk that he would assault other people. It was noted that he was engaging "*to some degree*" with all the services that were being offered or provided to him.

99. During the discussion, it was agreed that Ms Robinson was once again going to present the case to CMHT in support of appointing a Care Coordinator. It was recorded that "*most of the professionals present, strongly felt that care coordination from CMHT would be important* […]". Dr Ahmad recommended care coordination as KS had multiple complex needs. He noted that numerous agencies were involved. KS needed consistent support, including by way of helping him to engage with the community rehabilitation services. In the meantime, Ms Gill from IRIS was identified as the "*main worker*" until CMHT potentially took on KS's case in the New Year. Mr Stoyanchev was of the view that KS's mental health concerns had not been "*addressed*". However, it was indicated during the meeting that although CMHT should take the lead in supporting KS, they would not, in fact, support him until he was working closely with IRIS. IRIS, in turn, would only provide KS with an "*inpatient detox*" once he was in stable accommodation. KS was due to have an alcohol assessment on the 8 January 2019 and was able to attend the Monday morning groups with IRIS, prior to the detox. Ms Gill indicated that KS was currently very unwell and it would be dangerous if KS stopped drinking altogether. The Crisis Team suggested they intended to discharge KS from their care in January 2019.

100. Dr Ahmad saw KS on 24 December 2018. He had reduced his alcohol intake and was attending IRIS regularly. Dr Ahmad explained that the outcome of the Professionals' meeting included assisting with his benefits in order, *inter alia*, to help facilitate his long-term accommodation, thereby achieving stability which, in turn, would lead to access to the "*psychological pathway*" following a referral by his GP. It was envisaged that the Crisis Team would support him over the New Year, including by way of regular contact. KS would complete

his registration with a GP. Steps would be taken to continue to reduce his alcohol intake and KS would remain engaged with IRIS. His support worker was to assist with his application for benefits. The Crisis Team was to "*pursue*" CMHT about appointing a short-term Care Coordinator, in order for him to have a single individual i) liaising with the multiple agencies involved in his care; ii) setting up a concerted plan to help him resolve his psychosocial issues; and iii) assisting KS in achieving some stability in his life, structuring his daily routine and engaging with the community rehabilitation services. Dr Ahmad was attempting to "*leave no stone unturned*" in his bid to ensure that KS was properly assisted. However, in his view, there were gaps in the available services for those who did "*not neatly fit into the (established) pathways*" and there was a lack of flexibility in the approach that was taken.

101. On 4 January 2019, at a CMHT Referrals Meeting it was again suggested that KS should be referred to the Positive Risk Panel. As before, the Positive Risk Panel did not discuss his case.

102. The reality of what occurred following the Professionals' meeting was that Mr Sesay tried and failed to see KS on 6 January 2019 by way of a home visit to review his circumstances, including the state of his mental health. It transpired that KS had left the hotel on 22 December 2018. There was a multi-disciplinary meeting on 7 January 2019 when the Crisis Team made a plan to speak to the "*social care team*" to establish whether KS had been in contact. On 11 January 2019, the CMHT Referrals Meeting declined KS's referral as they believed that he did not fall under CMHT's purview with regard to coordinating the efforts to address his social care and behavioural issues. The entry in the medical records simply records:

> "We do not feel that he currently has a mental disorder for which BHFT offers a treatment pathway and with which he can engage. He has multiple social care issues which are stressors in his life. We do not feel that he falls under the CMHT's purview with regard to coordinating the efforts to address his social care and behavioural issues. We will therefore discharge him from our service."

103. Therefore, despite the strength of feeling of the majority of professionals at the 21 December 2018 Professionals' meeting, CMHT again refused care coordination and that arguably critical element of his care, remained unfulfilled.

104. On 15 January 2019 KS was taken by the police to Prospect Park Hospital as a place of safety. On 21 January 2019, Dr Ahmad, following a Crisis Team

multidisciplinary meeting once again attempted to refer KS to CMHT, as he needed long-term support with his mental health difficulties including by way of a Care Coordinator. This was refused at a CMHT MDT meeting on 25 January 2019, on the basis that it did not meet the criteria. This approach was reiterated on 8 February 2019 at a further meeting of the CMHT MDT. As Mr Nicholas Moss KC (counsel to the Inquests) suggested, a standoff had been reached.

105. On 5 February 2019, Mr Stoyanchev received an email from Simon Dawson, casework coordinator from British Red Cross (Refugee Support). He reported that KS had deteriorated "*somewhat*" over the past couple of days, culminating in him threatening to take his own life on numerous occasions, cutting himself quite badly, and taking an overdose of tablets. They had called the emergency services several times recently and he had disclosed "*a clear well thought out plan*" to take his own life. He highlighted that KS had a deep distrust of the statutory services, in particular the crisis mental health team, because of his perception of their reluctance to provide him with the support he felt he needed. He referred to a voice which kept telling him to kill himself. He only felt a slight reprieve from this inner torment when he cut himself. Mr Dawson observed how his ability to make decisions fluctuated rapidly. Mr Dawson hoped that the statutory services would provide psychological and practical support. Mr Stoyanchev replied the following day, indicating that KS "*clearly needs support from CMHT/Crisis Team to address his mental health and consequent behaviour*".

106. KS returned to HMP Bullingdon on 25 March 2019 having appeared at Reading Magistrates Court and been sentenced as referred to at [43] and on 3 April 2019 he was intimidating, loud and abusive to staff, and threatened to sue a nurse. On 19 April 2019 it was decided KS had been "*stabilised*" by the prescription of Olanzapine and he did not need the assistance of the secondary mental health team. On 23 April 2019 it was reported he was engaging well with the various workshops he attended for substance misuse. It would appear that on 25 April 2019, the Probation Counter Terrorism Lead had shared the Extremist Risk Screening ("ERS") with Jenni Halliwell from the Offender Management Unit so that it could be shared with the mental health team at HMP Bullingdon. KS was released on 4 June 2019.

107. On 26 June 2019, KS was referred to CMHT by Gill Randle, KS's offender manager from the Thames Valley Community Rehabilitation Company (CRC). At the Referrals Meeting on 28 June 2019, it was agreed that KS's requirements did not fulfil the threshold for CMHT secondary care. The view was that his substance misuse and anti-social behaviour were the main contributors to his

difficulties. As analysed hereafter, I consider this conclusion is emblematic of what was a persistent failure by BHFT to have sufficient regard to his EUPD, the indicators of PTSD, his intermittent but repeated expressions of adherence to extremism, his increasing tendency to arm himself with offensive weapons, his unpredictable aggression and the consequential substantial risk that he posed to himself and the public.

108. The referral was closed with a recommendation for an onward referral to the Berkshire Trauma Stress Service ("BTSS") for consideration of KS's suitability for treatment. This was deemed to be the most appropriate "*pathway*" for the management of his trauma symptoms. The aim was for BTSS to assess the benefits of trauma therapy as there was an indication of childhood trauma. This was to run concurrently with his engagement with IRIS, who at the time were commissioned to provide services for drug and alcohol related issues in Reading. What this recommendation seemingly failed to consider was that BTSS required the individual in question to have been stable for a sufficient period of time before accepting him or her. Furthermore, BTSS had notably long waiting lists for assessment and then for treatment (in all, about two years). KS had previously cooperated with IRIS but that service, acting alone, was ill-equipped to address his significant psychiatric difficulties. This is vividly demonstrated by the email sent by Phillip Knight of IRIS shortly afterwards, on 24 July 2019, to Ellie Pollitt of Launchpad (who was assisting with KS's housing) explaining that KS had not completed any assessments and was without an allocated worker. Mr Knight stated that they were very concerned for KS's safety and, in their estimation, he remained a high risk for others. Ms Pollitt had referred KS to CPE on 22 July 2019 because of her concerns about KS.

109. On 4 July 2019, Ms Randle again referred KS to CMHT because he was very distressed. The referral was refused, it being noted in the decision that none of KS's referrals had been accepted, that there had been differences of opinion as to his mental health status and there was no role for CMHT. An attempt was made to refer KS to BTSS but – as I have just noted – they required the individual to have been stable for a sufficient period of time before accepting them and they had a long waiting list.

110. On 16 July 2019, KS told a caseworker at the British Red Cross that he wanted to obtain a gun and shoot members of the public and he wished to locate and kill a man and his family because his intended victim had recently uploaded a video of KS on to social media. With KS's consent, this information was passed on to the police. This fitted a pattern of KS informing representatives of the British Red Cross that he wanted to hurt various people with guns, crossbows

and knives. Mr Malhotra considered, perhaps unsurprisingly, KS posed a threat to the lives of others. Indeed, the British Red Cross had a policy that staff were never see him alone, he was to be seen for support in a public venue or at the Probation Service offices and if he arrived at the office unannounced, he should be asked to leave, and if he declined the police were to be called. I emphasise these were the instructions from an organisation that had strongly and generously supported KS over a significant period of time. The Reading Refugee Support Group took very similar precautions when they saw KS.

111. On 2 August 2019, Ms Robinson contacted safeguarding at RBC to explain that "*there is no evidence [that KS has a] mental illness so CMHT cannot support [him]. Possible PTSD and may need trauma counselling 'further down the line'… felt it was behavioural issues*".

112. On 8 August 2019 KS arrived at HMP Bullingdon having been remanded back in custody following his further recent offending. On 29 October 2019 a referral request was received by the In-Reach Team at Bullingdon, the referral having been made by Liaison and Diversion Services because of KS's diagnoses of PTSD and EUPD, and the risk that he was vulnerable to extremism. He spoke with a wing nurse "*about the possibility of him having sessions with a psychologist*" and he "*was very happy about it, wanting to know if it is a weekly (or) monthly session*". He said he needed help. KS, therefore, agreed to start psychological work. The wing nurse referred KS to the Secondary Mental Health Team and the referral was accepted on 31 October 2019. KS's case was discussed and he was placed on the waiting list for the psychologist Dr Komarzynska. However, despite having been on the waiting list to see her in 2016 / 2017, it seems he had to join the bottom of the waiting list.

113. Further background to this referral is to be found in the fact that on 5 November 2019, DC Samantha Stockdale from the Counter Terrorism Vulnerability Hub South wrote to Police Constable ("PC") Mark Dunford, a Prevent Officer from CTPSE, to say that the referral had been made by their mental health nurse (Luc Taperell) for KS to be seen by the prison In-Reach team for a psychology assessment regarding his reported PTSD (and, I add, EUPD) for "*liaison and diversion*". He was known by the In-Reach team but had not been assessed whilst detained.

114. An initial mental health assessment was carried out on 6 November 2019; this was by Ms Rudolph, the mental health nurse who had seen KS when he was previously in HMP Bullingdon. Her clinical entry referring to this assessment was made in the medical records on 7 November 2019. She noted the referral from Liaison and Diversion, stating that KS was vulnerable to extremism. He

was assessed as posing a low risk of self-harm and of causing harm to others. KS said his mood was "*alright*" but this changed due to "*stressors or relationships with others*". He was keen for psychological intervention, which provided a "*window of opportunity*". It was considered he did not need a psychiatric assessment and that his problems would be addressed via psychological interventions. KS was added to Ms Rudolph's caseload and he was seen by her reasonably frequently in the months that followed. However, in the circumstances described below, he never received an appointment to start treatment with Dr Komarzynska. While he had supportive reviews with Ms Rudolph, preliminary treatment including Dialectic Behavioural Therapy (DBT) was not commenced, as it had been envisaged. Instead, his emotions and mood were evaluated at later meetings and consideration was given to discussing new coping strategies with KS within the restrictive prison environment.

115. Ms Rudolph's notes included that KS has a history of violence and aggression towards others, including members of the public, the police, prisoners and members of his family (namely, his brother). It was rehearsed that he had multiple previous convictions for assault and possession of offensive weapons. He had been recruited as a child soldier into an extremist Islamic group in Libya (in the rebellion against Colonel Gaddafi), and there were concerns that he has been radicalised. Previous documentation suggested that KS's risk towards others increased if he did not feel listened to, as this greatly increased his frustration and anger. At that stage, the risk he posed to others was determined as "*low*".

116. Ms Rudolph's impression of KS was:

> "Currently stable in mental state and mood, and feels more positive overall, which can be attributed to not having any current stressors present (namely legal proceedings are completed so he is now sentenced). Presentation can however change dependent on stressors and his relationships with others, especially if he does not feel listened to or does not feel that his needs are being met. Keen to start engaging with In-Reach Psychologist to begin addressing his previous and current issues, so have agreed to discuss this with them following this assessment."

117. Ms Rudolph additionally recorded that KS "*(f)eels that he is in a much better place mentally, and so is now keen to try to address these issues via psychological interventions*".

118. KS saw Ms Rudolph again on 13 November 2019, following an overdose on co-codamol. His sleep was poor, but his mental state was reported as stable and the risks of self-harm and harm to others were assessed as low.

119. In the meantime, on 4 December 2019 Nick Harborne from Reading Refugee Support Group wrote to NHS Berkshire West Clinical Commissioning Group. Mr Harborne was seeking funding for mental health support to his Group. Citing the recent deaths in the Fishmongers' Hall terrorist attack, he drew attention to KS as one of their clients who was "*now extremely vulnerable to being radicalised*" and stated:

> "In context of the recent deaths in London at the hands of someone's who was on a de-radicalisation programme, we have another client who is now is prison for 2.5 (years) and is now extremely vulnerable to being radicalised. He has received little in support from CMHT and has had no support plan that I am aware of in the 3 years we have been trying to support him. Prevent, Probation, Social Services, CMHT and the rest of us have all let him down. I am fearful if he does not now get the right support for his trauma whilst in prison, there could disastrous consequences on his release."

120. Ms Rudolph met KS again on 4 December 2019 when KS reported having cut his arm following feelings of frustration. There was a further meeting with Ms Rudolph on 17 December 2019. It was noted, following a suicide attempt, that KS remained on the waiting list for psychological assistance and appeared to be willing to engage with psychological work. As I have already described, Ms Rudolph proposed undertaking DBT work with KS (following a discussion with Dr Komarzynska) during the period before Dr Komarzynska saw him, but this never happened: indeed, it was never offered to KS. Ms Rudolph accepted their role in prison was to try, as best as they could (given the resources and difficulties in prison) to provide the same level of care as patients would have outside of prison. KS further met with Ms Rudolph on 9 January 2020, and 28 January 2020.

121. KS was referred to the Southwest Psychological Services by his Prison Offender Manager on the 13 January 2020. This was to assess him for one-to-one interventions as he could not be transferred to a suitable location to undertake take BNM plus ("Becoming New Me") Offender reduction programme. Nothing appears to have resulted from this referral.

122. KS was transferred from HMP Bullingdon to HMP Huntercombe on 12 February 2020. This appears to have been a pointless exercise. He remained there for less than four weeks. HMP Huntercombe was a prison used specifically for foreign national offenders. The only reason for KS to have been transferred there would have been in relation to matters regarding his immigration and removal status. However, by this time, KS could not be lawfully removed from the country and his immigration status was settled in that he had been granted 5 years discretionary leave to remain. While the transfer was both pointless and disruptive, the reason why it occurred (and whether this was a failure of the Home Office immigration side, or on the Ministry of Justice prison side) has not been adequately explained by either Department. Mr Vince, the Executive Director of the Directorate of Security at HMPPS, could only express the view that he was "*reasonably*" confident this would not happen again under new arrangements now in place.

123. On the following day, 13 February 2020, Dr Komarzynska made the following clinical entry:

> "[…] due to transfer to another prison, (KS) was discharged from the mental health team. He has been seen by a mental health nurse every two weeks. He was not seen by a psychologist as he was not able to engage in any psychology work. Before the transfer to another prison there was a plan to discharge him from the psychology waiting list. Therefore, he will not be referred to psychology in the new establishment."

124. Dr Komarzynska accepts that this is an unsatisfactory note. No foundation has been provided for the assertion that KS was "*not able to engage*". Instead, Dr Komarzynska simply speculated that he must have indicated to someone (unrecorded) that he was no longer prepared to be cooperative. She has subsequently improved her record keeping, particularly as regards the level of detail she provides.

125. On 13 February 2020, Laura Rixon of the National Probation Service contacted Dr Hasanen Al-Taiar, a psychiatrist supporting HMP Bullingdon and she asked him about possible treatment avenues for KS, but nothing of assistance was suggested. On or about 20 April 2020, Ms Rixon was informed that because KS was not under the In-Reach team in Bullingdon, there was no one who could "*hand over*" his "*mental care*" to the community mental health services.

126. While at HMP Huntercombe, on 18 February 2020 KS resumed work on substance misuse with the prison's Drug, Alcohol, Recovery and Treatment ("DART") team. On at least one occasion he was late for a meeting (24 February 2020); he attended under the influence of unprescribed medication on 26 February 2020; and he attended without difficulty on 2 March 2020. On 24 February 2020, a health professional observed in the Huntercombe medical notes that KS had previously been engaged with the mental health team in Bullingdon and she had in mind a referral to the mental health team.

127. He returned to HMP Bullingdon on 6 March 2020 and on 9 March 2020 he was re-referred to the Psychosocial Team for Substance Misuse.

128. On 16 March 2020, KS requested an appointment with the In-Reach Mental Health Team. There is a further significantly unsatisfactory entry in the medical notes for 16 March 2020, which is clearly unreliable. It states:

> "Recently transferred to Huntercombe where he was offered psychological interventions by KK Psychologist (who is based both in Bullingdon and Huntercombe), however, he declined to engage. As such he was discharged from their In Reach Team. Discussed and agreed that as he had already declined to engage with psychology so recently, he would not be accepted to the waiting list at this stage. Any future referrals should go to the Primary Team as per pathway where they could first see him re: engaging with psychology in future."

129. KS had not been offered psychological interventions by Dr Komarzynska at Huntercombe and there is no entry in the records to suggest that in discussions with the In-Reach team he had declined to engage. Indeed, that suggestion would only make sense if there had been a discussion about, or an offer of, psychological services whilst at Huntercombe, for which there is no evidence. As just described, Dr Komarzynska states that no such offer was made.

130. At a meeting on 17 March 2020 at which Dr Komarzynska was present, this referral was declined because KS had "*declined to engage with psychology so recently*", with the consequence that he was not admitted back on to Dr Komarzynska's waiting list. Furthermore, it was indicated that any future referrals would need to be via the primary care mental health team (provided by Care UK – now Practice Plus Group) and not via MPFT.

131. Given this approach, it is striking that the following day, 18 March 2020, Elaine Grieve, a primary health care nurse, contacted Dr Komarzynska, with an exceptional request concerning KS ("*it is rare that I try to add to your list as I know*

you are so busy"). She had just seen him on a review under the Assessment, Care in Custody and Teamwork ("ACCT") process (this is the care-planning process for prisoners identified as being at risk of suicide or self-harm). She believed he would greatly benefit from Dr Komarzynska's services because he was "*struggling to cope on a normal level with life due to many past events*". Dr Komarzynska replied that "*we have to follow the referral process - every referral needs to be sent to primary care, then each case will be assessed. However, are you sure if Mr Saadallah is an appropriate referral to psychology?*". She then added:

> "I tried to work with him and he was not ready to engage in psychology work, he was also recently discharged from psychology and mental health case load whilst in Huntercombe.
>
> It is apparent that he is struggling at the moment and that he has an extensive history of traumatic events. If he has a different attitude to therapy or mental health work (unfortunately he needs to do the work we can't do it for him) at the moment and he will engage with us and commit to the change we will review his case. […]"

132. In my view, this description of the relevant history is notably unsatisfactory. There is no persuasive evidential basis for the suggestion that KS had "*so recently*" declined to engage with the psychological services. Dr Komarzynska in evidence simply raised the possibility that someone must have said this to her. The only documented occasion when KS had decided not to engage was when the agreement was reached as far back as 22 February 2017 that psychological intervention would not commence at that stage, albeit expressly on the clear understanding that depending on the outcome of the court processes, this decision could, as a matter of course, be reviewed in the future. Ms Rudolph agreed that if KS has said he was no longer interested in psychological work, she would "*have likely documented it*". Furthermore, she accepted that he should not have been denied psychological services simply because on a "*bad day*" he expressed less interest than at other times. During questioning by Mr Skelton KC on behalf of the families, Dr Komarzynska accepted that a mistake had been or may have been made, and, if so, KS should have remained on the waiting list of prisoners requiring psychological assistance.

133. In this context it is important to note that Dr Komarzynska was of the view that the complexity of KS's "*presentation*" was such that any effective therapy ("*even if he had been willing and able to engage*") would have had to have been long term. Brief intervention (*e.g.* three months), in her view would not have been sufficient to address the complexity of his needs. Dr Komarzynska's waiting list was usually at least 4 months long and could extend to up to 9 months or

significantly longer (indeed, on occasion, as long as two years). There were about 500 prisoners in Huntercombe and over 1000 in Bullingdon. She suggested a prisoner should not be on the waiting list for longer than three months and expressed the view that her service would benefit from an additional psychologist and the resources to run educational groups.

134. On 19 March 2020 KS's sentence was reduced by the Court of Appeal.

135. In April 2020, Simon Proudlock, a consultant psychologist for BHFT, spoke with Andrew Bates a forensic psychologist who worked for the Probation Service (but was seconded for one day a week to the OHFT) about KS because he had identified significant signs of trauma. Mr Proudlock considered that KS might meet the criteria for the BTSS, whilst expressing that would be a matter for the service to determine. Although he passed on the relevant contact details to Mr Bates, he observed the waiting list was at least a year for access to treatment.

136. The medical records reveal that, despite some lapses, in April, May and the beginning of June 2020 KS was in a relatively stable condition in prison and this may well have been a suitable time for him to receive treatment from a psychologist. Indeed, on 13 April 2020 at a meeting with Nurse Patience Tuso, KS said he wanted to engage with in-reach psychology but no referral ensued.

137. Prior to his release from HMP Bullingdon, KS had an outburst in his wing when he threatened that people would take notice of him when he was out of prison and he would stab someone. This did not form part of an intelligence report until two days after the attack in Forbury Gardens.

138. KS was released from Bullingdon on 5 June 2020. I have considered the actions of BHFT following KS's release below, alongside my consideration of the actions of the Probation Service.

139. **PFD**: I have heard evidence of a number of improvements that have been made since this attack as regards the failings set out above. I am nevertheless concerned that there remains a risk of future fatalities in relation to which action should be taken. I will therefore be issuing a PFD report to the Secretary of State for Justice (as regards the Prison Service), BHFT and MPFT concerning the significant issues that I have identified above. The reports will be focussed, *inter alia*, on, first, the failure by BHFT to provide a care co-ordination role, in order to optimise the prospect of KS achieving sufficient stability to be able to enter longer term treatment for his personality disorder and symptoms of PTSD. Second, the failure by the Prison Service and MPFT to take steps to retain

KS on the waiting list for psychological treatment or restore him to that waiting list, in order to provide him with adequate psychological treatment. Consistent case-management and long-term therapy had a real potential to reduce KS's aggressivity, impulsivity and substance abuse, along with his offending. These and other linked matters will be raised, therefore, in the PFD reports in this context.

140. In conclusion, there were five particular failures by BHFT 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 Dr Ahmad 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 Dr Ahmad's 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.

KS's criminal offending and managing his extremist risk: the involvement of Prevent, JEXU, MAPPA, Pathfinder and Probation

Prevent

141. Prevent is one of the four elements of Contest, the government's counter-terrorism strategy. It aims to tackle the ideological causes of terrorism, to stop people becoming terrorists or supporting terrorism and to assist the rehabilitation and disengagement of those already involved in terrorism. The Home Office works with local authorities and a wide range of government departments and community organisations to deliver the Prevent strategy. KS was referred to Prevent (in the community) on four separate occasions (strictly, three referrals and one re-opening) between February 2017 and May 2019.

142. Whilst a wide range of authorities have duties under Prevent, a referral to Prevent is initially triaged by counterterrorism police. Under this Police Gateway Assessment, a Prevent police officer under supervision from a more senior officer will typically check for information internally in police and counterterrorism police systems, as well as from other agencies involved with the person referred. A decision would then be made as to whether the case was suitable to be put forward to a "Channel Panel" or closed at the initial assessment stage. Channel is a local authority led, multi-agency Prevent programme, designed to support and safeguard those who are at risk of being drawn into terrorism offences within the UK. It is the primary mechanism for managing and supporting individuals entering into Prevent. The Channel programme is voluntary and requires an individual to give informed consent to receive support. The case would be put to the Channel Panel if there are reasonable grounds to believe that a person is at risk of radicalisation, and therefore appropriate for support through Prevent. If the referral progresses and it is assessed that there is a genuine risk of radicalisation, the case is considered by a multi-agency Channel Panel of professionals who collectively assess the case. The Channel Panel is chaired by the Local Authority (here RBC) If accepted by the Panel, a tailored package of intervention and support would be drawn up. Such support is delivered with the knowledge and engagement of the individual concerned.

143. In KS's case, a common theme of the four referrals was his express wish to return to Libya to commit violence, and it is of particular note that the final referral in May 2019 was because KS stated he intended to join ISIS (Daesh)

with his brother and a family friend as soon as he returned to Libya. These four Prevent referrals were on each occasion closed because, firstly, he was sentenced to various terms of imprisonment and was, consequently, no longer in the community and, secondly, because of a widely accepted assessment that any risk he posed was based on his mental health difficulties, as opposed to an adherence to an extremist ideology. By way of example of the latter point, DS Stanley, the then Prevent officer in SECTU, interviewed KS on 4 December 2018. He only viewed a small part of the overall intelligence picture in advance. He concluded that KS was not voicing any clear ideological views of a terrorist or extremist nature. It was suggested that his grievances were founded in his perceived lack of support with his alcohol abuse and mental ill health. To a real extent this was a misleading view of KS, based on an incomplete knowledge of his history. This misapprehension of KS's sometimes inconsistent but nonetheless persistent extremist mindset regrettably continued to a significant extent in the approach taken to him throughout the period under review. DS Stanley 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.

144. I note, additionally, KS was not known to the Prevent Directorate within the Home Office prior to the attack. They were informed after the events in Forbury Gardens that four Prevent referrals had been made but none of them were progressed to the Channel Panel for discussion, with each being closed at the point of initial assessment by the counterterrorism police. It has been accepted during the present proceedings that KS had a complex immigration history with some clear potential ideological concerns which the system failed to "*pick up*".

145. The failure by the Prevent system to identify and act on the risk that KS posed, notwithstanding the clear signs of radicalisation that were well known, is a matter that has caused me some real concern. I have been told that "*significant lessons have been learned*". Improvements, it is said, 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*". Mr Stewart, the Director of Prevent, agreed that mental health should never be a reason not to make a Prevent referral. In this context, I note that DCS Wright

accepted that with a dangerous and complex individual such as KS, the different organisations involved need to cooperate in order to understand and assess him. This was another example of that critical guiding principle not being implemented in a sufficient or satisfactory way.

146. I have addressed the failures in obtaining the full intelligence picture and, in the analysis of that intelligence at [41] and [143], I have referred to individuals involved in those failures but the cumulative picture points also to failures of training, supervision and selection in this important work. There were other procedural weaknesses. For example, Mr Dunford readily had to admit that the third Prevent Referral was closed without the Police Gateway Assessment having been refreshed; without the visit to KS that has been suggested by the supervisor having taken place; and without any further assessment of the vulnerability risk or threat. That speaks not only to unacceptably poor work by Mr Dunford, but also a marked failure by those supervising his work. Mr Dunford suggested that he felt geographically isolated from his team and not well supported. Whatever the reasons, the overall standard of Prevent work involving KS at this time in particular was simply not acceptable. I consider some of the work of Prevent officers alongside the Probation Service below.

JEXU

147. As part of the overall landscape, linked to the work of Prevent in the community is the Joint Extremism Unit ("JEXU") (which replaced "EXU"). It has responsibility for bringing together the Home Office and HMPPS as the strategic centre for all counterterrorism ("CT") activity across both the prison estate and probation. It has responsibility for policy and "*supporting*" operational delivery. It exercises oversight of the "*CT network*" and a coordination role, whilst also providing training. Importantly in the present context, JEXU aims to establish collaborative links with other bodies. Mr Vince gave evidence, *inter alia*, about the work of JEXU.

Pathfinder and Probation

148. Pathfinder is a Prison and Probation Service led, multi-agency process which is intended to provide a focus on Counter Terrorism risk management:

- Prison (sometimes called Custody) Pathfinder is for those in custody. All "*TACT and TACT-related*" offenders (*viz.* those convicted of terrorism or terrorism connected offences) are automatically managed within the Prison Pathfinder process for the entirety of their sentence.

Any other offenders who are the subject of extremist-related reporting or concerns are expected to be referred to Pathfinder.

- Community Pathfinder is intended to mirror the process in the community and is Probation led. The Prison Pathfinder Scheme was of long standing. In the Reading area, the Community Pathfinder Scheme was implemented after a pilot in June 2018, albeit there was limited overlap between the prison and community schemes.

149. The Pathfinder "*nominal*" was expected to be discussed in both local and Regional Pathfinder meetings with the aim of ensuring local, regional and national oversight of any terrorist risk.

150. KS was first referred to the prison Pathfinder team in January 2017 and discussed at the meeting at HMP Bullingdon on 14 February 2017. This was on account of intelligence that KS had stated he wanted to go to Libya to fight against people who had killed his family. There were concerns that KS was keen to speak with Omar Brooks. This latter problem was addressed by separating the two men and putting KS on security monitoring. Due to the absence of any new intelligence at the Pathfinder meeting in March 2017, KS's Pathfinder file was closed. At Pathfinder meetings in May and June 2017, KS was mentioned under "*any other business*".

151. Ms Nunn (as already set out, the Head of Adult Safeguarding for BHFT), in her role as Prevent Lead, received a call on 31 October 2017 from Sara Hansen from CJLD. Ms Hansen explained they were with KS who had been arrested and had disclosed he was previously a freedom fighter in Libya. The team were concerned about his history and possible vulnerability to gangs and exploitation. Ms Nunn, as a consequence, advised a prison Prevent referral.

152. On 1 November 2017, KS was recalled to HMP Bullingdon. He was made active on Pathfinder again and discussed at a meeting on 14 November 2017, after intelligence was received from Berkshire Healthcare that he had said "*I don't want to be here. I want to return to Libya to die*". Although it was known he had significant mental health problems, at the December 2017 Pathfinder meeting he was made "*dormant review*" on Prison Pathfinder.

153. KS was then discussed again at a Prison Pathfinder meeting on 10 April 2018 after intelligence was received to suggest that he was "*planning to return to Libya to start a revolution and come back to Britain to blow people up*". This was single-strand intelligence and did not result in any action apart from discussion.

154. KS was raised again at the Prison Pathfinder meeting on 4 May 2018, although he had been released from custody on 1 May 2018. Staff from KS's wing had noted that he seemed "*delusional*".

155. In April 2019, KS was re-opened on Prison Pathfinder. His mental health history was noted, as well as various contradictory comments he had made previously about his desire to fight for and against ISIS. He was removed from Prison Pathfinder on 23 May 2019.

156. KS was released from HMP Bullingdon on 4 June 2019.

157. KS was discussed at a Community Pathfinder meeting on 8 August 2019 following a further arrest (Community Pathfinder was only available in Thames Valley after April 2019 – this role had previously been solely occupied by the Multi-Agency Extremism Screening Meetings ("MAESM"), which was police as opposed to HMPPS led)). This meeting of Prevent on 8 August 2019 was attended by Katharine Rogers, the Head of Probation National Security Unit (East and South Central), Helen Smith, also from the Probation Counter Terrorism team, DS Spiers and Scott Pilkington, the then Regional Counter-Terrorism Lead for Thames Valley, and others. An overview of his history was set out including his PTSD symptoms and history of trauma, the reports of being radicalised in Libya and the threats of harm to the Queen which had led to his arrest. Given the involvement of both Community and Prison Pathfinder schemes at this time, I note in passing that it has been accepted that continuity between the Prison and Community Pathfinder schemes was at this stage "*a fairly new concept*".

158. On 9 August 2019, PC John Bowness, the Neighbourhood Supervisor for Whitley and Church Neighbourhood Policing Team, sent an email to various individuals who had responsibility locally for safeguarding adults and their mental health, suggesting that consideration needed to be given as to how KS was to be managed once released. Mr Sesay agreed that little had improved as regards KS since 2016 in the sense that he still exhibited the same mental health problems, along with continuing tendencies to aggression, suicidal ideation and self-harm. There was no care plan in place to manage his mental health and social care problems.

159. KS was returned to HMP Bullingdon from HMP Wandsworth and he was added to the agenda for the Prison Pathfinder meeting that took place on 22 August 2019. Because he was on remand, no decisions were made regarding future intervention.

160. On 30 August 2019, Mr Sesay was told that Ms Rixon was taking over as KS's probation officer ("*community offender manager*"), following a recent assessment that he posed a high risk of harm to the public and himself. Of significance to issues I address later in these Factual Findings, offenders are released from custody with standard and bespoke licence conditions. These conditions are intended to provide a framework for managing their risk. She took over from Ms Randle (who had been managing KS since March 2019) and their role was to facilitate the re-integration of the offenders who were their responsibility into the community and to manage the risk they pose to the public. Ms Rixon had taken over from Ms Randle because the latter worked for the CRC and because the risk posed by KS was deemed to have increased to serious harm, he was no longer appropriate to be handled by a private company. He was a difficult and challenging case because of his complexity and mental health issues. Ms Rixon considered that given KS's behaviour was "*escalating*" it would be helpful to have a Professionals' meeting.

161. Ms Rixon confirmed she would have read back in the NDelius contact log for approximately the last 6 months and she would have considered the most recent OASys risk assessment. Ms Pollitt from Launchpad and Mr Harborne at Reading Refugee Support Group provided Ms Rixon with information about how KS was vulnerable to radicalisation and wanted to return to Libya. However, Ms Rixon was unaware that he had fought in Libya or for Ansar al-Sharia, that he had killed others, or that he had reported to the mental health team that he had thrown explosives into a government premises then masqueraded as a rescuer, or that Dr Ahmad who saw KS repeatedly, had told police he may have psychopathic tendencies. This made him, in her view, a very high risk. She said that this information should have been disclosed to the Probation Service, both via and independently of MAPPA.

162. On 5 September 2019, Ms Rixon discussed KS with her line manager, Norma Kueberuwa. On 11 September 2019, Ms Rogers suggested that KS may be suitable for Prevent. Ms Rixon was copied into an email from Ms Smith to the Prevent Gateway.

163. KS was referred to Prevent on 11 September 2019 by Ms Smith who noted "*our main concern is in line with opinions expressed by others that his past trauma and mental health condition leaves him extremely vulnerable and potentially tricky*". However, there was an exchange of emails on 12 September 2019 with Ms Rogers who agreed with the assessment of Thames Valley Counter Terrorism Police (*viz.* DS Spiers) that KS lacked "*ideology*" and was not a national security

threat; instead, the focus should be on addressing his mental health. Ms Rogers agreed but noted that KS was vulnerable to exploitation which could make him a candidate for Prevent and the Channel intervention programme. Ms Rogers therefore suggested that Channel could be an option if they were not successful in engaging mental health services for KS. Ms Rixon indicated she was influenced and reassured by their views as to the ideological risk KS posed.

164. A Professionals' meeting took place on 23 September 2019. Those in attendance were Ms Rixon, Mr Knight from IRIS, Mr Sesay from the Reading Mental Health Social Care Team, Mr Malhotra representing the British Red Cross, Ms Pollitt from Launchpad and Mr Harborne on behalf of the Reading Refugee Support Group. Ms Rixon did not invite CMHT because she wanted to meet with those already working with KS and she lacked a direct point of contact with anyone within CMHT: it was not clear who should be invited. DS Spiers declined to attend, although I note that this arose because of the level of uncertainty he had early in this post about whether it was appropriate to reveal his counter terrorism policing role to non-governmental parties attending meetings.

165. Mr Sesay expressed the view that KS had problems with social functioning and that the risks he posed appeared to be linked to his mental health difficulties. Mr Malhotra indicated that the British Red Cross had tried to secure mental health support, but in the view of his organisation the prison and community mental health teams had failed KS. In the event, the British Red Cross tended to act as a proxy for BHFT. Mr Malhotra viewed KS as presenting a high risk of harm to the public and himself. In short, he was assessed as very vulnerable and in need of support and therapy. Ms Pollitt outlined that KS had been in contact with Launchpad for "*a couple of years*" and expressed the view that KS had unmet complex needs. She had persistently raised with the various relevant agencies their assessment that he was clearly very unwell mentally and he can quickly become paranoid and dissociative. Despite the significant background information indicating the trauma he had experienced and his complex needs, he had failed to meet the threshold for care co-ordination. By way of conclusions, it was observed that during much of his time in the UK, KS had either been "*sectioned*" or had been in custody, periods when he benefited from an element of institutional support and structure. Whenever he was in the wider community, however, he consistently presented as being in crisis. It was considered, therefore, that he has "*unmet mental health needs*".

166. There was general agreement that he would benefit from intervention when in custody, which would then be transferred to the community team on release in order to ensure consistency of care. It was remarked that there had been numerous referrals made by numerous agencies which had failed to secure any intervention. It was suggested that it was apparent that KS needed support on a one-to-one basis. His tendency to self-harm and threats of suicide were noted. It was expressed that KS felt that no one understood him and he had been let down by the relevant services in the UK. It was observed that KS had been repeatedly turned away by mental health services, and there had been an absence of any specialist intervention. It was suggested that a residential placement might be necessary, to reflect the stability of the prison environment, particularly given he was unable "*to engage therapeutically if he is presenting in crisis*" and was drinking alcohol. Ms Rixon agreed to refer KS to MAPPA Level 2 and the Prevent / Channel agendas, with a view to securing additional support, specifically from CMHT and the In-Reach team.

167. In an email sent the same day as the Professionals' meeting, Ms Rixon suggested to Zoe Hanim, Prevent Lead and Chair for Reading Channel Panel, that everyone present at the meeting had agreed that KS was seemingly being let down by the community and prison mental health services. She asked if there were Prevent or Channel meetings which she could attend to discuss KS's case, and whether Prevent or Channel "*held sway over the mental health services*". This email was copied to Ms Smith and Ms Rogers, respectively a CT probation officer and CT probation lead.

168. After the Professionals' meeting, Ms Rixon emailed the London Therapeutic Centre at the Refugee Council to establish if they could offer any treatment for KS. The London Therapeutic Centre did not have anything available to offer KS. Ms Rixon also emailed the Refugee Resource and asked them for information about treatments. They did not reply.

169. On 24 September 2019 Ms Rogers sent an email to indicate it was her opinion and that of "*Prevent police colleagues*" that KS was not appropriate for Prevent and should continue to be managed through MAPPA (it would have been exceptional for Level 2 MAPPA and Channel to run at the same time). Ms Rixon was guided by those she considered, understandably, to be the counterterrorism experts.

170. On 30 September 2019 Ms Rixon completed a full review of OASys, including the Risk Management Plan and Initial Sentence Plan for KS. OASys is the risk assessment tool used by the Probation Service. In the Risk of Serious Harm summary, Ms Rixon identified that amongst those in this category were

"*stranger males approached in public. This has been in the context of interrupting an offence or where Mr Saad Allah feels threatened and under attack. This would not require any conflict and has largely come from his own paranoia*". Now that KS was back in prison, he was removed from Ms Rixon's caseload and was not "*actively in her care*". This meant that there was a gap in her involvement until February 2020.

171. On 3 October 2019, KS was discussed again at the Prison Pathfinder meeting. It was suggested that there was no new intelligence about KS that raised counter-terrorism concerns (it was recorded that there were no counterterrorism or radicalisation issues at HMP Bullingdon, which was incorrect). The attendees noted he needed mental health support due to past trauma. However, it is not apparent that any actions resulted from this meeting and he was made "*dormant review*" on Prison Pathfinder.

172. On 10 October 2019, KS was raised at a Community Pathfinder meeting. It was suggested that KS was "*presenting a mixed ideology as he had recently attended a local Church and expressed that he had converted to Christianity*." He had been considered by Prevent and discussed at Channel (an element of Prevent). As described elsewhere, these are elements of the multi-agency approach to identifying and supporting individuals who are at risk of being drawn into terrorism. It was reiterated that KS had mental health issues and that "*what he (said) when he (was) 'unwell' could end up being terrorist issues*". It was agreed that there would be a Vulnerability Hub Referral (potentially to access psychologists and nurses).

173. On 31 October 2019, KS was brought up at the Prison Pathfinder meeting because of concerns about his vulnerability to extremism. It was observed that he had been sentenced to 2 years and 8 months in custody and therefore he could be closed off from Pathfinder again if necessary but would remain active for the time being.

174. KS was raised at the Prison Pathfinder meeting 28 November 2019 by Mr Pilkington because the Community Pathfinder was anxious about him and his vulnerability to extremism and there had been an update from probation on 25 November 2019 suggesting there was a need for the prison to pursue a mental health referral both in custody and the community in order to try to encourage an assessment of and support for KS's mental health. The possibility of involvement with the Willow Project was raised. Furthermore, Counter Terrorism probation wanted Pathfinder to pursue an Approved Premises placement for his release, in order to provide stability and increased support. However, at this meeting he was removed from Custody Pathfinder as no new

intelligence had been submitted for discussion and those in attendance suggested there were no concerns around extremism or radicalisation and he had been sentenced to 2 years 8 months' imprisonment. Yet Helen Smith (CTPO) as part of the Extremism Risk Screen had recorded in August 2019:

> "Arrested on 7.8.19 - assaulted a member of the public with a baseball bat and assaulted arresting officer, made concerning comments upon arrest "The queen and the magistrates can suck my dick". Had also attended local Christian church in Reading, stating he had converted to Christianity to priest, reporting person had concerns re his presentation in the church. Potential mixed ideology concerns."

175. Following reports on 23 September 2019 from Launchpad and the Reading Refugee Support Group raising a variety of concerns, Ms Smith had suggested in September 2019:

> "Some concerns have been raised that KS may hold a mixed ideology, alongside his mental health and violence concerns, and that if he were to commit an attack that this may come under the remit of an extremism/terrorist related offence due to his presentation and the statements he may make at the time. This risk is assessed to be in the form of a potential lone actor. It is of concern that he speaks of martyrdom and suicidal ideation. However, it is unclear how engaged he is with any extremist group, cause or ideology due to the trauma he has experienced and his complex mental health concerns, which appear to be the focus to address."

176. This material was before the Pathfinder meeting on 28 November 2019. Mr Pilkington in evidence accepted that the conclusion that no new intelligence had been submitted relevant to concerns around extremism or radicalisation was incorrect. He also accepted that they viewed his change of religion "*too simplistically*". I note, additionally, he had not seen a prison psychologist and had not attended the Willow Project (however, Ms Rixon decided not to pursue this option because the project primarily works with survivors of domestic and sexual abuse). Although his prison sentence had been reduced by the Court of Appeal, there was no action to monitor for intelligence or relevant adverse behaviour in custody. It was observed at the meeting that others in the prison had responsibility for his mental welfare and in due course it was reported that he was on the psychology waiting list for his past trauma. Mr Pilkington agreed during his testimony that a valid option was to keep KS open to Pathfinder and continue to receive feedback to establish whether he stabilised and, as a consequence, other interventions potentially could follow.

177. An additional disadvantage of the closure of the Prison Pathfinder on 28 November 2019 was that the Community Pathfinder and Prevent were unaware of his release on 5 June 2020.

178. I note in passing that in December 2019, staff at a Safety Intervention Meeting at HMP Bullingdon discussed KS and considered he may need to be assessed for the Kaizen programme. Kaizen is a programme for adult male prisoners who pose a high or very high risk. The programme includes violent offenders. KS was assessed as suitable on 11 December 2019. However, he was not placed on the programme because of the amount of time left on his sentence and the fact that the programme was not available at HMP Bullingdon. The Theological and Ideological Interventions Programme was launched in January 2019, aimed at drawing prisoners away from extremist views and behaviour engaging with their ideological worldview and theology. KS was potentially eligible for the programme as a terrorist risk case during the period that he was subject to Pathfinder management in prison but no referral was made to the programme by the Prison Pathfinder Team. Mr Vince considered there was an insufficiently clearly identified ideological or theological drive in KS's case.

179. On 27 March 2020, Debbie Graham (manager of St Leonards Approved Premises) indicated she may not be able to accept KS on release, having previously accepted KS's referral in principle. On 2 April 2020, she said she would be rejecting the referral if COVID-19 lockdown conditions were still in place. The refusal was confirmed on 14 May 2020. On the relevant National Approved Premises Form it was observed vis-à-vis "*an arrival on 6 June 2020*":

> "He currently does not express any extremist ideology. This was connected to Islamic extremism, he has now converted to be a Christian and is due to be baptised. He has expressed no extremist views in relation to his new faith, which appears to be a protective factor."

180. As Ms Graham confirmed in evidence, if his extremist risk had been properly understood, they would have "*found a way*" to accommodate KS in Approved Premises. It follows that on the basis of a full understanding of the level of risk posed by KS, Ms Rixon would have assessed him as "*very high risk*" which, in turn, would have been determinative of KS being accepted at St Leonards or another Approved Premises notwithstanding the problems presented by COVID-19 and KS himself.

181. Ms Rixon was unaware that KS's flat was still available to him, and she took numerous steps to try to secure accommodation for him.

182. On 3 April 2020 Ms Rixon sent an email to a number of recipients requesting information as to who was still working with KS, given he was due to be released on 6 June 2020 and she wished to discuss the support that could be put in place prior to his discharge. Mr Sesay advised Ms Rixon that she needed to contact mental health services, including CPE and BHFT CMHT, to which Ms Rixon responded that she had already taken those steps, and had been "*signposted to Pathfinder due to his criminality*". Ms Rixon was appealing to CPE in order to secure a referral to trauma services given this represents his "*underlying problem*", and she noted KS appeared to be relatively stable because he had been on medication in prison and was not taking drugs or drinking alcohol.

183. Additionally on 3 April 2020, Ms Rixon completed a new "Duty to Refer" form to notify RBC that KS was at risk of becoming homeless upon his release. She informed the Council, Launchpad, British Red Cross and Reading Refugee Support Group of KS's new release date. She contacted Hayley Tye, KS's prison offender manager at HMP Bullingdon and asked whether KS had been examined by anybody in the Mental Health Team within the prison (the In-Reach Team) who could provide KS with a link to similar services in the community to those he had been receiving in prison (she was unaware that no treatment had been provided in prison). Ms Rixon contacted Mr Bates, the forensic psychologist. In due course they met and he suggested that BTSS may be able to assist but it transpired in due course that this avenue was not open to KS (see [195] below).

184. On 13 February 2020, Ms Rixon spoke to Mr Malhotra at The British Red Cross about KS. She asked him for information about KS's accommodation. She also spoke to Ms Graham (St Leonards Approved Premises). She was concerned about where KS would live when he was released.

185. On 12 May 2020, Ms Rixon spoke with Mr Harborne (Reading Refugee Support Group) who was concerned about the arrangements for KS's release, particularly as regards his mental health.

186. Generally, during May and June 2020, Ms Rixon took varied and multiple steps to try to ensure that KS would not be homeless and would receive appropriate support and treatment for his mental health problems. This included, additionally, contacting Change Grow Live, RBC's alcohol and drugs recovery service and numerous other individuals and organisations. Of very

considerable significance, Ms Rixon had been told by CMHT that she was unable to refer KS for their consideration until the date of his release. Ms Rixon considered he needed a Care Coordinator and she urgently wanted him to be assessed and moved into stabilisation therapy, prior to engaging with long-term therapy.

187. During her evidence, Ms Rogers accepted that with the intelligence of which she is now aware vis-à-vis KS's case, there was scope for an investigation to have been opened by counter-terrorism police and by MI5. She had been unaware, for instance, of the link to Ansar al-Sharia, KS's 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 or if such an investigation had taken place, 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.

188. I am of the view, additionally, that this history demonstrates the importance of 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. Mr Pilkington and Ms Rogers testified that now 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. Mr McAndrew, the Head of the Security Department at HMP Bullingdon, similarly testified that processes are now in place to ensure that this always happens.

189. Generally, 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 and therefore 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. 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.

190. I turn next to the important events in June 2020. KS was released on 5 June 2020. Ms Rixon met him and he signed his licence conditions which included the following:

> "5. While under supervision you must:
>
> > i) Be of good behaviour and not behave in a way which undermines the purpose of the licence period;
> >
> > ii) Not commit any offence;
> > […]"

191. The licence conditions which he signed expressly set out that:

> "8. If you fail to comply with any requirement of your supervision (set out in paragraphs 3, 4 and 5 above) or if you otherwise pose a risk to the public, you will be liable to have this licence revoked and be recalled to custody until the date on which your licence would have otherwise ended."

192. Ms Rixon considered that KS was positive, future focused and motivated. Ms Rixon contacted KS again on 8 June 2020. He was due to speak to Change Grow Live, Launchpad and the British Red Cross. He was agreeable to Ms Rixon referring him to the OHFT Pathfinder service, given this service offered psychological therapy to men who struggle with complex emotional regulation and interpersonal difficulties, personality disorder and high-risk forensic needs. This referral was made on 11 June 2020. Ms Rixon kept in close contact with KS by telephone or text.

193. There was a Professionals' meeting on 12 June 2020, at which Ms Rixon, Mr Malhotra from the British Red Cross and Mr Stoyanchev were present. Mr Malhotra set out that KS had not been assessed by a mental health specialist since being released from prison. Importantly, he explained that in previous years a pattern had emerged whereby KS's mental health was stable when he first came out of prison but thereafter it quickly deteriorated in the absence of mental health support. Mr Malhotra asked Mr Stoyanchev if he would be able to provide support in this context. Mr Stoyanchev explained that his team dealt with those who have unmet social care and support needs. As regards his mental health, he suggested KS was the responsibility of BHFT CMHT. Mr

Stoyanchev further posited that Ms Rixon could refer KS to the RBC Mental Health Social Care Team if she believed such a step would be useful as the Care Team could provide some "*wellbeing*" support. Ms Rixon explained she had tried to refer KS to BHFT CMHT via CPE but they indicated they would not accept the referral until he had left prison. She had then referred him on the day of his release, to be met with the response that they could not accept referral because he should be directed to the OHFT Pathfinder service. This healthcare service (which is entirely separate from the Prison and Community Pathfinder Programmes against extremism) was a Thames Valley psychotherapy service run by OHFT as part of the delivery of the National Offender Personality Disorder Strategy. Its aim was "... *to provide a needs-led psychological assessment and treatment service for a complex population of individuals who typically fall outside of available community psychological and mental health resources*". She had previously attempted to take this step on 9 April 2020. Ms Rixon said she was going to re-refer KS to CPE with a view to appealing their refusal. Although Ms Wise, the RBC Executive Director of Communities and Adult Social Care, indicated during her evidence that any dispute or impasse between BHFT CMHT and adult mental health social care should have been escalated to the relevant Director for resolution, in KS's case this never happened.

194. It had been noted that KS was "*smoking weed*". KS admitted this to Ms Rixon on 16 June 2020, although the records also suggest that Ms Rixon's first knowledge of KS reverting to cannabis use was earlier, on 12 June. Ms Rixon explained to KS that smoking cannabis could aggravate any pre-existing mental health issues.

195. On 17 June 2020 the referral for KS to BTSS was refused on the basis of his recent offending behaviour, aggression, ongoing emotional dysregulation, and recent substance misuse history. BHFT's CPE commented as part of this rejected referral that it was agreed "*to recommend referral to Pathfinders service as originally advised*". However, on the same day, Ms Rixon received the response from the OHFT Pathfinder service in relation to the referral for KS. The difficulty was that, as with BTSS and the EUPD pathway, the OHFT Pathfinder service required patients to demonstrate 8-10 weeks' stability within the community after being released before the OHFT Pathfinder will carry out an initial assessment. In my view this typifies how referrals bounced from one Service Provider to another, in this instance on the very same day. As Ms Rixon candidly set out, this left her feeling very disheartened, sad and hopeless. Both CMHT and the OHFT Pathfinder service had rejected her referrals for KS and, as she expressed the position, it appeared that nobody in the mental health services was prepared to deal with him. She felt she was going round in circles, an assessment with which it is very difficult to disagree.

196. I pause in the chronology to make two observations. First, that it was Mr Bates's evidence that there was a tendency in mental health services that if anyone had any kind of offending story, it was recommended that they should be referred to the OHFT Pathfinder service, without understanding the criteria for acceptance. There was, therefore, a miscommunication between the mental health services which was not assisted by the fact that generic mental health services were provided by BHFT and the specific forensic services, including the Pathfinder service, were provided by OHFT. This resulted in individuals being recommended who would not be accepted because of their instability. In any event, the OHFT Pathfinder service only accepted a handful of referrals at any one time (and a total of 22 in the last year it was in service). Second, Mr Bates gave evidence of the potential utility for someone in KS's position of the Integrated Risk Management Services ("IIRMS") provided by OHFT. IIRMS requires quite a high level of engagement by the offender and the staff providing the service. This can require the staff to escort the offender to and from appointments, provide psychological support as well as other support to them with their practical needs in the community such as accommodation and benefits in order to contribute to their general rehabilitation and establish their stability in the community. Work with the offender can begin in prison and continue in the community. Mr Bates was of the view that IIRMS would have been the "*best bet*" to stabilise KS, but it was never offered to him and there were in any event only 25 "*spaces*" for this service at any one time and it was in any event operating at capacity. I note that the service has subsequently been expanded as "Enhanced IIRMS".

197. Mr Sesay spoke with KS on 17 June 2020, by way of an initial assessment as part of the initial triage process (the first step when a new referral is received). It was a positive telephone call, which was mostly concerned with his physical needs such as needing to move out of his temporary accommodation and certain household items. He said his mental health was reasonably fine, and he was eating and drinking. KS agreed that Mr Sesay should contact "*housing/charities*" to try to obtain certain items for him. Mr Sesay concluded that his presentation was "*OK*"; he was unable to detect any evidence of risk to others; and he found it "*impossible to reconcile how he was on this call with what subsequently happened*".

198. On 18 June 2020 a line in an email from Ms Rixon to Mr Malhotra set out "*(KS) is in desperate need of mental health intervention, and the window is rapidly closing where we are going to have a realistic chance of helping him*". This was an apt prophetic assessment by someone who had spent a considerable amount of time considering the extent of KS's problems and the risk he posed.

199. Indeed, the accuracy of this prediction was demonstrated on the same day when KS told his brother, Aiman Saadallah, that he believed someone was performing magic on him and that ghosts wanted to kill him. Aiman Saadallah informed the duty worker at BHFT. The duty worker passed the issue to the Crisis Team. Ms Rixon independently contacted him by telephone because she had received an email from the British Red Cross, in which it was suggested KS urgently wanted to speak with her (Ms Beagent had spoken to KS). Her contemporaneous notes of what KS said over two telephone calls included the following:

> "ghost man?
>
> gonna take my blood and white cells?
>
> Thursday to Sunday.
>
> Pulling me through a magic crystal maze.
>
> Magic stick man.
>
> Crying, very scared.
>
> Mum / sister tell me bad things will happen to me. At home in Libya, they say they are going to make me seizure.
>
> Music is a sin, when I listen she gets ill. People shout at me through the window. Talk to me through the TV, I hear voices. People died in my flat, they come out by magic.
>
> I have the key to stop something worse than coronavirus happening. I can't tell you unless I can guarantee my safety from them. How can I stop magic? I can't give the magic back to them, I have 5 years to cope massive things happening over the world by stopping the world war. Asked me to find the magical people in London, and the devil lady. I find them from a book, then I'm summonsed by magic. They need someone to speak to them from the professionals, it's our responsibility. The BBC brought them."

200. Ms Rixon's written summary of the conversation included the observation that in her professional judgment "*he seemed really strange and not lucid at all, he seemed scared and upset*". She thought KS should be "*sectioned*" (as opposed to

being recalled on licence) and advised KS to speak to the Mental Health Team, which he did (indeed, he indicated again on 18 June 2020 that he wanted to engage with mental health support). KS thereafter spoke to the Team about magic and things under his bed. He said that he thought that he was possessed and that he needed a priest or Imam to get the JuJu out of him. He denied being under the influence of drugs or alcohol. The person who took the call formed the view that the CPE and the Crisis Team were passing KS "*round the services*" and did not want ownership of the problem. That is a conclusion with which I entirely agree.

201. Ms Beagent also called the Crisis Team and was told that they would only accept referrals from a 111 number, that is the police, a GP or a paramedic. Dr Bonner accepted that this was incorrect. In this context, as I have explained in dealing with the healthcare response, BHFT's Crisis Team tried to visit him on the afternoon of 19 June 2020, but he was not at his flat when they called, and KS was given an appointment to meet the Crisis Team at 3.00pm on 20 June 2020.

202. Ms Rixon spoke to her manager, Ms Godfrey, about her concerns and tried to speak to KS numerous times: at 17:54, 19:52, 19:57, 20:01. She could not reach him and left a message about meeting with the Crisis Team the following day.

203. Although that completes this section, there is one final and important thing that needs to be said. As Professor Blackwood has indicated, Ms Rixon, who had only been a probation officer for three years and who had only been assigned to KS at the end of August 2019, is to be singled out for praise following her tireless attempts to "*master the fragmented system*" and to secure consistent mental health intervention for KS. As I have stressed above, she appreciated the dangers posed by KS and the need for action to avoid, in Dr Ahmad's words, "*the massive risk (that was) brewing*". Indeed, Ms Rixon and Dr Ahmad both unstintingly attempted to secure the long-term support and psychological therapy which KS needed. They equally, therefore, deserve fulsome recognition for their prescient and fulsome attempts to achieve a proper level of psychological intervention for someone who had very significant psychiatric problems.

204. **<u>PFD</u>**: I note that since these attacks there have been a number of changes. By way of some examples of improvements, in March 2021 the Dormant Review Standard Operating Procedure was introduced. This provided guidance as to when and how to complete a review of a dormant Pathfinder case (the Dormant Review process); this is intended to ensure that those who have previously presented a terrorist risk are reviewed before a significant change of

circumstances, such as release from custody. Dormant reviews are now intended to be a standing agenda item at Pathfinder meetings.

205. In October 2022, the Pathfinder Guidance Framework Operational Delivery Guidance ("PGF") was issued alongside the Operational Delivery Guidance. This is an assessment which must be completed for all terrorist-risk offenders who have been made an active case of concern at Pathfinder and it replaced the Extremism Risk Screening which was used in relation to KS.

206. 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. The guidance encourages increased information sharing and attendance at key meetings for this cohort of prisoners. This was for dissemination to all mental health providers involved in Pathfinder to ensure that relevant staff prioritise these meetings.

207. 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.

208. HMPPS Psychology Service Group ("PSG") "*support*" is now located within the Probation Service National Security Division ("NSD"), with a senior forensic psychologist located in each NSD unit. NSD psychologists provide psychological consultations on cases with Specialist Probation Practitioners ("SPPs") and Senior Operational Leads in the probation regions. NSD psychologists play a role with MAPPA meetings, in the sense of assessing risk, contributing to case plans by assisting with risk management, including release planning.

209. 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. I will therefore be issuing a PFD report to the Secretary of State for Justice in this context.

MAPPA

210. MAPPA was introduced by the Government in 2001 to help manage the risks of harm to the public presented by sexual and serious violent offenders, and (since 2010) terrorist and terrorist connected offenders. MAPPA requires the three agencies that comprise the Responsible Authority ("RA"), the Prison Service, the Probation Service and the Police, to work together in a structured way, to manage the risks offenders may present, through the agreement and monitoring of risk management plans. When necessary, they must draw in other "Duty to Cooperate" ("DTC") agencies including Education, Employment, Housing, Mental Health and Social Care Services. MAPPA is not a statutory body, but rather is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a co-ordinated manner. The MAPPA structure involves managing offenders under both levels and categories.

211. There are 3 MAPPA levels. Most offenders are managed at Level 1. At Level 1, the risks posed by the offender are managed by the lead agency without the need for formal multi agency meetings. This does not mean that other agencies will not be involved; rather the lead agency should be confident that their Risk Management Plan is sufficiently robust to manage the identified risks and that there are no barriers to the implementation of agreed multi-agency actions requiring ordinary agency management.

212. Level 2 MAPPA is for cases where formal MAPPA meetings would add value to the lead agency's management of the risk and: i) the offender is assessed as posing a high or very high risk of serious harm, or ii) exceptionally, the risk level is lower but the case requires the active involvement and co-ordination of interventions from other agencies to manage the presenting risks of serious harm, or iii) the case has been previously managed at Level 3 but no longer requires Level 3 management.

213. Level 3 MAPPA management is for cases that meet the criteria for Level 2 but where management issues require senior representation from the Responsible Authority and Duty to Cooperate agencies. This may be when there is a perceived need to commit significant resources at short notice.

214. Prior to these events, there were three MAPPA Offender Categories (Category 4: Terrorist Offenders, has been added since these deaths). The three Categories were:

Category 1 - Registered sexual offender. This is not relevant to KS.

Category 2 - Violent offender or other sexual offender. In simplified terms, this category covers those convicted of specified violent or sexual offences and sentenced to imprisonment for a term of 12 months or more (including a suspended sentence) in a single qualifying sentence.

Category 3 - Other dangerous offender. These are offenders who do not meet the criteria for either Category 1 or Category 2 but who have committed an offence indicating that they are capable of causing serious harm and requires multi-agency management at Level 2 or 3. By definition, therefore, there is no such thing as a Category 3 Level 1 Offender.

215. There is an expectation that eligible individuals (*i.e.* individuals who meet the MAPPA criteria) are referred to MAPPA six to eight months prior to release from prison, which should enable multi-agency work to commence in preparation for release.

216. Linked with the preceding section, the Prison Service was not invited to the three MAPPA meetings discussed below (the expectation is that a Prison Service representative, at an appropriate level of seniority, will attend at each Level 2 and 3 MAPPA meeting). Indeed, the Prison Service should have been invited. As Mr Vince explained, the expectation was and is that with a pre-release MAPPA meeting or any MAPPA meeting when the offender is still in custody, the prison where the offender is being held will complete an Offender Information Sharing Report known as the MAPPA F form. Its purpose is to collate information about the offender from prison records, staff, OASys and ERS assessments. The statutory MAPPA Guidance requires the Prison Service to complete a MAPPA F form for all MAPPA Level 2 and 3 meetings when an offender is in custody.

217. There was a level 2 MAPPA meeting on 3 August 2018. This was attended by, *inter alia*, Mr Ennis (National Probation Service), Inspector Penny Jones and Mr D'Aguiar (probation officer). I observe in the context of this meeting that the MAPPA guidance states that Home Office immigration enforcement should be invited to attend all MAPPA level 2 or 3 meetings about foreign national offenders. However, representatives of immigration enforcement were never invited to the MAPPA meetings concerning KS. This would potentially have facilitated a more detailed conversation about KS's case and the identification of failings, such as the delay in providing him with a biometric card. KS's vulnerability to radicalisation was raised at this meeting. It was noted that his

mental health had started to deteriorate and he had returned to self-harming. Notwithstanding this development, CMHT had indicated they were unable to help and had suggested a referral to OHFT Pathfinder. Prospect Park Hospital had said that KS did not pose any risk to the public, nor did he have any mental health issues. A reduction from Category 3, Level 2 to Category 3, Level 1 was recorded. This is concerning because – as I have set out – Category 3 Level 1 was not recognised in the MAPPA guidance. A Category 3 offender by definition required management at Level 2 or 3.

218. There was a MAPPA level 2 meeting on 7 September 2018. KS had been admitted as an inpatient at Prospect Park Hospital the previous day. This was weeks before the restructuring and Jacob Macbeth attended the meetings to represent the Joint CMHT. He was employed by RBC in the Adult Social Care Mental Health Team as a Senior Forensic Social Worker. A Community Psychiatric Nurse ("CPN") employed by BHFT had previously attended MAPPA meetings on behalf of the Joint CMHT, however this ceased in 2015/2016. When the joint service was dismantled, it was agreed that RBC were to "*represent mental health services*" at MAPPA meetings, feeding back as appropriate to BHFT. The latter body would only attend if there were individuals with whom they were currently working. Martin Gill, the service manager for BHFT CMHT, agreed in his evidence, however, that it was important for someone from the Trust to attend, to explain any limitations in the treatments that could be provided and to clarify whether the challenges presented by someone in KS's position were linked to his mental health, and, if so, the importance of stabilisation for long-term trauma treatment.

219. Mr Macbeth was invited and attended. He had been informed in advance that KS was "*not open to CMHT*" and the only service currently involved within BHFT was the Crisis Team. The only action for BHFT following the meeting was "*to monitor and plan for KS's discharge from hospital*" given he was a voluntary inpatient at the time. At the date of the referral the Probation Service assessed his risk of causing serious harm to the public as high but at the meeting the Probation Service Offender Manager stated that this was now assessed as being very high. The decision at this meeting was to remove KS from MAPPA. This was procedurally wrong because there were actions that were still outstanding. Ms Thornden-Edwards, the Chief Probation Officer & Executive Director in HMPPS, accepted that this, amongst other matters, was a shortcoming in the way KS was managed by MAPPA.

220. A year later there was a further MAPPA level 2 referral on 24 September 2019, made by Ms Rixon. The reasons she gave for the referral included the high risk of harm KS posed to himself and the public, and that his risk would increase

significantly if he did not consistently take his medication and returned to problematic consumption of alcohol. As set out at [99] the Professionals' meeting had concluded he could not be appropriately supported in the community without access to support for his mental health. It was suggested that KS had become a "*revolving door*" through the various agencies owing to his mental health, which was "*unstable and (had been) left untreated*".

221. A MAPPA level 2 meeting was held on 4 October 2019 as a consequence of this referral. KS was in Category 3 due to the relevant offence and sentence and his risk was such that it required multi-agency input at a Level 2 meeting. It was attended by Thames Valley Police (Inspector Penny Jones), the National Probation Service (Mr Ennis and Ms Grace), the RBC Mental Health and Adult Social Care Service (Mr Macbeth), Change Grow Live - who had taken over the provision of drug and alcohol services from IRIS (Mr Knight) and RBC's Housing Department. CMHT were invited but did not attend and Ms Graham (Probation Service/St Leonards Approved Premises) was similarly invited and did not attend. Ms Rixon accepts that a representative from the prison should have been invited (this was mandatory). A written report from Ms Smith (Counter Terrorist Probation Officer), proposed that as KS was a MAPPA case, then MAPPA should take priority and lead in his case management. It also suggested that due to his mental health and vulnerabilities Prevent did not appear to be the most suitable avenue. With substantial foresight, Ms Smith expressed potential concern that he could become a "***<u>lone actor</u>***" (my emphasis) if unable to access the support he needed to address his experiences and trauma. A report sent by Mr Dunford (based, in turn, on comments by DS Spiers), stated that there was no evidence to suggest that KS's crimes were rooted within terrorism or extremism. 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.

222. It follows, therefore, that given the lack of appropriate attendees from BHFT, there was an overly restrictive focus on PTSD, ignoring KS's personality disorder. The minutes of the meeting suggested that KS would be featured at the forthcoming Channel Panel in a week's time. The minutes also recorded that Mr Dunford's written report had stated that "*(m)y concern is that if we were to put him through the Channel process it may exacerbate his issues rather than help him and in the long run that is not helping anyone*". It should be noted in this context that KS never did get put forward by Prevent to the Channel Panel.

223. It was indicated that CTPSE were aware of KS as he had stated that he would either like to commit suicide or return to Libya and die as a soldier for the Libyan Front and that he was a trained soldier. It was anticipated that on

release he would reside at St Leonards Approved Premises, in order to receive treatment in a controlled environment. He was assessed as posing a high risk of harm to the public and it was agreed that he would be managed at MAPPA Level 2 as a Category 3 offender but no review date was set. Ms Rixon considered that "*those in charge*" of MAPPA would bring him back prior to his release – that was certainly her intention, including by way of a fresh referral on her part – but this did not occur. She accepts, with hindsight, that it was an error of judgment on her part not to re-refer KS to MAPPA. Of particular interest given one of my overarching conclusions, Professor Blackwood agreed that if KS returned to substance misuse in breach of his licence conditions, the option of recalling him to custody might have been an appropriate short-term treatment option.

224. Two things are to be stressed at this stage. First, as analysed at [250], I consider that the assessment made by DS Spiers and Mr Dunford, based as it was on a very limited consideration of KS's background was simply inadequate. Mr Dunford, as with DS Spiers, accepted that he was unaware of some key elements of the intelligence picture on KS (*e.g.* the link with Omar Brooks and having fought for Ansar al-Sharia), which would have led him to suggest to MAPPA that there were significant concerns. Second, Ms Smith testified that if the extremist risk had been better assessed and the overall intelligence picture had been properly shared and assessed, the outcome of this meeting would have been very different, in the sense that KS would have been managed at Level 3 with contingency plans to cater for his deterioration in the community on release from prison. I found this evidence persuasive.

225. Relevant in this context, there was a meeting of the Inter-Departmental Risk Management Team (these were multi-disciplinary meetings involving prison and healthcare staff) on 26 May 2020, shortly before KS's release. It was noted that in February 2020 he received a letter from RBC withdrawing his tenancy and making financial claims against him. He was assessed as posing a risk of physical harm through violence, the use of weapons, inflicting emotional and psychological harm. Those at risk were suggested to be members of the public and, of relevance to what happened in Forbury Gardens, male strangers were particularly identified, along with his brother, police, probation and prison officers, detention officers, staff from the Reading Refugee Support Group, Launchpad and IRIS. Although there was reference to Reading Community Mental Health Team and Reading Adult Social Services needing to assess KS's mental health and social care requirements and "*to make referrals and offer signposting for assessments/diagnosis as needed*" and mention was made of counselling and trauma-based therapy, nothing specific was advised and no reference was made to BHFT.

226. Mr McAndrew testified that there was a lack of any evidence of MAPPA or other agencies on the "*outside*" seeking to draw information from prison security as to KS's security risk and the intelligence information that was held by the prison. As Mr McAndrew has set out:

> "An important learning would be to utilise information from time spent in Custody. Gaining feedback surrounding current issues and presentation regarding mental health, drug use and behaviour would have provided a more holistic and current picture of his situation."

227. On a further related issue, seven MIRs entered on the system prior to the attacks on 20 June 2020 had not been linked to KS on account of human error, when they should have been because they concerned him. This meant that they would not have been readily available when intelligence information was being sought on KS. If a standard request had been made for the intelligence profile of KS, because the individual MIR had not been matched with KS, they would not show up. This could have been of significance, but in fact these seven MIRs did not contain any intelligence information concerning an extremism risk of relevance to the present Inquests. This was a failing that, nonetheless, should be addressed by training and the content and distribution of any relevant standard operating procedures.

228. 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 Ms Rixon 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. Mr Vince 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.* Ms Rixon) 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.

229. Although Ms Rixon accepted it was an error on her part not to have re-referred KS to MAPPA prior to his release, in my view it would be entirely unfair to attribute any material blame to her on account of this single misstep. As I have already set out, her diligent, intelligent and unstinting approach to securing appropriate care for KS in an attempt to minimise the considerable risk he posed is deserving only of praise. She would have been aware that MAPPA had failed to provide any effective intervention up to and after 4 October 2019, and there was no reason to suppose that the news of his early release was going to change the minds of CMHT (who would not in any event have attended any further meeting of MAPPA because they had not accepted a referral for him), along with those who had determined that KS did not pose an extremist risk but instead had mental health problems that required, if necessary, a referral to the CPE or to the Crisis Team. As she said in evidence, the critical step with which MAPPA could have assisted was to secure the involvement of CMHT, and that proposal had consistently been rebuffed. Furthermore, for a crucial period her liaison with Andrew Bates had led her to hope that she had found a solution to starting appropriate therapeutic intervention via BTSS.

230. **PFD:** Given my concerns as to the absence of effective intervention as regards KS by Prevent and MAPPA, and although I am told considerable financial investment has been made since 2020 for the security investment programme and I have been informed in detail of changes that have been made, I remain concerned that a risk of future fatalities still subsists in relation to which action should be taken. I will therefore be issuing a PFD report to the Secretary of State for the Home Department and Secretary of State for Justice in this context which will include my concern over the handling of the seven MIRs.

Deportation

231. There was a notional period when KS could have been deported between 29 September 2012 when his visa expired and 15 October 2012 (when he applied for asylum), if he had been encountered during that short period by officials who realised he was an overstayer and made the relevant referrals. But KS would have needed to have cooperated with this process (escorted removals were not then occurring) and to have refrained from applying for asylum. It is unrealistic to suppose KS would have done either. In any event, KS would have been very low priority for removal as a non-criminal short-term overstayer and even if he had come to the attention of the authorities, they may well have not taken any action.

232. On 31 January 2013, the First-Tier Tribunal dismissed KS's appeal concerning his asylum claim, which had been refused on 6 December 2012. Given the evidence that had by then emerged particularly as regards his use of firearms and the groups such as Ansar al-Sharia with whom he had had dealings, his case should have been referred by the Asylum Directorate to the Special Cases Directorate. This did not occur but it is by no means clear whether, if that had happened, the case would have been referred to MI5. The failure to refer the case to the Special Cases Directorate was, in the words of Ms Sutton, a fundamental failure. His appeal against the First-Tier Tribunal was refused by the Upper Tribunal on 8 February 2013 and his appeal rights were exhausted on 1 March 2013. Asylum support ended on 22 March 2013. Although enforced escorted returns to Libya recommenced in June 2013, this was only for "*documented cases*" and KS did not have a passport. Full details of the passport he used to travel to the UK were held in the British Embassy in Tripoli. It was valid to the 4 March 2015. There was no process in place to obtain a substitute passport from the Libyan authorities without KS's consent, which was not forthcoming (at least from 8 July 2013). An interview at the Libyan Embassy would have been necessary.

233. On 4 September 2013, KS applied for the Assisted Voluntary Return ("AVR") Scheme via Refugee Action, thereby indicating his preparedness to return to Libya. The policy at this time was to suspend all enforcement action once an AVR had been submitted. By 14 November 2013, KS had indicated he did not want to return to Libya and had only applied to AVR scheme "*to obtain housing and funds*". It would have been impossible to enforce KS's return because he would have needed to cooperate with attendance at the Libyan Embassy to progress the substitute travel documents and in enabling access to his medical records.

234. There was a single period, however, between 26 March 2014 and 12 July 2014 when KS was not required to attend the Libyan Embassy to obtain replacement travel documents and he could have been removed. However, KS had indicated on 26 March 2014, on reporting, that he did not want to return and had a solicitor considering his case. On 9 May 2014 his reporting was varied and KS became subject to three-monthly reporting requirements. He was not due to report to the authorities again until 6 August 2014. On 15 May 2014 he was encountered by Greater Manchester Police and he indicated he had seemingly changed his mind and did want to return to Libya. The police informed the Home Office of this, and KS was told to attend his next reporting event to complete the paperwork. On 12 July 2014 the battle for Tripoli Airport commenced, and any realistic opportunity to remove KS then ceased given the risk to his life if deported. Although between 26 March 2014 and 12 July 2014

there was a brief window of opportunity for removal, the security situation in Libya was deteriorating and it would have been necessary for the Libyan authorities to have responded extremely speedily to the request for substitute travel documents. Furthermore, given the state of KS's mental health, the removal would necessarily have been escorted and there would have been real concerns about the safety of the escorting staff, who would have included a medic. Viewed realistically, I do not consider that it would have been feasible to remove KS during this extremely short period.

235. I pause at this point to interject with the observation that from 12 July 2014 KS was still in the UK illegally, his case for asylum having been refused. He had no legal status in this country, which meant he was unable to work or to access benefits, housing or governmental support. Yet he was also unable to return to Libya because of the situation in Tripoli.

236. 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. However, even applying the correct guidance, a decision to remove KS would very likely not have been taken because of his known mental health conditions and his criminality which was insufficiently serious. Furthermore, deportation at this stage was a practical impossibility given the risk to his life in Libya and the closure of Tripoli airport.

237. On 25 March 2016 KS was granted "*section 4*" support (which included accommodation and a payment card) but this was discontinued on 21 December 2016. Ms Sutton agreed that the lack of money, accommodation and access to full health care risked exacerbating his vulnerabilities. There were multiple teams dealing separately with his asylum claim, his applications for support and other administrative issues, such as his "*enrolment for biometrics*" and safeguarding issues. These "*hand-offs*" between separate parts of the Home Office led to "*delays in progressing his case*".

238. On 28 June 2017, the Upper Tribunal handed down judgment in the case of ZMM, the effect of which was to establish that "*(t)he violence in Libya has reached such a high level that there are substantial grounds for believing that a returning civilian would, solely on account of his presence on the territory of that country or region, face a real risk of being subject to a threat to his life or person*". On 1 May 2018, it was recommended that deportation action should not be pursued because of the country situation in Libya, and that KS should be granted 6 months' discretionary leave to remain, which would have been a correct

approach in light of KS's criminality and the inability lawfully to deport him. However, it transpired that in April 2018, the Home Office had already indicated to KS's legal representatives an intention to grant five years' humanitarian protection, upon which KS agreed to withdraw his appeal against the refusal of his further asylum claim. Regrettably, errors multiplied. On 15 November 2018, during the course of defending an application for judicial review brought by KS, it came to light that, as just set out, the Home Office had previously undertaken to grant him 5 years' humanitarian protection and the Director of Criminal Casework agreed this should be granted. Yet when this direction was processed on 22 November 2018, the caseworker, in error, granted 5 years' discretionary leave to remain rather than 5 years' humanitarian protection. This mistake was not uncovered until the decision was made not to pursue deportation in 2020. Although these mistakes had no practical effect on removing KS to Libya, they add to the history of worrying mistakes.

239. The idea was floated of removing KS to Libya via a third country but as Ms Sutton explained the practical problems associated with such a move would have been formidable, including leaving KS destitute in a third country.

240. By way of conclusion on the issue of deportation, in reality there was never a sufficient opportunity to deport KS given the grave situation in Libya and the necessary requirements for his removal. I have not listed all the mistakes that were made by the Home Office in this context but they were multiple and, as revealed by those cited above, of very significant concern, albeit none of them were the cause, separately or cumulatively, of impeding an opportunity to remove him from this country. Given the overall handling, however, of KS's case, there is a persuasive basis for suggesting that 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 on an accurate basis. It was simply good fortune that one or more of the errors did not result in KS still being in England when he ought to have been returned to Libya. I regret to observe that the handling of KS's case fell, at times, far below the standard that could properly be described as acceptable.

241. **PFD:** Notwithstanding improvements that have been made in recent years, I will have observations to make in due course to the Secretary of State for the Home Department in a PFD report as regards the multiple failures in the handling of KS's case.

Discontinuance of proceedings

242. 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 that KS was soon to be deported. On 28 May 2020, an administrative officer in the Home Office's Foreign National Offender Returns Command sent an email to the Information Research Bureau PNC Data Integrity Team which is part of Thames Valley Police requesting, *inter alia*, that the email was forwarded to the officer in the case so that consideration could be given to taking no further action in respect of these offences in favour of the Home Office pursuing KS's deportation. Following further communications with the Crown Prosecution Service, on 29 May 2020 the decision was taken to discontinue the proceedings. This was a clear failure by the Home Office – the proceedings were discontinued based a plainly erroneous understanding of KS's immigration status and removability. However, KS had been granted bail and was not due in court until 10 July 2020, therefore after the events in Forbury Gardens.

243. This mistake had no impact, therefore, on what occurred on 20 June 2020 but in different circumstances it could have been of real significance. Changes have been instituted, namely a request is only made for consideration to be given to discontinuing a case when written approval has been given by an assistant director, Grade 7.

244. **PFD**: Notwithstanding any improvements that have been made, I will have observations to make in due course to the Secretary of State for the Home Department in a PFD report as regards these failings.

The Lack of Recall to Prison

245. Whether or not a decision is made to recall a prisoner on licence to prison will depend on a careful assessment of all the relevant information and circumstances. As the present Inquests vividly demonstrate, this can be a critical decision in the context of public safety. It follows that my assessment of this aspect of the history is vitally dependent on an understanding of the adequacy of the arrangements for sharing relevant information between the agencies concerned with this potential step.

246. At the outset I note that although the Probation Service had access to VISOR (the Violent and Sex Offender Register), this was an unsatisfactory system in the sense that it could only be accessed via particular terminals in designated offices, the information uploaded on to it was partial and it was markedly

difficult to use. Furthermore, it did not provide any analysis of the material uploaded. Instead, intelligence would have tended to be passed to probation via security reports. However, the security and intelligence reports in relation to KS were, on occasion, markedly deficient which meant that the local police and the Probation Service were critically ill-informed as to the risk posed by KS. Some of the relevant evidence on this issue has been considered earlier in these factual findings.

247. Mr McAndrew testified that one of two ways that probation staff could get a detailed understanding of a prisoner's intelligence profile was through that information being shared at a Pathfinder meeting. The other was if there was a MAPPA meeting, when the prison would share, albeit in sanitised form, a read out of the significant parts of a prisoner's intelligence profile by way of the MAPPA form F.

248. The following four instances of failures to communicate the true position are merely examples of the failure to share information that was necessary for making decisions such as these:

i) DS Spiers accepted that a four-page "*trace summary*" completed in May 2019, omitted significant information such as KS's historic association with terrorist offending in 2017, his link with Omar Brooks, and his potential support for, and links to, ISIS and Ansar Al-Sharia. Although, for instance, the recorded counterterrorism "*system traces*" included reference to intelligence about KS's stated desire to blow people up and to travel abroad to shoot people, the 24-word assessment section made no mention of anything other than KS's history of assaults. All, or nearly all, of these omitted factors were unknown to DS Spiers.

ii) On 17 June 2019 a CTPSE General Intelligence Report concluded "(*t)here is no intelligence that suggests KS wishes to commit any terrorism offences. (DS) Spiers assesses that KS does not present a CT/DE risk at this time and a robust support package is in place*". On any view, this was a partial and misleading assessment.

iii) On 27 & 28 August 2019, DS Spiers exchanged emails with Ms Randle (Community Rehabilitation Company) in which he listed the frequency of KS's offending, observing that he uses weapons "*to get revenge*" but he then expressed the view that

"*there is no ideology present*". DS Spiers accepted he had been "*narrow in his assessment*" and "*was not seeing the wider picture*".

iv) On 11 September 2019, DS Spiers was asked by Ms Rogers as to whether KS would be suitable for a Channel referral, given Launchpad (Reading) had written referring to his escalating outbursts and on the basis of KS's references to having been recruited to a Libyan liberation army as a childhood soldier, whilst wanting to be a martyr and being prompted by voices in his head. In their view, either KS would get killed or he would kill someone else. DS Spiers replied that they were seeing a "*lack of ideology*" and KS was not a national security threat, although he was a risk to those he wanted to harm. These views were then provided to MAPPA on 3 October 2019 on behalf of CT Prevent by Mr Dunford, in almost exactly the same format as expressed by DS Spiers. This provided the rationale for the closure of the Prevent referral. This view was, therefore, adopted, repeated and acted on.

249. ACC Metcalfe agreed that the evidence provided clear examples of information not being shared. As a stark example of this, commented on by ACC Metcalfe, KS had told the immigration authorities in his asylum interview in 2012 that he had been a member of Ansar al-Sharia but that had never been reported to the counter-terrorism police, including after it was proscribed in 2014. A further demonstration of this was the failure by CTPSE to pass on to Thames Valley police on 16 July 2019 (when they made contact because KS had said he wanted to hurt other people, get a gun and shoot the public) information as to KS's military training and having been taught how to do use an AK47 assault rifle, which he used while in Libya for some years. The response simply was "*CTPSE do not hold any current intelligence. Appropriate measures are in place to ensure that he doesn't leave the UK*".

250. ACC Metcalfe accepted, furthermore, that the material in the possession of CTPSE demonstrated an extremist ideology on KS's part and training in violence. He was of the view that numerous assessments made by CTPSE as to the risk that KS posed were either incorrect, wrong, inadequately researched, deeply contradictory, misconceived or showed an insufficient understanding of the context in which KS had been operating in Libya. One assessment as to KS's capabilities was "*indefensible*". Furthermore, there was an indication of a lack of understanding on the part of CTPSE officers as regards the conditions in Libya at the time or an acknowledgment that an individual can have mental

health challenges and simultaneously have a propensity for violence and be a subject for radicalisation. In my view these are significantly troubling failures.

251. Added to this problem as regards sharing crucial information about KS, the police OASIS command and control system (subsequently replaced and updated) and the Niche system (a records management system for all aspects of crime recording) did not readily provide the police with access to the relevant information that had been communicated to them (see [261]).

252. This critical deficiency in intelligence-sharing and access to intelligence forms part of the crucial backdrop to events on 19 June 2020 when KS's brother, Aiman Saadallah, called Thames Valley Police at 14.44, following a visit by KS who had showered and shaved at his brother's home. The record of Aiman Saadallah's call on the police OASIS system is as follows:

> "(KS) said he is going to go to heaven and has left some stuff in the flat for the caller. He has indicated he is going to harm himself and others. (KS) said he was going to blow himself up - did not give any indication on how he intended to do this. (KS) has just got out of prison."

253. This call should have led to a visit by police officers at KS's address within an hour.

254. The record continues at 14.53:

> "(KS) has some (previous) mental health issues. He has a personality disorder and PTSD. He was on some medication but he's just got out of prison. So unsure what (medication) he is on now. He was at Prospect Park yesterday. Staff at the hospital called caller to say (KS) was suffering with hallucinations. (KS) has made comments about the devil speaking to him when he was in prison. When he was in prison he told the caller he was going to blow himself up' (KS) has tried to harm and kill himself lots of times in the past. He has tried to jump off a bridge and out a window. Before he has been sectioned under the MH Act before and is known to cut himself. (KS) has used blades to cut himself before. Caller states that (KS) does not have a blade with him now caller is referring to razor blades."

255. The record then sets out that although KS is usually disturbed, it is "*not like this*". It is then described that he is a danger to others. Critically, at 15.39 the record continues:

"**I have had a brief check of niche and there is nothing to support any terrorist/lone wolf ideology.** I believe that this is currently a cry for help/mental health-based incident. I will speak with CTPSE to ensure that he is not known on their systems." (my emphasis)

256. At 16.41, there is the following record:

> "**From CTPSE**: We are aware of this male for similar reporting in the past. He was assessed by Prevent in 2018 but was not adopted by them. We have no current intelligence of concern to make area aware of in addition to what is already included in this log."

257. At 17.49, it is set out:

> "Have spoken with caller, he has since spoken to his brother - he said he seemed a lot happier on the phone this time round. His brother stated he was at home. He spoke with him around 1500hrs. His brother said he was only joking with the (previous) comments **but caller doesn't trust that he was joking**. But he seemed in happier spirits when spoken to." (my emphasis)

258. The record continues at 18.18 that the police had spoken with the Crisis Team and established they had called at KS's flat whilst he was out and that they intended to make contact on the following day. As a result, no further action was required by the police.

259. It would appear that the officers on duty did not gain access to KS's full criminal record. Certainly, on the OASIS Command and Control System there was only the briefest summary:

> "Warnings for mental disorder, self-harm, violent, **assault police**, alcoholic, suicidal, weapons *may possess knife - 2013**. Most recent occurrence arrested for offensive weapon 20 August 2019. Also (previously) arrested for assault police, (criminal damage), theft, assaults, public order […] multiple older for similar."

260. They additionally brought up a few scant details of the convictions that had resulted in the sentence leading to his release on 5 June 2020. There were, additionally, 14 warning markers which included KS carrying weapons. There was nothing on the system referring to KS's (frequent) adherence to a terrorist ideology.

261. Inspector Rowe, who was on duty on the evening of 19 June 2020 as Force Incident Manager ("FIM"), explained that the OASIS Command and Control system had undoubted limitations if an officer was trying to gain a full picture of an individual's history (OASIS has now been replaced by a Microsoft system). Keyword searches on Niche are complex and can take time and the Control Room did not have a dedicated intelligence analyst. This problem still persists. The criminal and intelligence history screen may have multiple tabs which individually can be quite long. Moreover, the information is partially hidden because it was necessary to expand the relevant column in order to view the content. As a result, the individual interrogating the system is dependent on "*warning markers*" inserted by others which is done on a selected basis. DS Spiers agreed that the information available on Niche was extremely limited. Inspector Rowe was unaware of any of the concerning background information relevant to KS save for the few details which I have just set out.

262. Inspector Rowe, additionally, agreed that KS's then licence conditions should have been established, particularly bearing in mind his recent release from custody for a knife-related offence and the gravity of the present threats. It is to be noted that the probation officer's contact details are routinely provided at the relevant point on the PNC record of convictions, which in this instance revealed that KS was on supervised licence on conditional release. The PNC record would have been available in the Control Room but it was not seemingly viewed by those on duty. Inspector Rowe accepted that his recent release from prison on licence was a "*potentially relevant*" factor.

263. The police did not pass any of this information concerning the report from Aiman Saadallah to the Probation Service, via the established mechanism for the police to share material with probation out of hours. Inspector Rowe said that if he had known that KS was on licence and had the active support of an offender manager, consideration would have been given to contacting them. Moreover, if he had been aware of the full background intelligence picture on KS, he would definitely have ordered that contact be made with probation.

264. It is critical in this context to recall that Ms Rixon was clear that an out of hours recall would have been almost certainly actioned in these circumstances, if the relevant information had been provided. There are senior probation officers and regional directors on duty out of hours and the recall would, therefore, have been effected the same evening. Ms Rixon additionally testified that it had not been made clear to her, at team meetings or at MAPPA, that it was considered that, although KS had a personality disorder and elements of PTSD, he was fully responsible for his criminal behaviour. Therefore, if he chose not to abstain from drugs and alcohol, there was little that could be done in the

short-term and the agencies such as probation needed to deal with risk he presented. This reinforced that her view on 19 June 2020 would have been that KS should have been considered for urgent recall to prison.

265. In a similar vein, Ms Rogers, as set out at [187] above, had been unaware of KS's link to Ansar al-Sharia, his potential psychopathic tendencies and the extent of his sometime grievances against the UK. She testified that if probation had known of these and other factors or if an investigation by counter-terrorism police and by MI5 had taken place, their view of KS's risk level could well have changed to very high risk. Moreover, as a CPPC MAPPA 3 case with an identified terrorist risk, his recall to prison for breach of his licence conditions, and his detention, would have occurred within 2 hours. Ms Graham from St Leonards, faced with a high-risk offender who had made the threats that Aiman Saadallah reported on the 19 June 2020, would have "*pushed strongly*" for an emergency recall to prison. If he was very high risk, the paperwork would probably have been prepared in advance.

266. Instead, KS was visited at home by three police officers at around 19.15 (over four hours after Aiman Saadallah's telephone call). It would appear that all they had been told was that this was a "*welfare check*" and they had not been briefed, therefore, as to the details of what had been relayed by Aiman Saadallah to the police earlier in the day. After repeated knocking, KS opened the door. He was dismissive of the enquiries they made as to his wellbeing. With hindsight, it can be seen on the body-worn camera footage that KS positioned himself in such a way that he made it less likely that the police officers would see or get close to the knife from Morrisons which was lying in the area of his bed. In my assessment, the officers cannot be criticised for not spotting this at the time. PC Perham, who had met KS previously, considered he was the "*best he'd ever seen him. He was the most talkative with me and able to have somewhat of a conversation*". I accept without reservation that on the information available to the officers undertaking this visit, including from PC Perham's previous dealings with KS, they had no reasonable grounds to arrest KS or to consider detaining him for his own safety or the safety of others.

267. **PFD**: The failures in creating and running a system whereby intelligence in this context is collected, analysed and appropriately distributed/made available has caused me considerable concern. Accordingly, I shall be sending the Secretary of State for the Home Department and Chief Constable of Thames Valley Police PFD reports in this regard.

The Security Service

268. Witness F gave extensive evidence on the operation of the Security Service ("MI5") in circumstances such as the present, to the extent appropriate to discuss in open court. He provided an informative and helpful contribution to the Inquests. Ultimately, his evidence demonstrated that there were no material additional steps that could have been taken by MI5 which would have affected the outcome of this case.

269. Critically, Witness F emphasised that in addition to operating within the limits of the law, MI5's finite resources are prioritised against the large number of subjects of interest known to MI5 at any one time. Accordingly, since 2011, MI5 have had in place a formal triage process which means that certain priority individuals are focussed on.

270. MI5 first received information about KS in late 2016. Prior to the decision to open a Lead investigation in 2019, KS was the subject of three 'triage" assessments by MI5 under their Intelligence Handling Model ("IHM"). On each occasion, the intelligence received was justifiably assessed not to meet the threshold for the creation of a Lead investigation. For the first triage in late 2017, MI5 were informed that KS had indicated that he wanted to kill himself, and that he had aspirations to return to Libya to engage in violence. For the second triage, MI5 were informed that whilst incarcerated KS expressed a desire to return to Libya to start a revolution before returning to Britain to "blow people up". The credibility of this information was unknown but it led to the second triage event being conducted in May 2018. MI5 was informed that KS's poor mental health had a significant impact on his behaviour. CTPSE indicated, albeit they provided out-of-date and inaccurate information, that KS was being held in HMP Bullingdon and was due to be deported to Libya. They assessed that as KS would not be released into the general population, and any future risk would be based in Libya, he did not pose a threat to UK national security at this time. CTPSE therefore recommended that no further action be taken and, unsurprisingly, MI5 agreed with that recommendation. Had the correct position been communicated, a Lead investigation would have been opened. The third triage was in December 2018. MI5 received information that whilst in custody in a police station in November 2018 KS had raised the prospect of returning to Libya to engage in violence in support of his family, as well as claiming that he intended to commit suicide and ensure that others died in the process if he was not deported imminently. None of the threatened violence was considered to amount to terrorist intent and/or ideology. MI5 concluded that it did not meet the threshold for a Lead investigation.

271. Although there would have been a case, based on the cumulative effect of all the information from the three triages, to open an investigation at this stage, there is no basis for concluding that this would have resulted in a different outcome from that reached following the opening of a Lead investigation in April 2019, to which I now turn.

272. In April 2019, investigators received information suggesting that KS had claimed he was going to return to Libya and join the Islamic State of Iraq and ISIL, alongside his brother and an associate. Ml5 discussed this information with CTPSE and a joint decision was reached that a Lead investigation should be opened. The purpose of the investigation was to gain a better understanding of KS's mindset, establish the nature of his travel aspirations, and mitigate any identified threat to national security.

273. It was during the course of this Lead investigation that MI5 investigators became aware that KS had fought for Ansar al-Sharia in the Libyan uprising in 2011. MI5 also became aware of his immigration position and elements of his mental health difficulties.

274. The main focus of MI5's Lead investigation was on the risk of KS travelling for extremist purposes. Although there is a basis for suggesting the Lead investigation could have been widened, no credible information existed to suggest that KS was planning an attack in the UK. In the event, MI5 conducted a range of enquiries during the investigation but did not obtain any intelligence to suggest that KS had a genuine intention to travel to Libya for Islamist extremist purposes or further information that KS subscribed to an Islamist extremist ideology more generally. In particular, MI5 received no intelligence to corroborate or otherwise substantiate the information received in April 2019. It was assessed that KS did not want to return to Libya, and indeed at no subsequent point did he seek to do so. Additionally, MI5 were unable to identify a valid, current travel document belonging to KS. MI5 therefore assessed that the reporting was unfounded. MI5 therefore concluded that it was no longer necessary or proportionate to maintain its investigation.

275. In June 2019, MI5 and CTPSE, therefore, agreed to close the Lead investigation. I have no doubt it was a reasonable decision to close the Lead investigation at this point. As Witness F explained, there were relatively few remaining options for further investigative actions to develop coverage of KS, and those that remained were, justifiably, no longer judged to be necessary and proportionate. Furthermore, it was unlikely that the Lead investigation would have met the threshold for referral to a Priority investigation to commit further resource and coverage. I agree with these conclusions. In summary, MI5 had no credible

intelligence to suggest that KS was planning an attack in the UK and since the closure of the investigation they received no information to suggest he posed a risk to the UK's national security. In the circumstances, there was no realistic possibility of MI5 preventing the attack at Forbury Gardens from taking place.

276. **PFD:** Although slightly different decisions might have been taken, such as opening a lead investigation in 2019, these had no impact on the outcome of this case and they relate to the exercise of judgment in difficult situations. As regards the Security Service, therefore, I will have no observations to make in a PFD report to the Secretary of State for the Home Department. I will be raising, as indicated elsewhere, the issue of the sufficiency of the material provided to MI5 by CTPSE in 2017 and 2018, which I consider to have been inadequate.

Probation

277. During the evidence it became apparent that in a few instances probation should have made different decisions, for instance, as I have already highlighted, Ms Rixon overlooked to convene a MAPPA meeting prior to KS's release on 5 June 2020. Another example was the quality of a pre-sentence report prepared for a sentencing hearing in March 2019. The author of the report had not completed her training and her line manager had not checked the report before it was issued. Although I do not intend to enumerate them, the problems were multiple and the standard of the report was very low. The consequence of this poor work could have been significant in that the risk level was put at medium instead of high (*e.g.* in contradistinction Mr D'Aguiar's assessment of risk was high). The potential ramifications were wide: not only did the report, given its contents, have a potential adverse effect on the outcome of the court case but the probation role was, as a consequence, allocated to the Thames Valley Community Rehabilitation Company for a period of some months; moreover, there was a missed opportunity to secure forensic psychological assessment and input. However, the case returned to the National Probation Service in late August 2019 and on any realistic assessment, the terms of this report did not contribute to the outcome on 20 June 2020.

278. **PFD**: I consider these were essentially isolated events, the significance of which has been recognised by the National Probation Service. This and the other relatively minor matters are not of sufficient significance as to lead me, in due course, to make further observations in a PFD report to the Secretary of State for Justice.

KS's planning for the attack

279. Mr Justice Sweeney described the period immediately prior to the attacks as follows:

> "After his release from a prison sentence on 5 June 2020, the Defendant began to plan his attack and, by 15 June 2020, had identified Forbury Gardens as a potential venue for it. On 17 June 2020, he reconnoitred Forbury Gardens and confirmed it as the venue."

280. Adding slightly more detail, on 15 and 16 June 2020, KS used the internet to view images of Forbury Gardens and the sizeable Maiwand Lion, a statue which is considered by many to symbolise Reading and spirit of the town. He additionally viewed an image relating to "*Operation Volcano of Rage*".

281. On 17, 18 and 19 June 2020, KS accessed material on the internet which included information about the attack on the Twin Towers, the Daesh/Islamic State flag, potential job opportunities and a mosque in Reading, and the Islamic Association in London. Additionally, he looked for information on witchcraft. He viewed an image of firearms.

282. On 19 June 2020, KS purchased the knife he used in this attack from Morrisons. It had an eight inch or 20 cm blade. He produced identification to prove he was old enough to buy the knife.

283. Evidence was given as to KS's movements during the early part of 20 June 2020. He visited a local store called Whitley shortly before 8.30 am. In the mid-morning, he researched the Abu Bakr Mosque Reading online, which he tried to contact by telephone but his call was not answered (it coincided with morning prayers). He made contact, again by telephone, with his brother Aiman Saadallah, his sister Khiria and an associate, Michael or "Mickey" Haynes. Money was transferred to KS by Mr Haynes for welfare purposes. During the morning, KS spoke to a neighbour, Adam Lamond, most likely about buying cannabis. The latter had no intention of assisting KS in this regard. Shortly after midday he travelled by bus into Reading and called a telephone number ending 4170 three times (this number was associated with drug dealing). Thereafter, he withdrew £60 from an ATM at a Tesco store on the Oxford Road, whilst wearing gloves. He purchased denim shorts, white trainer socks and a black "hoody" from Primark. He then returned home, now wearing a Union Flag bandana around his neck. The denim shorts were of a length to enable KS to disguise the knife. Mr Justice Sweeney concluded that the clothes he bought were designed to ensure that he blended in with those in

Forbury Gardens on a summer's evening, to enhance the element of "*maximum surprise*" which he clearly hoped to achieve.

284. KS next went out shortly after 15.30. He was now wearing the denim shorts and a grey "hoody". He most probably bought cannabis from two men outside the store called Whitley. He used an ATM inside the store and he then returned home.

285. KS left his flat for the final time at a little after 18.00. Later found amongst the paperwork at his flat was a note which read:

> "May God release the prisoner who took part in wars, (may) he serve God's land with good. Do not be afraid brother, one day from God, we will break the prison chains. He forgives the sins. We will be free and carry out jihad and ask my Lord God that when I hold the arm, tears of joy will come down about the Hoor-al-ayn [the Virgins of Paradise] that will be happily waiting for me."

286. There were notes found referring to the Book of Revelation and the Day of Judgment.

287. He gave two bibles to a woman who was coming into the block of flats as he was leaving. He wished her either a "*better*" or a "*good*" life. As to KS's state of preparedness and what was in his mind, Mr Justice Sweeney concluded:

> "When the Defendant left home to carry out the attack, the knife was in the backpack that he took with him, together with a plastic razor. His intention, for the purpose of advancing his extremist Islamic cause, was to kill as many people as possible in as short a time as possible, and thereafter to escape - then to injure himself with the plastic razor in the hope that he could pass himself off as a victim."

288. He walked to Reading Town Centre, taking just over 30 minutes. He bought a bottle of water from Bays Piri Piri takeaway and left his small change in a collection box for an Islamic charity. DCS Wright assessed that these acts were consistent with KS cleansing himself and preparing for jihad. The CCTV footage of his time in the takeaway shows KS seemingly acting in a calm and rational manner.

289. KS then went to Forbury Gardens. It is important to observe, as indicated by DCS Wright, that the authorities had no prior intelligence that KS had been planning an attack in Forbury Gardens. KS stood at one of the side gates for about 15 seconds. This gave him a good view of where people were sitting and provided him with an opportunity to decide who he was going to attack from amongst those on the nearby grass area.

290. KS then moved to a seating area opposite the park, outside the "Veeno" bar on the corner of Valpy Street and The Forbury. He threw certain items away. He determinedly tried, but failed, to destroy his mobile telephone by hitting it with a rock or a piece of concrete and stamping on it. He left it by his bag, near some bins. He also placed a disposable razor on the ground by the bins. He concealed the knife in his shorts. As he crossed the pavement heading back towards Forbury Gardens, KS removed the Union Flag which he had been wearing on his knee and discarded it on the pavement.

<u>The attack by KS and the assistance provided by those present at the scene</u>

291. Mr Justice Sweeney's summary of what occurred is as follows:

> "9. Having entered the Gardens, he waited until he was close to the first group and then commenced his attack with ruthless speed and brutality such that, as I have already indicated, James Furlong, Joseph Ritchie-Bennett and David Wails had no chance to react, let alone to defend themselves. Using his combat experience, in each of their cases the Defendant targeted a vulnerable area where a single thrust of the knife would, as he intended, inevitably cause death.
>
> 10. As I have also touched on already, it was the loss of the element of surprise that saved Stephen Young from the same fate, and (although the Defendant sprinted across to the second group) saved Patrick Edwards and Nishit Nisudan as well.
>
> 11. During the course of his attack and afterwards, and because he was seeking to advance a political, religious, or ideological cause the Defendant was shouting in Arabic "*God is the greatest*" and "*God accept my Jihad*".

292. A member of the public in the park, Lawrence Wort, described KS "*darting*" at the first group which consisted of James Furlong, Joseph Ritchie-Bennett, Dr David Wails, Stephen Young, Ionut Paraschiv, Oliver Seaman and Roger Smith.

KS shouted something in a foreign language. The three men who died were each attacked from behind and Mr Wort described KS as exerting himself whilst he stabbed his victims (the sound he made was like a "*grunt*" from a tennis player). The attack was quick and, at least initially, the group clearly did not appreciate what was happening.

293. It is to be stressed that KS targeted vulnerable parts of the victims' bodies, especially major blood vessels, which if compromised would almost undoubtedly lead to loss of life. James Furlong was stabbed to the neck, cutting the carotid artery and jugular vein. This led to catastrophic internal bleeding and the inhalation of blood. Dr David Wails was stabbed to the left of his upper back, and the knife punctured the apex of his left lung and it severed the left subclavian artery and the common carotid artery. This resulted in a torrential internal haemorrhage. The electrical activity which a Helicopter Emergency Medical Service ("HEMS") paramedic later thought could be detected during treatment was something which often occurs *post mortem*. Joseph Ritchie-Bennett, as with James Furlong, received a single stab wound to his neck, which severed the internal and external carotid artery and "*nicked*" the jugular venus system, again causing a massive internal haemorrhage and the inhalation of blood. With each of the deceased, the evidence overwhelmingly indicates that they would have had fleeting or no awareness of what had happened, given they would have been deeply unconsciousness in well under a minute – indeed, most likely within a few seconds – a state in which they would feel no pain.

294. Mr Young was stabbed on the left side of his forehead, leaving an injury of 5 centimetres. He made his way out of the park, where he was assisted by passing members of the public.

295. As KS ran towards the second group, Mr Smith and Mr Paraschiv shouted out that he had a knife. This group included Patrick Edwards, Nishit Nisudan, Orsiloya Bacai, Rali Mischova and Matt Mercer. KS ran at speed towards them. Indeed, Mr Edwards estimated that there was only about 7 – 10 seconds between his first sighting of KS to the latter disappearing out of the park. KS inflicted a two-centimetre wound to the middle of Mr Edwards's back, which penetrated his chest resulting in a small haemothorax (a collection of blood in the space between the chest wall and the lung). He was held in hospital overnight because blood had "*pooled*" in one of his lungs. KS tried repeatedly to stab Mr Nisudan in the face, and on the third attempt succeeded. He inflicted a significant wound to Mr Nisudan's right cheek, with an associated fracture to his cheekbone and nerve damage, which required surgery. His face is now partially numb and he has been left with a significant scar. His right palm was

wounded and there were cuts to his fingers resulting in tendon damage. These latter injuries were the result of his attempts to defend himself.

296. The attack overall lasted for only approximately 30 seconds and the CCTV footage reveals that KS moved very quickly whilst stabbing the victims in the two groups.

297. As Mr Justice Sweeney set out (see [291] above), KS had been able to draw on his combat experience when attacking the victims. However, I am additionally persuaded by the evidence of Dr Cary, the Consultant Forensic Pathologist, that KS must have received training as to how most effectively to kill with a knife in circumstances such as the present. As Dr Cary has set out:

> "In my opinion it cannot be a matter of chance that all three died of a single stab wound that damaged major blood vessels at the junction region of the head and the neck. This implies that there had been targeting of this region, potentially reflecting an intention to kill. The ability to target this region may have been self-taught, including through the use of instructional video material available on-line. It could also have been taught by others, including as a possibility (if relevant) in a training camp. From a purely pathological point of view I am unable to determine which of these applies."

298. Returning to Mr Edwards, following his injury, he demonstrated noteworthy courage. Whilst calling 999, he turned to help Mr Nisudan but saw that the latter was being assisted by Ms Bacai. Instead, therefore, whilst talking to an ambulance service call taker by telephone, he went over to the first group in order to aid one the three most seriously injured victims, who he later believed to have been James Furlong. He described this victim to the paramedic as appearing to be "*lifeless*" (he had stopped breathing). The operator indicated he should perform CPR (cardiopulmonary resuscitation). Although Mr Edwards felt somewhat panicked at this suggestion, he decided he should "*just get on with it*" because he knew what to do. He commenced CPR and after about a minute a police officer indicated he was doing a good job and suggested he should carry on. A little later another police officer took over administering CPR. It follows that notwithstanding his own potentially life-threatening injury, which had not been assessed or treated, Mr Edwards' preeminent concern was for the welfare of the other victims. Although there were many acts of public-spirited generosity during the immediate aftermath of KS's attack, Mr Edwards notable lack of concern for himself whilst he cared for a more seriously injured victim is of considerable credit to him.

299. In a statement which he made on 22 June 2020, Mr Edwards described that immediately following the events in Forbury Gardens he experienced a "*savage emotional reaction*" and was considerably upset. He particularly felt a strong sense of guilt that James Furlong had died and that he had not chased or tackled KS. Although such a reaction is entirely understandable, it is self-evident that such thoughts are, for the best of reasons, entirely misplaced.

300. Evidence from two individuals particularly demonstrates the impressive assistance which was provided to the victims by some quick-acting members of the public immediately after the attack. Indeed, their reaction is paradigmatic of the praiseworthy response of those members of the public who sought to help the injured men.

301. First, James Antell was sitting about 10 metres from the first group. He became aware of what he describes as a commotion. As soon as he heard a call for "*first aid*", he ran over to help because of his training in first aid. He initially tried to assist James Furlong by looking for obvious wounds. He noted that his breathing was shallow and irregular. Along with another member of the public, he applied pressure to Mr Furlong's injury. He then moved over to help Joseph Ritchie-Bennett, who was totally unresponsive. Mr Antell found the wound to the back of his neck. Thereafter, police officers arrived and Mr Antell assisted them in attaching and operating a defibrillator. He applied a bandage to the neck wound. Next, he provided information to the first paramedics who attended at the scene. Mr Antell acted responsibly, humanely and with great presence of mind in an extremely difficult situation.

302. Second, Hannah Lennon similarly responded in a public-spirited and effective manner. She is a trained nurse and in the immediate aftermath of the attack she initially assisted two of the victims who had been stabbed but who were able to walk by persuading them to sit on a bench, in order to avoid fainting and to help in the process of staunching their wounds. Thereafter, she assisted with the three fatally injured victims, particularly by describing the nature of their injuries to the 999 operator and giving her assessment of their levels of consciousness. Prior to the arrival of the police, she ensured that pressure was being applied to each of the sites of their wounds. She ran to fetch a defibrillator from a nearby hotel and she assisted police officers in operating one of the devices when, for one victim, no heart rhythm was detected. Once the ambulance crews arrived, she left the park. Her actions are worthy of particular recognition.

303. KS managed to escape from Forbury Gardens, jettisoning the knife as he went, and he returned to the area outside the Veeno bar where, as he had planned, he cut himself with the razor and then endeavoured to make off. However, he was courageously chased by Mr Smith, Mr Paraschiv and PC Packman (an off-duty police officer). Shortly afterwards, the pursuit was taken up by PS Watkinson (a local Reading Response PS) together with PCs King and Steele. They tackled KS while unarmed, despite being fully aware of the stabbing in Forbury Gardens very shortly before. They did not await Taser or Armed officers but tackled him quickly and impressively. All of those involved in the pursuit of KS are deserving of significant praise. He was arrested at the junction of Friar Street and Cheapside. He relied on the cuts from the razor to support a false story that he told shortly after his arrest to hospital staff, in the presence of escorting police officers, to the effect that he had sustained injuries when he grabbed at a robber's knife.

304. There were 38 calls to the emergency 999 number. In one of these, it was suggested that more than 10 ambulances were needed. The handling of these calls by the Emergency Call Takers ("ECTs") has been audited. In the main there was compliance with the expected standards. Put generally, the "*multi-casualty-event process*" was used correctly once it was established that more than one person had been injured and the relevant details had been recorded via the ETHANE "*tab*". The instances when the expected standards were not met or when process concerns were identified did not affect the clinical care provided to the injured (*e.g.* an ECT, firstly, failed to stay on the line with the caller until the ambulance had arrived; secondly, changed the Nature of Call ("NoC") in inappropriate circumstances; and, thirdly failed to utilise the ETHANE form to record the details and to create a "*coded incident*" (see [341] for a description of ETHANE)). There has been feedback and additional training for the relevant ECTs as a consequence of these and other errors.

<u>The role of the police in the immediate aftermath of the attack</u>

Acting Detective Chief Inspector James Turner

305. The officer filling the joint roles of FIM and Tactical Firearms Commander ("TFC") for this incident was Acting Detective Chief Inspector James Turner, to give his present rank. He was a Silver Commander. He joined Thames Valley Police ("TVP") in March 2002 and became a FIM in January 2016 on promotion to the rank of Inspector. As part of FIM accreditation, he spent time with the National Police Air Service (NPAS) and with the Protection Group, in order to understand their roles and capabilities. He also completed a diverse range of "*online training packages*". He was mentored for a period by an established FIM.

306. He received telephone calls on a telephone landline on his desk. He was accompanied by call handlers and supervisors. During the incident he was looking at three screens on which the data he needed to consider was displayed. Above these three main screens, there was a fourth screen to which he additionally referred when using the three radio channels which were potentially relevant to this incident, *viz.* a local area policing channel, a firearms channel and the "*event*" channel which is reserved to the FIM. To reduce the risk of confusion, the microphone for one of the channels was operated at a louder volume than the other two in order to enable Mr Turner to transmit on a single channel. The optimum position was for all involved to move to the event channel, but this required general access to that channel, as well as the ability for everyone concerned to change channel simultaneously.

307. The Command-and-Control system was displayed on one of the three main screens, which was the main system on which Mr Turner would have relied to receive information in relation to the incident, including the response of the emergency services. It was somewhat old-fashioned in its layout, displaying information in "*teleprint*" format (a black screen showing green text, with no "*mouse functionality*"). This was the Uniplexed Information Computing System ("UNIX") which he navigated using a keyboard. One of its limitations was that if messages were received simultaneously from different sources, the lines of incoming text from each message tended to intersect or criss-cross each other on the screen which could be confusing. Mr Turner emphasised how the messages were not always displayed, therefore, as a single block of information and the log tended to become muddled.

308. He had one dedicated assistant "*loggist*", Sam Furlong (a Control Room Operator), who additionally assisted with the radio and made telephone calls on Mr Turner's behalf.

309. The content of the UNIX log "grew exponentially" and it was a significant challenge for Mr Turner to keep abreast of the information as it came "*flooding in*". Indeed, the log "*grew at a rate*" with which Mr Turner could not keep up. This incident entirely failed to conform to the "*usual pattern*", in that ordinarily after the initial surge of information, the rate at which new information is added quickly reduces. Mr Turner referred to the continuous tidal wave of information from the UNIX log, the three different radio channels, by telephone and from the personnel in the room. He had never previously had to deal with this level of material. As he set out in a power-point presentation to senior commanders in the police and from other agencies after this event, under the arrangements in place at the time the "*FIM will be overwhelmed!*". As well as volume, Mr Turner was concerned about other aspects of the management of

communications in the sense that, by way of example, he had been unable to reach the Gold commander during the course of these events and there were two Control Rooms which had simultaneously taken control of the crime scene. He considered an improved process needed to be implemented to manage the communications. Mr Amos, the Head of Resilience and Specialist Operations, for the South-Central Ambulance Service ("SCAS") suggested that his service had a similar experience. Mr Turner indicated that thought was being given to moving – in a "*virtual*" sense – all the non-incident communications into a single control room, freeing up the other to deal with the major event. Mr Turner highlighted that Mr Furlong did not have the capacity to act as loggist, whilst answering the telephone, and filtering and relaying the incoming information on his behalf. As a consequence, Mr Turner had, impromptu, co-opted another member of staff to assist with some of these tasks. Mr Turner candidly accepted that the "*tabletop training*" he had received failed to prepare him for the challenges of this incident.

310. Mr Turner, as already indicated, held the dual responsibility of the role of the FIM as well as being the only officer accredited to command a firearms response. Fortunately, with 15 minutes of the log being opened, Inspector Rowe had taken over all other "*business as usual*" elements of Mr Turner's responsibilities within the Force.

311. It has been accepted that the problems that emerged, as just described, have needed to be addressed for the benefit of future major incidents. Subsequent to these events a new Contact Management Platform ("CMP") has replaced the UNIX log and this has resolved the problem of simultaneous messages being recorded by way of intersecting text. Mr Turner 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. Mr Turner 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.

312. I was struck by the potential for serious mistakes to occur because the FIM was at times, in a real sense, overwhelmed by the demands of the role, and I recommend that the relevant systems and the available technology are given careful scrutiny and that any proposed improvements, such as those which I

have just described, are tested under conditions that will lead to a credible evaluation. That said, I am wholly confident that notwithstanding the difficulties confronting Mr Turner, he dealt with this challenging situation with notable competence and neither his work nor that of his colleagues who helped coordinate the police response had any adverse impact on the response to the attack by KS in Forbury Gardens. I have addressed hereafter certain discrete aspects of the involvement of Mr Turner and the Control Room.

Operation Plato

313. The first emergency call was taken at 18.57 by SCAS. A record was made on the UNIX system that at 18.58 a message was received that a man had been stabbed in the face who was bleeding quite badly and that possibly 10 people had been stabbed. The perpetrator, with a knife, had run off. On first reading the log at around 19.00, Mr Turner was aware that at 18.59 the South-Central Ambulance Service ("SCAS") had been called and that a local PS had been sent. As of 18.59, it had been reported that the knife had been jettisoned by the attacker in Forbury Gardens and there was a description that three or four people had been stabbed, two of whom were lying on the ground. By 19.02 the ambulance service had indicated that they were deploying resources to the scene. Further 999 calls were received, which included the information that one victim had been stabbed in the mouth.

314. At about 19.02, therefore, Mr Turner was aware that there were multiple victims and that he needed to consider whether to declare "Operation Plato". This would have triggered a large-scale, multi-agency response, with significant firearms resources being drawn from neighbouring forces. Military assistance is typically sought in these circumstances and the TVP Gold command would contact the Home Secretary. The Fire Service, as well as the ambulance service, would respond, and there would be an investigative response from those responsible for Counter Terrorism. The relevant area would be divided into zones, with varying levels of restrictions as to who is permitted to enter them. The implementation of zones could potentially have had the significant adverse effect of restricting the opportunity for the ambulance service to attend the scene at the earliest opportunity because even in a "*warm*" zone, the ambulance crews would need to have been appropriately trained and equipped, and to be protected by police officers. The need to identify and establish the zones, along with addressing a firearms response – both of which are an integral part of Operation Plato – would have become Mr Turner's major preoccupations. Declaring Operation Plato would additionally diminish the ability of the relevant authorities to deal with other emergency and non-emergency calls and once Operation Plato is called, it is not easy to "*stand it down*". Mr Turner, at an

early stage, was of the view that the right resources were attending at Forbury Gardens without the need to call Operation Plato.

315. One of the significant factors that Mr Turner had in mind was that this was not a situation in which the police were going to have difficulties gaining access to multiple victims, given the attacker had fled the scene, dropping his weapon. It is to be stressed that the log at 19.00 read "*the male suspect has gone out of view, suspect went out of the park running towards to station* (sic)" "*he had nothing with him, he was just running*". Furthermore, although he could not discount the possibility that the attacker had access to other weapons or that KS's flight was a precursor to a secondary attack, there was no evidence to indicate the likelihood of either of these possibilities. He decided, therefore, not to call Operation Plato, albeit he kept this decision under review throughout the period of the response by the emergency services.

316. There was an early message at 19.01 which raised an ambiguity as to whether there were four victims or four attackers and another message at 19.04 which referred to the "*main offender*" and that "*they*" had come "*from behind the Forbury*", but given the content of all the other relevant messages which clearly indicated a lone assailant, I consider that Mr Turner was entitled to conclude that this incident involved a single perpetrator. This is particularly the case when one bears in mind that Mr Turner was aware of the message as early as 19.01 that the perpetrator had been chased, detained and placed in handcuffs.

317. Nonetheless, Mr Turner at 19.05 placed a message on the UNIX system to ensure that those attending were aware that this was potentially a terrorist attack and there could be a secondary attack or multiple attackers.

318. I have no doubt, both with the benefit of hindsight and based on the information available to Mr Turner at the time, it was the correct decision not to call Operation Plato. Although it is impossible in these situations to discount entirely the possibility of a further or secondary attack – for instance one that is deliberately delayed – all the available information pointed towards a lone knife attacker who had opportunistically inflicted multiple injuries and then fled the scene at speed, prior to his early arrest. In my view, when Operation Plato was eventually called by Inspector Summers at 19.48 this step was unjustified given the information then available. Put broadly, the scene and the perpetrator had been secured and the victims had received appropriate treatment. Mr Turner candidly described that he regretted having not countermanded this later decision to call Operation Plato. Under arrangements since instituted, Operation Plato can only be declared by a Tactical Firearms Commander (who in practice is likely to be the FIM).

319. A further related matter which is of concern was that the ambulance service was unaware that Operation Plato had been declared. Operation Plato was called at 19.48 and Lindsey Hobbs, the Specialist Operations Manager for South Central Ambulance Service, first became aware of this at 20.46 when she received a telephone call from a colleague who was at the Silver Cell located in Reading Police Station. Ms Smith, the Bronze Commander on the ground for SCAS, only became aware of this when representatives of the fire service arrived and the SCAS control room at 21.13, via a telephone call. The solution to this potentially serious problem has been addressed by the use of the Emergency Service Inter Control talk group, which is discussed below at [351].

The police officers at the scene

320. At 19.00, Mr Turner was aware that PS Watkinson had indicated that he would "*act as Bronze*" meaning, he would provide "*supervisory control*" at the scene, leaving Mr Turner free to formulate the overall police response to the incident. Within the Gold, Silver, Bronze command structure, the individual allocated the Bronze role directly controls their organisation's resources at the incident and works with their staff at the scene. In my judgment, it was clearly correct that an officer at the scene should make the relevant deployment and other related decisions. PS Watkinson was acting as Bronze for only a short period of time (about five minutes).

321. With evident promptness, by 19.00 two police vehicles had been despatched to the scene and a minute later, at 19.01, Mr Turner was aware that Taser Trained Officers would be attending Forbury Gardens. It was clear by this stage that other police officers were being directed to Forbury Gardens.

322. At 19.02 PS Watkinson had arrived at the scene and had advised via the UNIX system that the discarded knife would not be touched. Mr Turner had been informed that a further sergeant and six constables were en route to Forbury Gardens. The Control Room was aware that CPR was being administered to the victims. There were a number of calls at this stage, not all of which were entered on the log, which arguably tended to indicate that the scene was safe, thereby enabling police officers to provide assistance to the injured.

323. By this time the relevant emergency services were converging on Forbury Gardens (the South-Central Ambulance Service ("SCAS") having been notified at 18.59), and by 19.04 Mr Turner was justifiably confident that the victims would be properly supported. His focus, therefore, turned to establishing whether there was an outstanding threat.

324. PC (now PS) Lake, as an officer who had undertaken some medical training, ran into the park with his "*trauma bag*" which included an Automated External Defibrillator ("AED"). He called out for more "defibs". He saw that PC Perham was providing CPR to Joseph Ritchie-Bennett and a member of the public had successfully fitted the AED to his chest. He checked on and assisted with the treatment being provided to James Furlong and Dr David Wails, including by way of the use of AEDs. He noted there was difficulty in making James Furlong's AED function. Although PC Housby attached two devices to James Furlong and shaved his chest hair, the second of the machines indicated that CPR should continue. PC Housby remained with Mr Furlong when the paramedics arrived and took over treatment. In due course, manual CPR was replaced by a LUCAS machine (a mechanical chest compression device, used to try to restart the heart).

325. PS Lake gave evidence that they were not using "*rescue breaths*" because of COVID restrictions, but in any event he was aware that chest compressions were the more important tool in attempting resuscitation. He helped with the moderation of the air flow to Joseph Ritchie-Bennett via a Bag Valve Mask ("BVM").

326. Inspectors Cox and Jones arrived at Forbury Gardens shortly after 19.05. Inspector Cox witnessed CPR being performed on James Furlong, Joseph Ritchie-Bennett and Dr David Wails by various police officers, and she noted the extensive assistance that was being provided by PS Watkinson and PCs Proctor, Dowson, Lake, Boekbinder and Wallace. She additionally saw various members of the public assisting the "*walking wounded*". Inspectors Cox and Jones jointly adopted the Bronze role at about 19.05, thereafter coordinating the police activity at the scene, particularly in providing assistance to the seriously injured. Inspector Cox sent PS Davis on a tour of the park to "*complete a visual reconnaissance*" and she moved the public first back to the middle of the park by the Maiwand statue, and then out of the park. She passed updates to the Control Room and requested additional resources, including defibrillators. Once the paramedics had arrived, she liaised with the Ambulance Paramedic Supervisor who asked that all the injured were gathered at a single location.

327. PC Gregory took over providing CPR to Dr David Wails from a female member of the public (another was holding Dr David Wails' head). Thereafter, PC Dowson assumed responsibility for administering CPR whilst Mr Gregory held Dr David Wails' head. In due course, they rolled Dr David Wails on to his side in order to try to locate the wound. Although this was successful, there was a notable lack of blood coming from the site of the injury, which was staunched with gauze. CPR was maintained. Later, Dr David Wails was once again turned

on his back and liquid started to accumulate in his mouth. After about 20 minutes, the ambulance crews started to arrive and took over treatment.

328. At 19.06 a message was placed on the UNIX system that had the capacity to cause some confusion. Information was received by the Abingdon Control Room (Mr Turner was based at the Milton Keynes Control Room) which came from an officer at the scene which indicated that SCAS was "*just arriving*". Mr Turner, in my view justifiably, concluded that one or more ambulances were then arriving at Forbury Gardens. Instead, this referred to the fact that the ambulances had started to arrive at a holding-off point, Reading Ambulance Station, which was close to Forbury Gardens (see [332] below).

329. By 19.09, Mr Turner was aware that all the police units that attended were involved in treatment.

330. In conclusion, therefore, a large number of Thames Valley police officers arrived at speed, enabling them to provide timely initial care to all the injured, and including to James Furlong, Dr David Wails and Joseph Ritchie-Bennett. An assessment of the steps they took has been provided by Professor Lyon, a highly qualified consultant in emergency medicine. He has viewed relevant sections of the police body worn video. His opinion is that the three deceased would very rapidly have been in a state of cardiac arrest as a consequence of the catastrophic bleeding resulting from their injuries. They each received rapid medical care from the police; indeed, given the context of this incident, in his view there was no delay in any of the deceased receiving excellent emergency assistance from the arriving police officers. Of particular importance, he noted that the CPR performed immediately on the officers' arrival was of high-quality.

331. **<u>PFD</u>**: Although much work has been undertaken since these events, I will be sending the Chief Constable of Thames Valley a PFD report as regards the problems confronting the FIM and the declaration of Operation Plato.

<u>The medical services at the scene</u>

The Holding-Off Point

332. A "*holding-off*" point is to be distinguished from a "*rendezvous*" point, since the latter is used on occasions when SCAS initially congregate with other agencies at an agreed location. Certainty as to precise timings is not possible, but a few minutes into a call logged at 19.05, SCAS were told that it was safe for the ambulance crews to leave the holding-off point and to travel to Forbury Gardens. This is a risk-based decision, taking into account all of the available

information. Mr Turner was of the clear view that if he had been aware that the ambulance crews were not going straight to Forbury Gardens, he would have advised shortly after 19.00 that they should proceed there immediately. Regrettably, therefore, it had not been revealed in the UNIX system that they were travelling first to the holding-off point at Reading Ambulance Station. However, very little, if any, time was lost because the first ambulance vehicles to attend the scene were recorded as arriving between 19.09 and 19.11. In reality, the majority of the medical personnel who attended travelled to Forbury Gardens without spending any, or any significant, time at the Ambulance Station (Michael Greenfield said he and Joanna Harding were there for about two minutes). It is important to stress that in the view of Professor Lyon if the medical personnel had been at the scene a few minutes earlier this would not have made any difference, in the sense that the injuries inflicted on the three deceased were not amenable to treatment and slightly earlier attendance by the ambulance crews would not have improved the position.

333. It is accepted as a consequence of this misunderstanding that the contemporaneous record of the communications (*viz.* the log) needs to make it entirely clear as to whether the medical services are travelling to, or have arrived at, the scene or some other location. In my view this is a critical requirement because with a different set of facts, this misunderstanding could have had serious consequences. Mr Amos was confident that this would not be repeated in the future because the ambulance service will be continually pressuring the police to indicate when it is safe to leave the holding-off point, albeit the decision is ultimately one for the ambulance service. Mr Amos additionally agreed with Mr Hill that any time spent at the holding-off point could beneficially be used to provide "updates".

334. **PFD**: The PFD evidence I have heard and read satisfies me that appropriate action has been taken in this area. These matters have been adequately addressed and I will not be sending a PFD report in this regard.

The standard of care at the scene

335. Apart from tentative questioning by counsel on behalf of the families as to, first, whether Level 2 or Level 3 PPE (personal protective equipment) should have been worn from the outset and, second, whether the deceased should have been taken immediately to hospital (issues which are considered respectively at [356] to [366]), there has been no material criticism by any of the Interested Persons as to the efficacy of the response of the medical services.

336. As with the police officers, an assessment of the quality of the care provided by the medical personnel has been provided by Professor Lyon. He is of the unreserved opinion that the clinical care delivered to James Furlong, Joseph Ritchie-Bennett and Dr David Wails was entirely appropriate, in what was a difficult situation. He considers there was nothing else that could have been done to save their lives. The clinical care complied with the published guidelines for the resuscitation of patients suffering traumatic cardiac arrest during COVID-19. Professor Charles Deakin, an expert in resuscitation and pre-hospital emergency medicine from Southampton University concluded their injuries were unsurvivable, however or wherever they were treated.

337. Professor Lyon's conclusions, supported by Professor Deakin, in my view, are compelling and entirely well-founded. I add that the speed at which the three men were treated, along with the diligence, perseverance and intelligence which characterised the sustained efforts expended on their behalf, merit particular acknowledgement. As briefly summarised hereafter, everything possible was done to save the lives of these three men.

Heather Smith

338. By way of brief detail, Heather Smith was the Bronze Commander on the ground for the ambulance service (SCAS). She heard about the incident at Forbury Gardens whilst driving in her work Land Rover Discovery ambulance vehicle. One curious eventuality was that Ms Smith was briefly "*stood down*" twice whilst she was en route to the holding point at Reading Ambulance Station at North Street which was close to Forbury Gardens. This was potentially because of the volume of telephone calls. This instruction to stand down did not have any adverse impact on her journey, not least because it was almost immediately rescinded, but it could have resulted in confusion and delay. She travelled at "*emergency speed*" to the holding point, from where she shortly afterwards travelled to Forbury Gardens, arriving at the scene at 19.11. along with two ambulances, each carrying two personnel. She had responsibility for coordinating the resources of the ambulance service at the scene. She was wearing Level 2 PPE. She spoke to a police officer who told her that there were three victims in cardiac arrest. She was joined by Chris Brooker, another employee of SCAS who acted for part of the time as "*loggist*", although he also provided treatment to the victims. Ms Smith familiarised herself with the position of the seriously injured. By the time Ms Smith and Mr Brooker entered the park there were three or four ambulances at the scene. Mr Brooker assisted with applying one of the LUCAS devices to one of the seriously injured victims.

339. Ms Smith coordinated the treatment of those who had received non-fatal injuries, including setting up a casualty collection point and organising their removal to hospital (two were driven to the Royal Berkshire Hospital and one to the John Radcliffe Hospital). She was unaware there was a "talk group" channel, which, importantly, could not be accessed by the Hampshire and Isle of Wight Air Ambulance Service (see [351]) below). She considered that sufficient medical resources had been sent to the scene and consequently formed the view that it was unnecessary for a Major Incident to be declared (instead, in her view, this situation was more akin to a Major Incident Standby/Critical Incident, which had been called). Professor Lyon agreed with Ms Smith, in that all those in need of care received prompt assistance and the health resources were not in any sense overwhelmed by the number of victims or the severity of their injuries. Indeed, the Professor considered that it was commendable that such extensive resources were deployed to the scene in such a short period of time. The sole cautionary observation by Professor Lyon in this context was that there is no country-wide, central control of the HEMS services which would be of assistance when there is a major incident of this kind, to alleviate the need for one ambulance service to request assistance from a neighbouring service. Although there was no adverse effect in the present case due to this lack of a central command facility, it would provide, on a national basis, a coordinated airborne response. Reassuringly, it would appear that work is ongoing in this context by the National Ambulance Resilience Unit.

340. Ms Smith's conclusions, therefore, as regards the number of ambulances and medical personnel were in my judgment well-founded. There were more than sufficient paramedics and ambulances at the scene (*viz.* six dual-crewed vehicles), followed rapidly by doctors and I am unable to accept the criticism by one of the witnesses that an inadequate number of ambulances attended to assist the injured. Ms Smith found it difficult to establish which police officer was in Bronze control at the scene (as set out above PS Watkinson initially acted in this role, followed by Inspectors Cox and Jones (see [326] above)), particularly since, at least initially, none of the officers appeared to be wearing the relevant tabard. This meant she was unable to "*co-locate*" with the police Bronze. She accepted, however, that she did liaise on specific issues with various police officers following her arrival and nothing has been identified to indicate that her inability to identify the police Bronze had any material adverse consequences as regards the treatment of the injured.

341. Although Ms Smith did not report back information in the approved METHANE or ETHANE format (*viz.* M = major incident, E = exact location, T = type of incident, H = hazards, A = access, N = number of casualties and E = emergency services needed or at scene), all the relevant information was

provided to the ambulance control room in a timely fashion. She now carries a laminated card with her to ensure that she recalls the various requirements of METHANE, which is part of the JESIP (Joint Emergency Services Interoperability Principles) mobile application available for use by staff on mobile telephones. Deborah Diffey, Head of Education and Quality Assurance at SCAS has outlined that for the future Command Staff from Bronze to Gold level have been reminded of the importance of good communication, in the proper format, with the Control Centre, including as to whether a major incident or major incident standby/critical incident has been declared (or is likely); the exact location of incident; the type of incident; access and egress from the area; the number of casualties; and the emergency services at the scene. Mr Amos confirmed the importance of information being sent in the approved METHANE or ETHANE format, and this has been addressed by the JESIP mobile application and via training, which has had a significant impact. Furthermore, ETHANE reports are used for routine incidents.

James Furlong

342. James Furlong was assisted by Mr Greenfield (paramedic) and Ms Harding (emergency care assistant) from SCAS, who started providing medical care at 19.15. They were wearing Level 2 PPE. They attached a LUCAS device for mechanical CPR. James Furlong was in full cardiac arrest and his ECG was showing an asystolic rhythm (a "*flat line*"). It was immediately apparent he had haemorrhaged catastrophically. Attempts were made to ventilate him once the Thames Valley Ambulance paramedic team arrived at about 19.20 (*viz.* Hannah Hirst and Charlie Shorthouse, who travelled together, the former having donned Level 3 PPE en route and the latter dressed similarly once they arrived at the car park). Hannah Hirst cleared his airway using suction and applied an iGel supraglottic airway (a specialist mask and tube designed to provide an airtight seal). Mr Greenfield and Ms Harding withdrew to don Level 3 PPE once Ms Hirst was in a position to take over treatment. Following Dr Rayet's arrival, James Furlong's airway was upgraded by way of an endotracheal tube. An EtCO2 (End-Tidal Carbon Dioxide) reading of 1.5 kPA had been observed, which is consistent with major blood loss. He was ventilated on oxygen and intubated (*viz.* a breathing tube was passed into his lungs) but his EtCO2 level continued to fall. He was administered intravenous adrenaline. An ultrasound revealed that his lungs were both inflated, there was no cardiac activity and the endotracheal tube was appropriately positioned. A "*fluid challenge*" (*viz.* a rapid infusion of fluids to resuscitate blood pressure) was administered prior to deciding whether to transfuse blood products but given the lack of improvement following the fluid challenge, it was decided that a transfusion would be ineffective. This decision, therefore, was not the result of a lack of available supplies of blood products, as confirmed by Dr Rayet and Professor

Lyon. Similarly, it was decided that a thoracostomy would be ineffective given the absence of chest injuries. Dr Jaspreet Rayet from HEMS was involved in the clinical decisions (see [343] below). James Furlong remained in asystole (*viz*. no electrical heart activity was detected) throughout. A decision was made by Dr Matthew Kerton to cease resuscitation at 19.51. He had ensured that appropriate consideration had been given to whether the state of cardiac arrest was reversible.

Dr David Wails

343. Sarah Knell (paramedic) and Chloe Taylor (emergency care assistant) from South Central Ambulance Service were the third of the paramedic teams to arrive at the scene. Ms Knell recalled that it took the four to five minutes to put on Level 3 PPE once they arrived at the scene. They attended on Dr David Wails at about 19.20 and took over the "*excellent*" CPR that was being administered by PC Dowson. A Lucas device was utilised. Mr Shorthouse had also been providing care prior to their arrival. A suspected collection of air between the lungs and the chest wall causing lung collapse had been identified, and Mr Shorthouse commendably performed bilateral needle chest decompression in the hope of releasing any trapped air. He additionally decided at 19.24 to perform right- and left-sided bilateral thoracostomies (surgical incisions to the chest wall) to exclude definitively the possibility that a tension pneumothorax was a cause of traumatic cardiac arrest. The LUCAS device was stopped and started before and after this treatment. Dr Rayet and Neil Plant (paramedic) from HEMS ultimately took over the care of Dr David Wails, which included endo-tracheal intubation. An iGel which had been used was upgraded to a size 4 tube. Dr David Wails had been in asystolic cardiac arrest and his ECG revealed a pulseless electronic arrythmia, a condition consistent with cardiac arrest which was not susceptible to treatment by a defibrillator. A transfusion of blood in these circumstances would have been ineffective. Minimal external bleeding was noted, and it was assessed, therefore, that Dr David Wails was bleeding internally. During treatment, intraosseous access was gained (to enable medication to be introduced directly into the bone marrow) and crystalloid fluids and adrenaline were administered. His pupils remained fixed and dilated throughout. His life was pronounced extinct at 19:53 by Dr Anna Dobbie, a HEMS doctor.

Joseph Ritchie-Bennett

344. Joseph Ritchie-Bennett was receiving CPR administered by members of Thames Valley PC Dowson followed by PC Perham and they were joined at 19.16 by Chris Dinsey (paramedic) and Richard Gundry (emergency care assistant) from SCAS. Intravenous access was gained via his arm and he was given sodium chloride as initial fluid resuscitation. Further assistance was

provided shortly afterwards by Mr Shorthouse (HEMS paramedic). An iGel supraglottic airway was fitted and Joseph Ritchie-Bennett was ventilated, although his EtCO2 trace was poor. The ECG record revealed an asystolic rhythm, followed by a period of pulseless cardiac electrical activity. There appeared to be a massive external haemorrhage from the left side of the neck and as a result direct pressure was applied to the wound. There was extensive bleeding into the mouth and throat, making airway management difficult. Bilateral thoracostomies were performed. CPR was administered via a mechanical LUCAS device. Joseph Ritchie-Bennett was transfused with one unit of pRBC (packed red blood cells) and one unit of FFP (fresh frozen plasma), once Mr Shorthouse had noted the pulseless electrical activity ("PEA") set out above (there was a PEA rate of 76). He was appropriately given TXA (tranexamic acid, a medicine to control bleeding). Professor Lyon was of the view that in administering adrenalin, the paramedics had appropriately followed the standard protocols. A Foley catheter was inserted into the wound tract by Dr Matthew Mak (HEMS doctor). Professor Lyon expressed the view that this is a rare intervention which was carried out with commendable skill. It is the only external technique or device which can be applied to a neck wound, save for haemostatic gauze which was additionally used in an attempt to control the massive bleeding. Dr Mak pronounced his life extinct at 19.56.

Other attendees

345. A significant number of other representatives of the emergency medical services arrived in rapid succession. These included representatives of the Thames Valley and London Air Ambulance Services (as indicated above, the latter is known as "HEMS", the Helicopter Emergency Medical Service). At 19.19/20 a HEMS helicopter (call sign HM24) landed at the nearby King's Meadow. The crew proceeded to the scene on foot (Dr Rayet from HEMS said this took 5 – 7 minutes), because the police had been provided with insufficient time to despatch a motorcar to collect them (they were unaware until the last moment where the helicopter was going to be able to land). Dr Rayet arrived at the scene at 19.26 and was appointed "Silver" (*viz.* the individual who manages tactical implementation of the strategic direction given by "Gold") for HEMS.

346. Dr Kerton, another HEMS doctor, arrived broadly at the same time but, as he recalled, after Dr Rayet.

347. Dr Brown, the Assistant Medical Director, attended at 19.48 as the Medical Incident Advisor ("MIA") to the ambulance crews at the scene having been alerted by a pager at 17.36. Dr Brown is a volunteer for the British Association for Immediate Care Scheme ("BASICS"), having received specialist training in immediate medical care. BASICS doctors provide an enhanced level of

emergency clinical care to patients and they are requested to attend incidents when the relevant dispatch criteria are met, namely a) when a major incident is declared; b) when advice regarding life-saving patient treatment plans is needed; and/or c) when medical advice and support on issues that fall outside of the Joint Royal Colleges Ambulance Liaison Committee ("JRCALC") Guidelines such as the termination of resuscitation or the administration of medication may be required. As Dr Brown indicated, in practice MIAs are frequently required in situations involving traumatic cardiac arrest and multi-casualty incidents.

348. There is a possibility (as described in the Review of Actions by South Central Ambulance NHS Foundation Trust into the present events dated 4 August 2020, at paragraph 1.11) that an opportunity was missed to send an earlier alert for an MIA to attend, but whether or not that suggestion is accurate it had no material impact on what occurred in terms of the treatment provided to the injured in the present case, particularly bearing in mind the sufficiency of the medical response. By the time Dr Brown arrived there were four doctors, six critical care paramedics, along with other registered paramedics and emergency care assistants already present at Forbury Gardens. These included representatives of HEMS, and as Dr Brown described, HEMS doctors are trained as MIAs. Dr Brown furthermore explained that an MIA is not necessarily asked to attend at the outset; instead, this deployment may await the arrival of a HEMS doctor who will assess what is required. Professor Lyon was of the view that the 15-minute delay in contacting the BASICS doctor might, in a different situation, have been important, for instance if there were insufficient highly qualified medical responders at the scene. The cause of this delay has been addressed in that there is now an automated reminder on the relevant system for the staff to call the BASICs doctor(s). As Mr Amos confirmed, all the operative has to do is to press a button.

349. Dr Brown's arrival coincided with that of Dr Shah Rahman (who acted as his loggist given there were sufficient doctors at the scene to provide emergency care). It is to be stressed, therefore, that Dr Brown was contacted not because there was a shortage of clinicians at the scene but in order to assist with coordination of the critical care services. As I have already described, the paramedics were engaged in advanced airway care, providing fluids via intravenous cannulation, delivering chest compressions, releasing chest air by the insertion of needles and much else besides.

350. Dr Brown was briefed by Ms Smith and Dr Rayet. Ms Hobbs (see [319] above) had also arrived at the scene at the same time as Dr Brown. The latter agreed with Ms Hobbs that it was unnecessary to declare a Major Incident because of

the resources already available. As Dr Brown explained, there are a number of disadvantages to declaring a Major Incident, in that the incident suite in the Emergency Operations Centre is "activated". It takes a not insignificant period of time to set up the dedicated computers which are used to run the Major Incident and to transfer the relevant personnel to the incident suite (possibly ten minutes). In Dr Brown's view this could have degraded the effectiveness of the response, which he considered was working well, and, in any event, many of the resources deployed during a Major Incident were already in place. Furthermore, if a Major Incident is declared, this has an adverse effect on "*business as usual*" (*e.g.* the hospitals have to ensure that they have adequate capacity to accept the injured, with the result that some patients at the hospital may be sent home). Moreover, in his view, since there were sufficient ambulances in attendance, it had been unnecessary to declare a Major Incident Standby (now termed a Critical Incident). It was a warm summer day and the demand on SCAS was fortunately slight. As Mr Amos explained, subsequent changes now mean that it is easier than it was at the time of these events to "stand down" resources which are not needed if a Major Incident has been declared.

351. Dr Brown confirmed that in future when some of those asked to respond to an incident are from outside the area covered by SCAS, a common radio channel will be used that will ensure that the relevant emergency service control rooms have access to the distribution of information. This addresses the potentially grave problem identified by the Hampshire and Isle of Wight Air Ambulance Service who were unable to access the relevant channel being used by other organisations during the response to this incident. Mr Amos confirmed that in future for any "*marauding terrorist attack*" ("MTA") or Operation Plato incident, communications will be via the Emergency Service Inter Control talk group which is a radio channel monitored by all the emergency service control rooms. Mr Amos explained that this talk group will be used by SCAS, TVP, the Hampshire and Isle of Wight Constabulary and the four regional Fire and Rescue Services for the initial "*declaration*" and to pass information, in plain English, which will include the type of incident and the attack methodology. This will enable Control Shift Officers in the control room to make decisions on "*who, what and where*" to deploy. It will be used for passing "*safety-critical*" information between the Control rooms. In addition, once the move has been made to the Inter Control Talk Group, all other "*resources*" responding to the incident (*e.g.* a helicopter crew from Birmingham) are placed on to an open mutual aid talk group, which will be used to keep them appropriately updated on the unfolding situation. They have conducted a number of training exercises to ensure these new arrangements are effective.

352. The National Ambulance Resilience Unit has ensured that this new approach has been shared nationally and there has been involvement by the Joint Emergency Services Interoperability Programme in its formulation.

353. At 19.43 the LAS HEMS helicopter crew were at the scene having been transported in a police vehicle from King's Meadows.

354. Finally under this heading, it is important to note that Mr Amos explained in detail other steps that have been taken by SCAS following the events in Forbury Gardens to ensure, as far as possible, that the response to any comparable future incident will be "*robust, consistent, efficient, and in line with national procedures*". Much of this, such as an improved triage system and extensive training, is technical and incremental in nature, addressing potentially important areas that did not arise in a notably significant way in the present case. It is unnecessary for me to rehearse all these developments and improvements save to note the evident care that has been taken to formulate this wide-ranging response. Nonetheless, I need to address four areas addressed by Mr Amos in this context. The first is that there was a plethora of telephone calls which came in as a response to this incident, many of which were handled well or, at least, sufficiently well. There were some, however, which were not dealt with appropriately and Mr Amos accepted that for the future training and continual professional development are essential to ensuring that terrorist incidents are managed effectively. The second is that there was the potential for confusion as to how many patients there were, and for the future there is now a "*designated patient flow role*" in the incident response framework based in the control room. The third is that there will be a tactical commander on duty in the control room 24 hours a day, seven days a week. The fourth is that henceforth there will be 35 specialist "*responder*" staff on duty between 06.00hrs and 02.00hrs (that is to say at all times save 2 am – 6 am).

355. **PFD**: Although concerns were raised on some discrete issues, such as the absence of a country-wide, central control of the HEMS services and Ms Smith's difficulties in being unable to "*co-locate*" with the police Bronze, the PFD evidence I have heard and read satisfies me that appropriate action has been taken in this area. I will not be issuing a PFD report on issues arising out the response of the medical services (I have addressed PPE and Immediate Transfer to Hospital separately below).

PPE

356. As Professor Lyon has observed, this fatal attack coincided with the COVID-19 pandemic, and the national ambulance services protocol mandated the wearing of PPE (*viz.* a full protective Tyvek suit, double gloves, eye protection and a protective facemask/respirator) prior to performing any advanced airway interventions, including "*rescue breaths*" (*viz.* mouth to mouth resuscitation). There was a short delay (a small number of minutes) whilst some of the ambulance and helicopter emergency service personnel put on this extensive protective clothing prior to undertaking advanced airway management. In Professor Lyon's opinion, this pause had no impact on the final outcome for those who died.

357. By way of detail, the position was that Mr Greenfield (paramedic) and Ms Harding (emergency care assistant) from one of the ambulance vehicles and Mr Dinsey (paramedic) and Mr Gundry (emergency care assistant) from another ambulance vehicle were wearing Level 2 PPE when they first entered Forbury Gardens. It is important to stress that at least some, if not all, of the members of these two crews believed they were the first to enter Forbury Gardens. After providing initial assistance, they briefly withdrew to put on Level 3 PPE. As Heather Smith observed, it is unrealistic to attempt to put on the entirety of the Level 3 PPE in a fast-moving ambulance and therefore the process could only, at most, be commenced en route (albeit Ms Hirst exceptionally managed to complete this task while being driven by Mr Shorthouse). Furthermore, the short delay whilst the crew changed into Level 3 PPE would have been necessary at some stage, either immediately on arrival or after providing initial care to the patient (the additional delay to withdraw to the ambulances to put on Level 3 PPE was, in Ms Smith's view, minimal).

358. It is of note that whilst travelling to the scene, Ms Smith was only aware of a single victim being in cardiac arrest and it was not until she spoke to a police officer following her arrival that she realised there were 3 victims in cardiac arrest. She missed, therefore, the call at 19.04 indicating that 2 victims were in cardiac arrest, along with the slightly later information from the ambulance control room at 19.07 that three people were receiving CPR. This was most likely because she was driving the Discovery vehicle which increased the difficulties of hearing the radio messages. If she had been aware that there were three individuals in cardiac arrest, she would have requested that all crews put on Level 3 PPE from the outset.

359. The COVID-19 pandemic presented a major health challenge for the health authorities, including for medical staff when, as in the present context, they were called to assist someone in cardiac arrest. Guidelines were issued covering this eventuality (see SCAS PPE Cardiac Arrest Arrival Guidance Release v1_2.pdf May 2020). These were not, however, seemingly directed at a major public incident involving multiple seriously injured victims but instead were focussed, as Professor Lyon testified, on events involving a single patient. Mr Amos agreed that this Guidance was not designed for multiple traumatic cardiac arrests at a single scene. Of equal importance, the Guidance indicated that if there was only one clinician on board the first arriving ambulance, which was the position with the two ambulance crews who believed they were the first to enter Forbury Gardens (Ms Harding and Mr Gundry were emergency care assistants), the first crew member was directed to don Level 2 PPE (*viz*. neither was to put on Level 3 PPE on arrival). The other ambulance crews, as directed in the Guidelines, entered the park in Level 3 PPE.

360. In all the circumstances, there was no breach of the Guidelines. Unsurprisingly, given the urgency of the situation, two of the attending ambulance crews, each with only one paramedic on board, believed they were going to be, or were, the first to enter Forbury Gardens. Accordingly, they entered the park appropriately dressed. They were able, as trained medical personnel, to provide immediate treatment without the pause that otherwise would have been necessary to dress in Level 3 PPE. As Mr Amos testified, the patients most likely to survive cardiac arrest are those undergoing weakness and dysrhythmia in the heart. Ventricular fibrillation is critical for reversing this condition and in this context the delay whilst donning Level 3 PPE would be a positive disadvantage. I note, moreover, that at an appropriate stage, members of the first two crews withdrew briefly to don Level 3 PPE once initial care had been provided.

361. In conclusion, therefore, the approach taken by Ms Smith and the ambulance crews to PPE was understandable and sensible, and, viewed realistically, it did not involve any breach of the Guidelines. Nor was there any material delay in delivering appropriate treatment which contributed to the deaths. Although this issue was understandably and appropriately explored on behalf of the families of the deceased, in my view the approach taken to PPE formed part of the highly effective response by the medical services.

362. **PFD**: It follows I will not be sending a PFD report in this regard.

Immediate transfer to hospital

363. This was similarly the subject of restrained and sensibly focussed questioning by Mr Hill, on behalf of the families of the deceased. In certain circumstances moving an injured victim at the earliest opportunity to hospital is the correct course of action. An example of this was given by Professor Lyon, that of someone who has received a penetrating trauma but who is not in cardiac arrest. It was not suggested that there is reputable medical opinion that advises moving individuals in receipt of injuries such as in the present case to hospital whilst they are in a state of traumatic cardiac arrest, prior to stabilisation. Indeed, Professor Lyon testified that such a step for someone in traumatic cardiac arrest will lead to a fatal result. As he observed, a patient in cardiac arrest needs to be resuscitated and their circulation restored, before leaving the scene if they are to have a chance of survival.

364. Professor Lyon added that the HEMS system ensures that senior doctors are on scene with the ability to administer advanced techniques such as haemorrhage control (*e.g.* using the Foley catheter). As was the case with Joseph Ritchie-Bennett, thoracotomies can be performed at the scene. Similarly, a blood transfusion can be undertaken *in situ*. Interventions such as these will be performed far more rapidly at the site rather than moving the injured individual to hospital, with the concomitant delay.

365. Dr Brown agreed that with a patient in cardiac arrest it is critical to have a period of stabilisation before moving them to hospital because to do otherwise may lead to deterioration in their condition. None of the three deceased were in a sufficiently stable condition, at any stage, to consider moving them.

366. **PFD**: It follows I will not be sending a PFD report in this regard.

KS's stance following the incident

367. By the time he returned from hospital to police custody, KS was indicating (at 17.10pm on 21 June 2020) that he wanted to plead guilty for "*the jihad he had done*". He suggested that he had tried to kill himself and that he "*did it*" because he wanted to be deported.

368. KS was seen on 23 June 2020 by a mental health team led by Andy Seys, a qualified mental health consultant. It was concluded that KS was not experiencing any acute mental disorder at the time. He was oriented as to date

and time, he was not distracted and there was no evidence of psychosis, thought disorder or thought blocking. He answered questions appropriately and fully. He was not depressed. The Team described him as "*malingering*".

369. During interviews on 24 June 2020, KS admitted the three murders and the attacks on the other three victims.

370. Consistent with what KS said, there was no evidence that he had planned the attack with anyone else or that he had received encouragement or direction.

<u>Conclusions</u>

The risks posed by KS

371. Although there are certain inconsistencies on KS's part as to the role he played in the violence which occurred at the time of the fall of Colonel Gaddafi in Libya, no doubts have been expressed by any Interested Person as to a persistent theme that he participated in violence during that notably chaotic period, fighting with one or more of the armed factions. Although his allegiances appear to have shifted over time, a continuing theme, notwithstanding some contradictions, has been his support for groups which have advocated a fundamentalist Muslim ideology, as typified by Daesh/ISIS/Ansar al-Sharia. It is to be stressed that this active adherence to the beliefs of groups that have furthered terrorism has not been consistently expressed – indeed, at one stage it was punctuated by an apparent interest in mainstream Christianity – but this had nonetheless remained a recurring theme over the entirety of the relevant period, as evidenced by KS's statements to a wide range of individuals in official positions. On any view, if the background intelligence picture had been adequately shared with the relevant organisations, KS should have been treated by, *inter alia*, the MPFT, the Prison Service, the Probation Service, the police, the Home Office, the Security Service, BHFT and RBC as someone who was either an extremist or, at very least, vulnerable to extremism. This mindset should then have informed the decisions that were taken as to his management and the risk he posed to others.

372. KS demonstrated a capacity for violence on repeated occasions after arriving in the UK, and his criminality in this context markedly deteriorated in the final 18 months prior to the events in Forbury Gardens, as evidenced by his convictions for carrying offensive weapons, including knives. He repeatedly threatened to take his own life and the lives of others. It is notable that many of those who had significant dealings with KS considered he was potentially (very) dangerous (*e.g.* as set out above, Dr Ahmad concluded there was a significant

risk to others when he was unwell and that, as of 5 December 2018, there was a "*massive risk brewing*").

373. Throughout the period under consideration, KS could be highly volatile in that he sometimes veered without warning from apparent calmness and rationality to a highly agitated and violent frame of mind. The triggers for this unpredictable behaviour on his part are difficult to identify with certainty but they appear to have included periods when he felt his concerns were being ignored, when a sufficiently responsive support system was not in place and stress arising from a crisis and/or substance misuse. In this context, prison and Approved Premises provided an environment which significantly aided his stability, and in a similar vein the active assistance of a Care Coordinator (*e.g.* Ms Robinson) was clearly beneficial prior to the termination of the joint CMHT service in 2018. As was noted by the British Red Cross and would have been generally apparent, when KS was released from prison, he often presented with a positive attitude but without support from the statutory services his mental health quickly declined shortly after release.

374. Although I accept Mr Gill's concerns about the risk of BHFT's services being overwhelmed if they accepted all those without a severe and enduring mental health problem who would benefit from their services, the rigid exclusion from care-coordination based on this distinction was excessively inflexible given the risks posed by KS if his PTSD and personality disorders were left unaddressed. This should not have been judged simply by reference to whether KS had a severe and enduring mental health problem; rather, there should have been greater focus on the risk to the public in the absence of long-term therapy for KS's personality traits, along with the benefits of BHFT providing a sufficient element of care-coordination by way of a mental health nurse which would assist in ensuring his mental health needs were sufficiently met. Professor Blackwood agreed with the description that there was a detrimental lack of consistent engagement with one responsible team, with a clear set of therapeutic goals. Dr Bonner, furthermore, accepted that the BHFT CMHT would, on occasion, assist those who may have personality disorders and traumatic histories if the severity of the personality disorder was such that they couldn't be handled at primary care level, although this did not happen in KS's case.

375. KS was frequently characterised as posing either a low or no risk to the public, on the basis that he appeared stable at any given point in time. This approach, in my view, failed sufficiently to take into account his volatility as just discussed. Instead, it was necessary to judge the risk he posed in the context of whether the triggers were present that were likely to lead to a significant

deterioration in his state of mind. Viewed generally, Dr Bonner agreed he should have been recognised as a high-risk patient who was in danger of causing serious harm, which should immediately have been acted on. As set out above, Ms Rogers had been unaware of KS's link to Ansar al-Sharia, his potential psychopathic tendencies and the extent of his sometime grievances against the UK. She testified that if probation had known of these and other factors or if an investigation by counter-terrorism police and by MI5 had taken place, their view of KS's risk level could well have changed to very high risk. Ms Rixon was of a similar view. Furthermore, a false distinction was drawn between whether he adhered to a fundamentalist ideology, on the one hand, and his mental instability, on the other. As is now seemingly accepted, in combination these had the capacity to potentiate his dangerousness; indeed, as Professor Blackwood observed, his psychiatric difficulties interacted with his interest in extremist Islamist ideology.

Trauma-based therapy

376. KS had developed PTSD symptomology and an emotionally unstable and antisocial personality disorder, characterised by mood instability, impulsivity, irritability and aggressivity (*per* Professor Blackwood). The "*working diagnoses*" of EUPD and PTSD were reasonable.

377. There has been no suggestion in these Inquests that if long-term trauma-based psychological therapy had been undertaken it would necessarily have been ineffective or would have had a poor chance of success for treating these conditions, albeit I accept, of course, that a positive outcome could not be guaranteed. Although this process required the active participation of KS when in a sufficiently stable state, on the evidence successful, long-term psychological intervention provided the best sustainable opportunity to address KS's mental difficulties and to reduce the risk that he posed to the public at large. Indeed, Dr Komarzynska considered that this process would facilitate identifying the most effective treatment, along with the skills that would allow KS to "*take back the control*". Her belief in this approach was demonstrated during her first meeting with KS in 2016 when she indicated his treatment should begin in the near future. After 2016, BHFT CMHT refused to accept any of the referrals made on behalf of KS.

378. Ms Rudolph agreed that the role of the health services in prison was to use their best endeavours, subject to any difficulties such as shortage of resources, to provide the same level of care for prisoners as was available in the community. For the reasons just set out, in KS's case this ought to have involved long-term trauma-based therapy, treatment, which I regret to observe never took place either in the community or in prison.

379. It was suggested that it would have been clinically inappropriate to start complex trauma work in prison if there was less than 3 months left of the immediate custodial term, since the individual would be left in a vulnerable position on release. In my view this contention exposes a lack of coherence in the provision of the relevant mental health services, certainly at the time of these events, for those who tended to move between custody and the community. There are many individuals whose mental disorders (*e.g.* PTSD or personality disorders) is either the cause of, or contributes to, repeat offending and serial prison sentences. On the basis of the approach taken in the present case they would have had a reduced – indeed, possibly, no – chance of receiving the psychological intervention they needed to break this cycle of criminality and imprisonment because of a lack of consistent treatment inside and outside of prison. There should have been at least the possibility of therapy beginning and then continuing after release or following imprisonment. This was particularly the case for those who posed a significant risk to the public and in relation to whom this threat could realistically have been addressed by long-term therapy.

380. As set out extensively above, because of the preconditions for commencing the work, BHFT CMHT and MPFT (who were commissioned to provide the relevant prison mental health care) never offered appropriate psychological therapy to KS.

Were these deaths avoidable?

381. It is my view, without relying on the potentially distorting view of hindsight, that these three deaths were avoidable, for two principal reasons.

382. **First**, the consistent evidence is that for someone with the disorders from which KS suffered, long-term psychological therapy provided a real prospect of achieving stability and an opportunity to break the cycle of self-harm and inflicting harm on others. BHFT and MPFT failed in this regard. To reiterate, BHFT placed KS in an inescapable Catch-22 dilemma because the treatment programmes for both PTSD and Personality Disorder had pre-conditions for the commencement of treatment that included a lengthy period of stability (free of significant substance abuse), whilst simultaneously they failed to provide the staged approach with initial support through care co-ordination repeatedly advocated by Dr Ahmad to help achieve that stability. As to the latter, I accept he should have been assisted in attempting to achieve the necessary stability, including as regards drugs and alcohol. This assistance should have extended significantly beyond simply "*signposting*" KS to other services, such as IRIS. As already rehearsed at [89], under the "*personality disorder pathway*", CMHT had

a team within the psychology department, run by experienced psychotherapists and psychologists, who were able to provide different levels of psychological intervention. I accept that BHFT had limited funds but given the deteriorating and significant risks posed by KS, the first priority for CMHT should have been initial psychological support and symptom management. Professor Blackwood referred to a "*holding community team*", which would ensure he obtained treatment for substance abuse and received appropriate medication as part of an inter-agency approach. Once KS had achieved better control over his emotions as a result of their intervention, then treatment could have commenced for his PTSD symptomology and EUPD. I note that KS was refused entry into services which might have helped in this regard, such as IAPT services (talking therapies) and BTSS because of his instability. In the event, no realistic options were offered to him, although Dr Bonner agreed that the psychiatric services should have worked alongside the other agencies to try to achieve stability for KS during the periods when he was keen to cooperate.

383. These difficulties were compounded by KS's inability to access secondary medical services prior to obtaining his biometric card (this was not the fault of BHFT). Furthermore, BHFT tended, wrongly in my view, to characterise KS as simply having "*multiple social care issues which (were) the stressors in his life*", which fell outside the remit of their services. As Professor Blackwood testified, KS had significant psychiatric difficulties that were addressable with treatment and that would have best been handled within a community mental health team who would have been able to do "*useful work*" with KS. I prefer the Professor's evidence to that of Dr Bonner's on this issue when she maintained that it was unlikely that KS would have engaged with BHFT's services. I accept that KS was inconsistent and difficult, but on many occasions he expressed a willingness to cooperate and engage, and he had sometimes participated consistently when services were offered to him. Indeed, Dr Bonner agreed there were periods when he was "*very much engaged*". Professor Blackwood also observed that KS's significantly increased risk of violent recidivism, with his pattern of offending becoming more serious, should have prompted a forensic psychiatric assessment.

384. MPFT never provided therapy, despite having indicated that this would commence shortly after 6 December 2016. He was incorrectly described as having expressed a lack of interest in these services (apart from the single occasion on 22 February 2017 when it was accepted that he was legitimately focussing on his release and multiple court appearances). The evidence indicates that generally KS remained keen to commence long-term therapy but he was labelled incorrectly as someone who was uninterested in treatment. Furthermore, the waiting list was extremely lengthy, thereby greatly reducing

his chance of receiving meaningful assistance in this regard whilst in prison. Moreover, on a return to prison he was at risk of having to re-commence the process of applying to join the psychologist's waiting list.

385. Finally in this context, as I have already indicated, there was a failure to provide a "*joined-up*" approach between BHFT and MPFT for someone in KS's position who was not handled by the In-Reach Team: as he moved between the community and prison, the tendency was for his case simply to be closed by whichever service he was leaving, and no (or insufficient) steps were taken to enable him to commence long-term therapy under one regime and thereafter to continue it in the other. Mr Gill candidly accepted BHFT did not have the resources to put a plan in place for individuals such as KS, in order to address the repeated crises that occurred once he had been released from prison. Instead, a reference needed to be made to the CPE. This is in stark contrast to those with severe mental illnesses (such as schizophrenia or bipolar affective disorder) for whom significant steps are taken to ensure they are reintegrated with community mental health teams on discharge. On the MPFT side, having lost his place on the waiting list for psychological therapy in February 2019, KS was not open to the Secondary Mental Health team at HMP Bullingdon, which contributed to a failure by MPFT proactively to handover of KS's mental healthcare on release from prison. Ms Rixon from probation was left to try to secure appropriate care for his mental health needs when he was released on 5 June 2020, albeit because KS was not on CMHT's caseload, BHFT refused to consider his position until the day of his release and, thereafter, between 5 and 18 June 2020, BHFT provided no meaningful assistance (that is until the Crisis Team attempted to provide prompt and positive assistance on 19/20 June 2020). It follows that for reasons that were self-evidently not in any sense Ms Rixon's fault, she failed in her endeavour to obtain assistance for this man with significant psychiatric difficulties who posed a risk of serious violence.

386. In my view, therefore, it is at least possible that the failure to provide long-term therapy, at least from 2016, meant that KS failed to achieve the level of stability that would have avoided him "*finally (settling) on jihad as the solution to his turmoil*". Indeed, consistent case-management and long-term therapy provided a real potential to reduce his aggressivity, impulsivity and substance abuse, along with his offending, between 2015 and 2019, albeit the impact on his extremist beliefs is more difficult to determine. Although I unreservedly accept that the severity of the events in Forbury Gardens on 20 June 2020 could not have been predicted, as Professor Blackwood observed it should have been anticipated that 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. I consider it at least possible that this risk could have been avoided.

387. **Second**, in my view a number of significant failings in intelligence-sharing coincided with the result that KS was not immediately recalled to prison when he should have been. As I have set out above, KS had repeatedly, albeit sometimes inconsistently, indicated he had a terrorist "*mindset*" along with a capacity to kill. He was rendered additionally dangerous by his serious psychiatric problems. At least adequate details of this background information, together with informed appraisals of the extent of the very high risk that he posed, should have been shared, *inter alia*, with probation and the police, in a form that was readily available to the police Control Room and the probation offender manager. If it had been, I have no doubt on the evidence that immediate steps would have been taken to recall KS to prison. It would be wholly wrong, however, to blame, for instance, Inspector Rowe and Ms Rixon for this failure: they were deprived of the core elements of the intelligence picture which revealed the extent of the risk he posed, information that would have prompted his immediate recall. Even though Inspector Rowe sensibly contacted CTPSE at 16.41 to obtain further information on KS, nothing of relevance was forthcoming.

388. It follows that I consider that these murders were probably avoidable. If the relevant information on KS had been shared and had been made available to Inspector Rowe and Ms Rixon after 14.44, KS would have been returned to custody on the night of 19 June 2020. I have grave concerns, in the present context, as to the efficacy of the systems, as they existed in 2020, for sharing information and making it readily available to key operational decision makers. This will form part of my PFD recommendations.

389. Furthermore, if the relevant background material relating to KS had been shared appropriately and he had been designated as "*very high risk*", he would have been accepted into Approved Premises, potentially sleeping in the lounge, which, given the structure of the regime and the consequent CCTV monitoring, could have changed the outcome of this case. As it was, KS whilst unsupervised on 19 and 20 June was able to plan for and carry out this attack.

390. In summary, therefore, the deaths would probably have been avoided if, first, the mental health services had given greater priority to stabilising KS and securing access to long term psychological therapy. Had they done so it is at least possible that the attack would have been prevented by the reduction of KS's aggressivity, impulsivity, substance abuse and extremism, although the effect on extremism is more difficult to determine. Second, if his extremist risk

had been better analysed, KS would probably then have been recalled to custody on 19 June 2020 meaning these attacks would never have happened.

Next Steps

391. It is against this background that I will be sending letters to various bodies addressing the need to consider taking steps to prevent future deaths. I have highlighted the relevant areas during the course of these Factual Findings. I hope that this final aspect of these Inquests will be completed within the next three weeks.